

Mail the completed form to: PO Box 6910, Canton, OH 44706
or email to ancillaryclaimsservices@aultcare.com

Dentist's Pre-Treatment Estimate Dentist's Statement of Actual Services

Place of Employment	Group Number
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PATIENT AND EMPLOYEE INFORMATION

PATIENT NAME				
First Name	Middle Initial	Last Name	Date of Birth	
Street		City	State	Zip Code
Phone Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

EMPLOYEE NAME				
First Name	Middle Initial	Last Name	Date of Birth	
Street		City	State	Zip Code
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				
Are you or any of your dependents employed elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, name of company			Phone Number	
Employee ID Number				

OTHER DENTAL COVERAGE			
Policyholder Name	Plan Name	Address	Policy Number

Was the condition related to any of these?
 Patient's employment Yes No
 Auto accident Yes No (If yes, please complete the information below based on the accident.)
 Date _____ Description _____
 Location _____

Is the patient a full-time student? Yes No (If yes, please complete the information below.)
 Name of School _____ City _____ Expected Date of Graduation _____

If eligible, is the person enrolled in:
 Federal Medicare Part A Yes No If yes, effective date for Part A _____
 Federal Medicare Part B Yes No If yes, effective date for Part B _____

Any person who, with intent to defraud or knowing they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I hereby certify that the above information is true and accurate to the best of my knowledge. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information with regard to this claim and the expenses reported.

Patient or Authorized Person Signature _____ Date _____

Authorization to Pay Benefits to Dentist: I hereby authorize payment directly to the undersigned provider of services, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

Employee Signature _____ Date _____

