MedCost Benefit Services
d/b/a MBS Third Party Administrators in California
P.O. Box 25987
Winston-Salem, NC 27114-5987
(336) 774-4400 Fax (336) 774-4420
1-800-795-1023

MEDCOST® BENEFIT SERVICES

STATEMENT OF DENTAL CLAIM

GROUP #_____

EMPLOYEE SECTION

1. PATIENT'S NAME | RELATION TO EMPLOYEE: SELF ☐ CHILD ☐ SPOUSE ☐ OTHER ☐ | ☐ M ☐ F | PATIENT'S BIRTHDATE / / | IF FULL-TIME STUDENT: SCHOOL

2. EMPLOYEE NAME (LAST, FIRST, MI) | MEMBER ID | BIRTHDATE / /

3. EMPLOYEE'S ADDRESS (CHECK HERE IF NEW ADDRESS ☐) CITY STATE ZIP

4. IS SPOUSE OR PATIENT EMPLOYED? ☐ YES ☐ NO | NAME & ADDRESS OF EMPLOYER | MEMBER ID | SPOUSE'S BIRTHDATE / /

5. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO IF "YES", PLEASE GIVE:
CARRIER NAME _____ ADDRESS _____ PLAN NO. _____

6. I AUTHORIZE PAYMENT TO THE DENTIST NAMED BELOW OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME
SIGNATURE OF EMPLOYEE _____ DATE _____

7. I 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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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.

SIGNATURE OF EMPLOYEE | SIGNATURE OF PATIENT IF OTHER THAN MINOR CHILD | DATE

WOULD YOU LIKE THE BALANCE OF THIS CLAIM SUBMITTED TO YOUR FLEXIBLE BENEFIT PLAN FOR CONSIDERATION? YES ☐ NO ☐

EMPLOYEE SIGNATURE _____ DATE _____

DENTIST SECTION

1. SOCIAL SECURITY NO. OR TIN | LICENSE NO. | PHONE NO. | 2. DENTIST'S NAME & COMPLETE ADDRESS

3. FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT ☐OFFICE ☐HOSPITAL ☐ECF ☐OTHER | X-RAYS ENCLOSED? IF "YES", HOW MANY? ☐YES ☐NO

4. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? IF "YES", ENTER BRIEF DESCRIPTION AND DATES.
YES ☐ NO ☐

5. IS TREATMENT A RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?
YES ☐ NO ☐ YES ☐ NO ☐

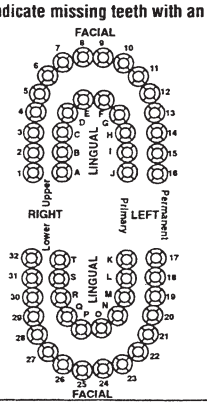
6. ARE SERVICES COVERED BY ANOTHER PLAN? IF "YES", GIVE NAME OF PLAN.
YES ☐ NO ☐

7. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF "NO", GIVE REASON FOR REPLACEMENT. GIVE DATE OF PRIOR PLACEMENT.
YES ☐ NO ☐

8. IS TREATMENT FOR ORTHODONTICS? IF "YES", AND SERVICES ALREADY COMMENCED, GIVE DATE APPLIANCES PLACED. GIVE MONTHS OF TREATMENT REMAINING.
YES ☐ NO ☐

9. EXAMINATION AND TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 AND USE THE CHARTING SYSTEM SHOWN.
CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE (DATE) _____ ☐ STATEMENT OF ACTUAL SERVICES

10. **Indicate missing teeth with an "x"**



Tooth No. or letter	Surface (M, O, D, B, L, LA, I)	Description of service (including xrays, prophylaxis, material used, etc.	Date service completed Mo. Day. Yr.	Procedure Number	Fee

10. REMARKS FOR UNUSUAL SERVICE

I CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.

Dentist's signature _____ Date _____

Total Fee