Dental Claim Form

Cypress Ancillary Benefits

Mailing Address: Cypress Dental: Claims
PO Box 1998
Milwaukee WI 53201

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

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

6. Employee/subscriber name and mailing address	7. Employee/subscriber Soc. Sec. or ID 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? ☐ No ☐ Yes If yes, complete 12-a.	12-a. Name and Address of carrier(s)	12-b. Group No(s)	13. Name and address of employer(s)

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 to me directly to the below named dental entity.

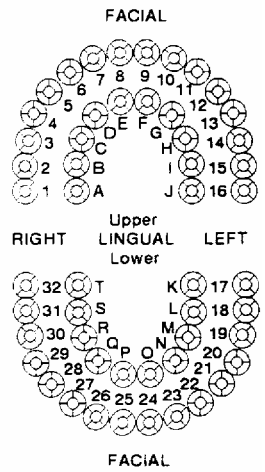
▶ _____ _____
Signed (Patient, or parent if minor) Date

16. Name of Billing Dentist or Dental Entity	17. Address where payment should be mailed	City, State, Zip	18. Dentist Soc. Sec. or TIN	19. Dentist License	20. Dentist Phone No.

21. First visit date current series	22. Place of Treatment ☐ Office ☐ ECF ☐ Hosp. ☐ Other	23. Radiographs or models enclosed? ☐ Yes ☐ No	How Many?

	No	Yes	If yes, enter brief description and date(s).	
24. Is treatment result of occupational illness or injury?				
25. Is treatment result of car or auto accident?				
26. Other accident?				
27. If prosthesis, is this initial placement?			If no, reason for replacement?	Date of Prior Placement?
28. Is treatment for orthodontics?				

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	Date Service performed	Procedure Number	Fee

For Admin use only

31. Remarks for unusual services

Total Fee Charged

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) Date