DENTAL CLAIM FORM

luminare health℠

Please send to address on your identification card.

Employee Information (Completed by Employee)

Patient Name	Relationship	Sex	Birthdate	If Full Time Student, List School and City

Employee Name (First, Middle, Last)	Employee Member No	Insured Birthdate

Employee Address	Employer Name:

City, State	Zip	Group Number

Are other family members employed? Yes No If yes, Employee Name Soc. Sec. No. Birthdate Relationship to Patient	Name and Address of Employer for other family member

Is Patient Covered by another Dental Plan? Yes No If yes, Dental Plan Name Group No. Name and Address of Carrier

AUTHORIZATION TO RELEASE INFORMATION -- I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to FMH CoreSource for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR) _____ DATE _____

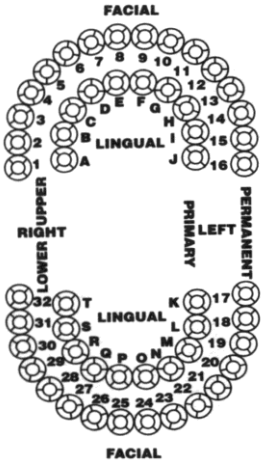
I hereby Authorize Payment Directly To The Below Named Dentist For Benefits Otherwise Payable To Me. (Employee sign and date)

Attending Dentist Information (Completed by Dentist)

Dentist name		Is treatment Result of Occupational Illness or Injury?	Yes	No	If yes, enter a description with dates
Dentist Mailing Address		Is treatment Result of Auto Accident? Other Accident?			
City, State	Zip	Are Any Services Covered By Another Plan?			
Dentist's Soc. Sec. No. or T.I.N.	Dentist License No.	If Prosthesis, Is This Initial Placement?			If No, Reason for Replacement
First Visit Date Current Services	Radiographs or Models enclosed? Yes No If yes, how many?	Is treatment for Orthodontics?			If Services Already Commenced, Enter: Date Placed Remaining Treatment Months

SELECT ONE DENTIST's PRE-TREATMENT ESTIMATE DENTISTS STATEMENT OF ACTUAL SERVICES

Mark missing teeth with X



EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH 32

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, ETC.)	DATE OF SERVICE	PROCEDURE NUMBER	FEE
				TOTAL	

DENTIST'S SIGNATURE _____ DATE _____