SAS Institute Inc.
World Headquarters
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Cary, NC 27513 USA
www.sas.com

Please mail claims to:
UMR
P.O. Box 30541, Salt Lake City, UT, 84130-0541
Fax Claims To: (877) 266-6923

DENTAL CLAIM FORM

CHECK ONE: ❑ DENTIST'S PRE-TREATMENT ESTIMATE ❑ DENTIST'S STATEMENT OF ACTUAL SERVICES

1 – MEMBER / PATIENT

Employee's name (First, Middle, Last)	Employee's Social Security #	Group # 76-420208
Present Address—Street	City	State Zip Code
Patient's name (First, Middle, Last)	**Patient's relationship to Employee** ❑ Self ❑ Spouse ❑ Child ❑ Handicapped dependent ❑ Self	**Sex** ❑ M ❑ F / **Birth Date** __/__/__

2 – OTHER INSURANCE

DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ❑ **YES** ❑ **NO** **IF YES, COMPLETE SECTION 2.**

Policyholder's name (First, Middle, Last)	Birth Date ____/____/____	Policyholder's employment status ❑ Active ❑ Disabled ❑ COBRA ❑ Retired ❑ Effective date: __/__/__

Policyholder's relationship to member ❑ Self ❑ Spouse ❑ Child ❑ Other	Other insurance carrier's name	Identification #	Effective Date ____/____/____

Contract covers: ❑ Policyholder only ❑ Policyholder and Spouse ❑ Policyholder and Child(ren) ❑ Family

3 – PATIENT'S CONDITION

a. **Attach physician statement (receipt or bill) which includes the diagnosis code, procedure codes, dates of service, place of service, charges, and physicians/supplier tax ID number and signature.**

b. Was this claim the result of an accident or injury? ❑ YES ❑ NO If yes, complete Question 3d

c. Accident or injury date ____/____/____ ❑ Work ❑ Auto ❑ School ❑ Other (Specify) ____________

d. Do you intend to file a claim against another individual, business, organization, or insurer for medical expenses arising from the accident or injury? ❑ YES ❑ NO Have you retained an attorney? ❑ YES ❑ NO

4 – DENTIST'S STATEMENT

DENTIST NAME	If Prosthesis, is this initial placement?	YES	NO	If YES, enter brief description and dates.
MAILING ADDRESS	Is treatment for Orthodontics?			
CITY, STATE, ZIP CODE				If NO, reason for replacement. Date of prior replacement:
DENTIST SOC. SEC. OR T.I.N	DENTIST LICENSE #	DENTIST PHONE #		If services already commenced enter Date appliances placed: MOS treatment remaining:

FIRST VISIT DATE CURRENT SERIES: PLACE OF TREATMENT: OFFICE HOSP ECF OTHER

RADIOGRAPHS OR MODELS ENCLOSED? ❑ YES ❑ NO HOW MANY?

EXAMINATION AND TREATMENT PLAN

TOOTH OR LETTER	SURFACE	DESCRIPTION OF SERVICE (including x-rays prophylaxis materials used, etc.) LINE #	DATE SERVICE PERFORMED MO	DAY	YR	PROCEDURE NUMBER	FEE

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) ➤ DATE

5 – AUTHORIZATION

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any Insurance Company, Prepayment Organization, Employer, Hospital, or Physician to release all information with respect to me or my dependents that may have a bearing on the benefits under this or any other plan providing benefits or services.

SIGNED (PATIENT, OR PARENT IF A MINOR) ➤ **DATE**

NOTICE—Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered a felony in some states.

6 – DIRECTION OF PAYMENT

REIMBURSEMENT TO BE PAID TO (CHECK ONE) ❑ **PLAN MEMBER** ❑ **PROVIDER OF SERVICE**

SIGNATURE REQUIRED (INSURED PERSON) ➤ **DATE**