

Date _____
 Eff. Date _____
 Can. Date _____
 Div. Code _____

Return Original Of This Form To:
CoreSource, Inc.
P.O. Box 2821
Clinton, IA 52733-2821

ATTENDING DENTIST'S STATEMENT

PART I — TO BE COMPLETED BY THE EMPLOYEE

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. PATIENT BIRTH DATE Mo. Day Year	5. IF FULL TIME STUDENT School	City		
6. EMPLOYEE/MEMBER/SUBSCRIBER NAME (FIRST, MIDDLE, LAST)				7. EMPLOYEE SOCIAL SECURITY NO.		EMPLOYEE BIRTH DATE Mo. Day Year			
8. EMPLOYEE MAILING ADDRESS CITY, STATE, ZIP				9. [Hatched Box]				10. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION	
11. IS SPOUSE COVERED WITH CoreSource, Inc.?	12. IF SO, WHAT IS GROUP ACCT NO?	13. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED If yes, Member's Name		14. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 13		15. SPOUSE BIRTH DATE Mo. Day Year			
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? [] Yes [] No If yes, indicate		DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER				
AUTHORIZATION TO RELEASE INFORMATION — I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable					SIGNED (PATIENT OR PARENT, IF MINOR)		DATE		
AUTHORIZATION TO PAY BENEFITS TO DENTIST — I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.					SIGNED (EMPLOYEE)		DATE		
CERTIFICATION — I certify that the foregoing information is true and correct.					SIGNED (PATIENT OR PARENT, IF MINOR)		DATE		

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

PART II — TO BE COMPLETED BY ATTENDING DENTIST

16. DENTIST NAME		17. MAILING ADDRESS CITY, STATE, ZIP		18. DENTIST SOC SEC. OR HTIN	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.	21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE <input type="checkbox"/> HOSP <input type="checkbox"/> ECF <input type="checkbox"/> OTHER <input type="checkbox"/>	23. RADIOGRAPHS OR MODELS ENCLOSED? <input type="checkbox"/> NO <input type="checkbox"/> YES	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO <input type="checkbox"/> YES <input type="checkbox"/>	25. IS TREATMENT RESULT OF AUTO ACCIDENT? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>	26. OTHER ACCIDENT? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>	29. DATE OF PRIOR PLACEMENT
31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USE CHARTING SYSTEM SHOWN											IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED	MOS TREATMENT REMAINING			
CHECK ONE: <input type="checkbox"/> Dentist's Pre-treated Estimate (date) <input type="checkbox"/> Statement of Actual Services Indicate missing teeth with an "X"		TOOTH # OR LETTER	SURFACE (i.e. M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.				DATE SERVICE COMPLETED MO DAY YEAR	PROCEDURE NUMBER (See Reverse)	FEE					
32. Remarks for unusual services.		SIGNED (DENTIST)				DATE		TOTAL FEE CHARGED							
I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE															

INSTRUCTIONS

FOR THE EMPLOYEE

1. Please answer all questions in Part I entitled "TO BE COMPLETED BY EMPLOYEE".
2. Sign and Date the "Authorization to Release Information."
3. If you wish to have your benefits paid directly to the Dentist, sign and date the "Authorization to pay Benefits to Dentist".

If authorized, payment will be made directly to your Dentist. A copy of the payment will be sent to you for your records. Otherwise, payment will be made directly to you.
4. If the patient has coverage under any other group or Government plan, submit the same bills to the other plan at the same time.

FOR THE DENTIST

- For claims involving Predetermination of Benefits:
1. Complete the section "TO BE COMPLETED BY ATTENDING DENTIST". Be sure to itemize charges for each proposed procedure.
 2. CoreSource, Inc. will review the treatment plan and will provide the estimate of benefits payable.
 3. Review the form and benefit estimates with your patient before the work is done.
 4. When you complete treatment, return the form with the treatment dates completed and your signature.
- For claims not involving Predetermination of Benefits:
1. Complete Part II. Be sure to date and itemize charges.
 2. Sign and date bottom of claim form when work is completed.

PLEASE NOTE: IF THE CLAIM FORM IS NOT COMPLETED IN FULL AND SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING OF PAYMENT WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED

DENTAL PROCEDURE REFERENCE LIST

I. DIAGNOSTIC/GENERAL	III. Restorative (Con't)	VI. Prosthodontics-Remov. (Con't)	VII. PROSTHODONTICS-FIXED (Con't)
<p>Examinations</p> <p>0110 Initial Oral Examination 0120 Periodic Oral Examination</p> <p>Radiographs</p> <p>0210 Intraoral-complete series (including bitewing) 0220 Intraoral-single, first film 0230 Intraoral-each additional film 0272 Bitewing, two films 0274 Bitewing, four films 0300 Para-occlusal-mandibular and mandibular-single film</p>	<p>Crowns - Single Restorations Only</p> <p>2710 Plastic (acrylic) 2711 Plastic - prefabricated 2720 Plastic with gold 2721 Plastic with non-precious metal 2722 Plastic with semi-precious metal 2750 Porcelain with gold 2751 Porcelain with non-precious metal 2752 Plastic with semi-precious metal 2760 Gold (full cast) 2781 Non-precious metal - full cast 2782 Semi-precious metal - full cast 2810 Gold (3/4 cast) 2830 Stainless steel 2891 Post and core 2892 Steel Post and composite or amalgam (in addition to above per tooth)</p> <p>Other Restorative Services</p> <p>2910 Recement inlays 2920 Recement crowns</p>	<p>Partial Dentures</p> <p>Acrylic Base</p> <p>5211 Upper without clasps 5212 Lower without clasps 5216 Upper with two chrome clasps, with rests 5218 Lower with two chrome clasps, with rests 5231 Lower with chrome lingual bar and two clasps, acrylic base 5241 Lower with chrome lingual bar and two clasps, cast base 5251 Upper with chrome palatal bar and two clasps, acrylic base 5281 Upper with chrome palatal bar and two clasps, cast base</p> <p>Adjustments to dentures (6 mos. after installation or by dentist other than dental providing appliances)</p> <p>5410 Complete denture 5421 Partial denture (upper) 5422 Partial denture (lower)</p> <p>Repair broken complete or partial denture</p> <p>5610 No teeth damaged 5620 Replace one broken tooth 5630 Replace additional teeth, each tooth 5640 Replace broken tooth on denture, no other repairs</p> <p>Adding teeth in partial to replace lost/retained tooth</p> <p>5690 Each tooth not involving clasp 6640 Each tooth involving clasp 6730 Raising upper or lower complete denture (office finish) 6740 Raising upper or lower partial denture (office finish) 6760 Raising upper or lower complete denture (laboratory) 6780 Raising upper or lower partial denture (laboratory)</p>	<p>5760 Gold (3/4 cast) 5790 Gold (full cast) 6791 Non-precious metal (full cast) 6792 Semi-precious metal (full cast)</p> <p>Other services</p> <p>8930 Recement Bridge</p>
<p style="text-align: center;">II. PREVENTIVE</p> <p>Dental Prophylaxis (including scaling & polishing)</p> <p>1110 Adults 1120 Children under 14</p> <p>Fluoride Treatments</p> <p>Topical application of sodium fluoride, four treatments 1210 Excluding prophylaxis</p> <p>Topical application of stannous fluoride, one treatment 1220 Excluding prophylaxis</p> <p>Space Maintainers</p> <p>1510 Fixed, unilateral type 1515 Fixed, bilateral type 1620 Removable, unilateral type 1625 Removable, bilateral type</p>	<p style="text-align: center;">IV. ENDODONTICS</p> <p>Pulpotomy (excluding restoration)</p> <p>3220 Therapeutic pulpotomy</p> <p>Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care, excludes restoration)</p> <p>3310 One Canal 3320 Two Canals 3330 Three Canals</p> <p>Periapical Services</p> <p>3410 Apicoectomy, performed as a separate surgical procedure</p>	<p style="text-align: center;">VII. PROSTHODONTICS-FIXED</p> <p>Fixed Bridges</p> <p>Bridge Pontics</p> <p>6210 Cast gold 6211 Cast-non-precious 6212 Cast-semi-precious 6240 Porcelain fused to gold 6241 Porcelain fused to non-precious metal 6242 Porcelain fused to semi-precious metal 6250 Plastic processed to gold 6251 Plastic processed to non-precious metal 6252 Plastic processed in semi-precious metal</p> <p>Abutments</p> <p>6520 Two surface gold inlay 6530 Three or more surface gold inlay 6540 Gold inlay, (inlaying cusps)</p>	<p style="text-align: center;">VIII. ORAL SURGERY</p> <p>(All procedures include local anesthesia and postoperative care)</p> <p>Simple extractions</p> <p>7110 Single tooth 7120 Each additional tooth</p> <p>Surgical extractions</p> <p>7210 Erupted tooth 7220 Soft tissue impaction 7230 Partial bony impaction 7240 Complete bony impaction 7291 Complete bony impaction presenting unusual difficulty and circumstances</p> <p>Alveoplasty (surgical preparation of ridge for dentures), per quadrant:</p> <p>7310 In conjunction with extractions 7320 Not in conjunction with extractions</p>
<p style="text-align: center;">III. RESTORATIVE</p> <p>Amalgam Restorations (deciduous teeth)</p> <p>2110 Amalgam-one surface 2120 Amalgam-two surfaces 2130 Amalgam-three surfaces</p> <p>Amalgam Restorations (permanent teeth)</p> <p>2140 Amalgam-one surface 2150 Amalgam-two surfaces 2160 Amalgam-three surfaces 2181 Amalgam-four surfaces</p> <p>Silicate Restorations</p> <p>2210 Silicate cement-per restoration</p> <p>Filled or Unfilled Resin Restorations</p> <p>2300 Composite resin-one surface 2311 Composite resin-two surfaces 2312 Composite resin-three surfaces 2335 Composite resin, involving incisal angle</p> <p>Gold Inlay Restorations</p> <p>2920 Inlay, gold two surfaces 2930 Inlay, gold three surfaces</p>	<p style="text-align: center;">V. PERIODONTICS</p> <p>Surgical Services</p> <p>4210 Gingivectomy or gingivoplasty, per quadrant 4260 Osseous surgery, per quadrant</p> <p>Adjunctive Services</p> <p>4330 Occlusal adjustment (limited; not involving restoration) 4331 Occlusal adjustment (complete; not involving restoration)</p> <p>4340 Root Planing, entire mouth 4341 Root Planing, per quadrant</p> <p>Miscellaneous Services</p> <p>4910 Periodontal prophylaxis (periodontal maintenance) procedures following active periodontal therapy</p>	<p style="text-align: center;">VI. PROSTHODONTICS-REMOVABLE</p> <p>Complete Dentures</p> <p>5110 Complete upper 5120 Complete lower 5130 Immediate upper 5140 Immediate lower</p>	<p style="text-align: center;">IX. ORTHODONTICS</p> <p>Comprehensive Full Banded Treatment (0021) (Preliminary Study, including cephalometric radiographs, wax-plate study and treatment plan) and final month of active treatment includes all active and retention appliances</p> <p>0090 Active treatment, per month after first month</p> <p>Other Orthodontic Treatment</p> <p>Appliance for Tooth Guidance</p> <p>0110 Removable 0120 Fixed or cemented</p> <p>Appliances to Control Harmful Habits</p> <p>0210 Removable 0220 Fixed or cemented</p>
			<p style="text-align: center;">X. ADJUNCTIVE SERVICES</p> <p>Emergency Treatment</p> <p>9110 Palliative (analgesic) treatment of dental pain, minor procedures 9220 General anesthesia</p>