Date _____
Eff. Date _____
Can. Date _____
Div. Code _____

**Return Original Of This Form To:**
CoreSource, Inc.
PO Box 2821
Clinton, IA 52733-2821

# ATTENDING DENTIST'S STATEMENT

## PART I — TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE: Self ☐ Spouse ☐ Child ☐ Other ☐
3. SEX: M ☐ F ☐
4. PATIENT BIRTH DATE: Mo. Day Year
5. IF FULL TIME STUDENT: School City
6. EMPLOYEE/MEMBER/SUBSCRIBER NAME (FIRST, MIDDLE, LAST)
7. EMPLOYEE SOCIAL SECURITY NO.
EMPLOYEE BIRTH DATE: Mo. Day Year
8. EMPLOYEE MAILING ADDRESS
CITY, STATE, ZIP
9.
10. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION
11. IS SPOUSE COVERED WITH CoreSource, Inc.?
12. IF SO WHAT IS GROUP ACCT. NO.?
13. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED? ☐Yes ☐No
If yes, Member's Name
SOC. SEC. NO.
14. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 13
SPOUSE BIRTH DATE: Mo. Day Year
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐Yes ☐No If yes, indicate
DENTAL PLAN NAME
UNION LOCAL
GROUP NO.
NAME AND ADDRESS OF CARRIER

**AUTHORIZATION TO RELEASE INFORMATION** — I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.
SIGNED (PATIENT OR PARENT IF MINOR) | DATE

AUTHORIZATION TO PAY BENEFITS TO DENTIST — I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.
SIGNED (EMPLOYEE) | DATE

**CERTIFICATION** — I certify that the foregoing information is true and correct.
SIGNED (PATIENT OR PARENT IF MINOR) | DATE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

## PART II — TO BE COMPLETED BY ATTENDING DENTIST

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. DENTIST SOC. SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE ☐ HOSP ☐ ECF ☐ OTHER ☐
23. RADIOGRAPHS OR MODELS ENCLOSED? ☐ NO ☐ YES
HOW MANY?
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO ☐ YES ☐
25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO ☐ YES ☐
26. OTHER ACCIDENT? NO ☐ YES ☐
IF YES, ENTER BRIEF DESCRIPTION AND DATES
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? NO ☐ YES ☐
IF YES, NAME OF OTHER PLAN:
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO ☐ YES ☐
(IF NO, REASON FOR REPLACEMENT)
29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS? NO ☐ YES ☐
IF SERVICES ALREADY COMMENCED, ENTER
DATE APPLIANCES PLACED
MOS. TREATMENT REMAINING

**CHECK ONE:**
☐ Dentist's Pre-treated Estimate (date) _____
☐ Statement of Actual Services

Indicate missing teeth with an "X"


31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USE CHARTING SYSTEM SHOWN

| TOOTH # OR LETTER | SURFACE (i.e., M, O, D, B, L, LA, I) | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO. | DATE SERVICE COMPLETED MO DAY YEAR | PROCEDURE NUMBER (See Reverse) | FEE |
|---|---|---|---|---|---|
| | | | | | |

32. Remarks for unusual services

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.
SIGNED (DENTIST) | DATE | TOTAL FEE CHARGED