BEST Life
BEST Life and Health Insurance Company

DENTAL CLAIM FORM

BEST LIFE and Health Insurance Company
PO. Box 890
Meridian, ID 83680-0890
800.433.0088 | Fax 208.893.5040

IMPORTANT
Predetermination is required for all treatment plans in excess of the amount listed in the insurance policy. Refer to the Certificate of Insurance for predetermination requirements.

ELECTRONIC PAYER ID NUMBER 95604

CHECK HERE IF THIS IS YOUR FIRST DENTAL CLAIM OR IF YOU HAVE MOVED SINCE YOUR LAST CLAIM ❑

EMPLOYEE COMPLETE

1 Patient's name	2 Relationship to employee	3 Patient's birthday	4 If full-time student – name of school?	5 Group number

6 Employee name First / Middle initial / Last	7 Employee social security number – –

8 Address	9 Employer	10 Occupation

11 City / State / Zip	12 Employee phone number ( )	13 Marital Status	14 Date employed / /

15 Is employee or spouse covered by another dental plan ❑ Yes ❑ No	16 Name and address of other insurance company	17 Spouse's date of birth / /

18 Name of spouse's employer	19 ID number	20 Group number	21 Spouse's social security number – –

22 If injured how and where did accident happen?	23 Did accident happen at work? ❑ Yes ❑ No	24 Date of accident / /

I hereby accept the treatment plan specified below and authorize my dentist to release any and all medical information including dental information to the above named administrator for purposes of claims administration and evaluation utilization, review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization.

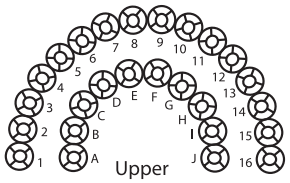
Patient's Signature (Unless a minor) ✗ _____ Date _____ Spouse's Signature (If other coverage) ✗ _____

DENTIST COMPLETE

26 Dentist name	27 Is treatment a result of accident or occupational injury?	No	Yes	If Yes, enter brief description
28 Address	29 Is treatment for orthodontic purposes?			
30 City / State / Zip	31 If prosthesis, or crown, is this initial placement?			If services already commenced, date appliance placed / /
32 Dentist license no / 33 Tax ID number / 34 Phone number ( )	35 Are missing teeth being replaced by prosthesis>			If no, reason for replacement, Date of prior placement / /
36 First visit date current series / 37 Are radiographs or models enclosed? No Yes How many?	38 Is patient covered by another dental plan?			Name of insurance company

PLEASE PLOT WORK
Identify missing teeth with "x"

FACIAL



FACIAL

Remarks for Unusual Services

Post treatment x-rays are required when submitting for payment if indicated below.

❑

IMPORTANT All treatment plans in excess of amount listed in the certificate of insurance requires pre-determination and submission of diagnostic x-rays.

For Administration Use only

39 Examination and treatment plan – List in tooth number order

Tooth No. or Letter	Surface (MO DO etc.)	Description of Service Only One Service Per Line	Date Service started Mo.	Day	Yr	ADA Procedure Number	Dentist Fee	Plan Allowable Amount

40 Work completed payment requested	I hereby certify that services listed have been performed and that the fees shown are the actual fees charged and do not exceed the fees charged my private and non-insured patient's. Dentist signature ✗ _____ Date _____	41 Total Fee	
		Plan Allowable	
		Deductible	
42 Assignment of benefits	I hereby authorize payment of benefits directly to the dentist named above but not to exceed the benefits otherwise payable to me under the plan. Patient's (parent) signature ✗ _____ Date _____	Plan %	
		Plan Pays	
		Annual Maximum	

It is further agreed that wherein the dental treatment provided under this plan does not conform to the standards of practice in the community. BEST LIFE and Health Insurance Company reserves the right to deny payment for such services or in the alternative seek reimbursement from the providing dentist.