SHEFFIELD, OLSON & McQUEEN, INC.

DENTAL CLAIM FORM

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Mail Claims To:

Sheffield, Olson & McQueen, Inc.
Claims Department
2145 Ford Parkway, Suite 300
St. Paul, MN 55116-1862

PATIENT COVERAGE INFORMATION

1. Patient Name (first, m.i., last)	2. Relationship to employee	3. sex (m / f)	4. Patient birthdate (MM DD YYYY)	5. If full time student (school, city)
	☐ self ☐ child ☐ spouse ☐ other ____			

6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate (MM DD YYYY)	9. Employer (company) name and address	10. Group number

11. Is patient covered by another dental plan? ☐ yes ☐ no If yes, complete 12-a. Is patient covered by a medical plan? ☐ yes ☐ no	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14-c. Employee/subscriber birthdate (MM DD YYYY)	15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other ____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Patient, or parent if minor) _____ Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Insured person) _____ Date _____

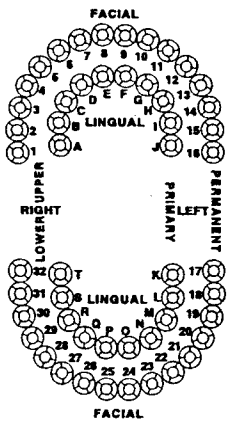
BILLING DENTIST

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.
17. Address where payment should be remitted	25. Is treatment result of auto accident?			
City, State, Zip	26. Other accident?			

18. Dentist Soc. Sec. or T.I.N.	19. Dentist license no.	20. Dentist phone no.	27. If prosthesis, is this initial placement?		(If no, reason for replacement)	28. Date of prior placement

21. First visit date current series	22. Place of treatment: Office / Hosp. / ECF. / Other	23. Radiographs or models enclosed? No / Yes / How many?	29. Is treatment for orthodontics?	If services already commenced enter:	Date appliances placed	Mos. treatment remaining

Identify missing teeth with "x"



30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee
					0.00

For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist) _____ License Number _____ Date _____

Total Fee Charged	
Max. Allowable	
Deductible	
Benefit %	
Plan pays	
Patient pays	