

Date \_\_\_\_\_  
 Eff. Date \_\_\_\_\_  
 Can. Date \_\_\_\_\_  
 Div. Code \_\_\_\_\_

Return Original Of This Form To:  
**CoreSource, Inc.**  
 P.O. Box 279  
 Sheldon, IA 51201-0279

**ATTENDING DENTIST'S STATEMENT**

PART I — TO BE COMPLETED BY EMPLOYEE

|   |  |  |  |   |   |                 |   |   |   |  |   |  |
|---|--|--|--|---|---|-----------------|---|---|---|--|---|--|
| 1. PATIENT NAME   |  | 2. RELATIONSHIP TO EMPLOYEE<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> |  | 3. SEX<br>M <input type="checkbox"/> F <input type="checkbox"/>                                   | 4. PATIENT BIRTH DATE<br>Mo. _____ Day _____ Year _____ |                 | 5. IF FULL TIME STUDENT<br>School _____ City _____    |   |   |  |   |  |
| 6. EMPLOYEE/MEMBER/SUBSCRIBER NAME (FIRST, MIDDLE, LAST)  |  |  |  |   | 7. EMPLOYEE SOCIAL SECURITY NO.                         |                 | EMPLOYEE BIRTH DATE<br>Mo. _____ Day _____ Year _____ |   |   |  |   |  |
| 8. EMPLOYEE MAILING ADDRESS<br>_____<br>CITY, STATE, ZIP _____  |  |  |  |   | 9.  |                 |   |   | 10. COMPANY (EMPLOYER) NAME AND ADDRESS AND / OR DIVISION AND PLANT LOCATION<br>_____<br>_____  |  |   |  |
| 11. IS SPOUSE COVERED WITH CoreSource, Inc.?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 12. IF SO WHAT IS GROUP ACCT. NO.?   |  | 13. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED?<br>If yes, Member's Name _____ SOC. SEC. NO. _____ |   |                 |   |   | 14. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 13<br>_____<br>_____ |  | SPOUSE BIRTH DATE<br>Mo. _____ Day _____ Year _____ |  |
| 15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate _____   |  | DENTAL PLAN NAME _____   |  | UNION LOCAL _____   |   | GROUP NO. _____ |   | NAME AND ADDRESS OF CARRIER<br>_____<br>_____ |   |  |   |  |
| 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 FRAUD 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  |  | 24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?  |                                      | NO <input type="checkbox"/> YES <input type="checkbox"/>  |  | IF YES, ENTER BRIEF DESCRIPTION AND DATES  |     |                     |
| 17. MAILING ADDRESS<br>_____<br>CITY, STATE, ZIP _____  |  | 25. IS TREATMENT RESULT OF AUTO ACCIDENT?   |                                      | NO <input type="checkbox"/> YES <input type="checkbox"/>  |  |  |     |                     |
| 18. DENTIST SOC. SEC. OR T.J.N.   |  | 19. DENTIST LICENSE NO.   |                                      | 20. DENTIST PHONE NO.   |  |  |     | 26. OTHER ACCIDENT? |
| 21. FIRST VISIT DATE CURRENT SERIES   |  | 22. PLACE OF TREATMENT<br>OFFICE <input type="checkbox"/> HOSP <input type="checkbox"/> ECF <input type="checkbox"/> OTHER <input type="checkbox"/> |                                      | 23. RADIOGRAPHS OR MODELS ENCLOSED?<br><input type="checkbox"/> NO <input type="checkbox"/> YES |  | 27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?<br>IF YES, NAME OF OTHER PLAN: _____ |     |                     |
| 28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?   |  | 28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?   |                                      | 28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?   |  | 28. DATE OF PRIOR PLACEMENT  |     |                     |
| 29. IF SERVICES ALREADY COMMENCED, ENTER  |  | DATE APPLIANCES PLACED  |                                      | MOS. TREATMENT REMAINING  |  |  |     |                     |
| CHECK ONE:<br><input type="checkbox"/> Dentist's Pre-treated Estimate (date) _____<br><input type="checkbox"/> Statement of Actual Services |  | 31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USE CHARTING SYSTEM SHOWN                                |                                      |   |  |  |     |                     |
|   |  | TOOTH # OR LETTER   | SURFACE (I.e. M.O., D.B., L.L.A., I) | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)<br>LINE NO.        | DATE SERVICE COMPLETED<br>MO. _____ DAY _____ YEAR _____ | PROCEDURE NUMBER (See Reverse)   | FEE |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
|   |  |   |                                      |   |  |  |     |                     |
| 32. Remarks for unusual services  |  |   |                                      |   |  |  |     |                     |

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.

SIGNED (DENTIST) \_\_\_\_\_ DATE \_\_\_\_\_

TOTAL FEE CHARGED \_\_\_\_\_

# INSTRUCTIONS

## FOR THE EMPLOYEE

## FOR THE DENTIST

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 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><b>Examinations</b></p> <p>0110 Initial Oral Examination<br/>0120 Periodic Oral Examination</p> <p><b>Radiographs</b></p> <p>0210 Intraoral-complete series (including bitewings)<br/>0220 Intraoral-single, first film<br/>0230 Intraoral-each additional film<br/>0272 Bitewing, two films<br/>0274 Bitewing, four films<br/>0330 Panoramic-maxillary and mandibular-single film</p>  | <p><b>III./Restorative (Con't)</b></p> <p><b>Crowns-Single Restorations Only</b></p> <p>2710 Plastic (acrylic)<br/>2711 Plastic-prefabricated<br/>2720 Plastic with gold<br/>2721 Plastic with non-precious metal<br/>2722 Plastic with semi-precious metal<br/>2750 Porcelain with gold<br/>2751 Porcelain with non-precious metal<br/>2752 Porcelain with semi-precious metal<br/>2790 Gold (full cast)<br/>2791 Non-precious metal - full cast<br/>2792 Semi-precious metal - full cast<br/>2810 Gold (½ cast)<br/>2830 Stainless steel<br/>2891 Post and core in addition<br/>2892 Steel post and to above-composite or per tooth amalgam</p> <p><b>Other Restorative Services</b></p> <p>2910 Recement inlays<br/>2920 Recement crowns</p> | <p><b>VI. Prosthodontics-Remov. (Con't)</b></p> <p><b>Partial Dentures</b></p> <p><b>Acrylic Base</b></p> <p>5211 Upper without clasps<br/>5212 Lower without clasps<br/>5216 Upper with two chrome clasps, with rests<br/>5218 Lower with two chrome clasps, with rests<br/>5231 Lower with chrome lingual bar and two clasps, acrylic base<br/>5241 Lower with chrome lingual bar and two clasps, cast base<br/>5251 Upper with chrome palatal bar and two clasps, acrylic base<br/>5261 Upper with chrome palatal bar and two clasps, cast base</p> <p><b>Adjustments to dentures (6 mos. after installation or by dentist other than dentist providing appliances)</b></p> <p>6410 Complete denture<br/>6421 Partial denture (upper)<br/>6422 Partial denture (lower)</p> <p><b>Repair broken complete or partial denture</b></p> <p>6510 No teeth damaged<br/>6520 Replace one broken tooth<br/>6530 Replace additional teeth, each tooth<br/>6540 Replace broken tooth on denture, no other repairs</p> <p><b>Adding teeth to partial to replace extracted tooth:</b></p> <p>6550 Each tooth not involving clasp<br/>6560 Each tooth involving clasp<br/>6730 Relining upper or lower complete denture (office reline)<br/>6740 Relining upper or lower partial denture (office reline)<br/>6750 Relining upper or lower complete denture (laboratory)<br/>6760 Relining upper or lower partial denture (laboratory)</p> | <p><b>VII. Prosthodontics-Fixed (Con't)</b></p> <p>6780 Gold (½ cast)<br/>6790 Gold (full cast)<br/>6791 Non-precious metal (full cast)<br/>6792 Semi-precious metal (full cast)</p> <p><b>Other services</b></p> <p>6930 Recement bridge</p>  |
| <p><b>II. PREVENTIVE</b></p> <p><b>Dental Prophylaxis (including scaling &amp; polishing)</b></p> <p>1110 Adults<br/>1120 Children under 14</p> <p><b>Fluoride Treatments</b></p> <p>1210 Topical application of sodium fluoride, four treatments<br/>1210 Excluding prophylaxis</p> <p>1220 Topical application of stannous fluoride, one treatment:<br/>1220 Excluding prophylaxis</p> <p><b>Space Maintainers</b></p> <p>1510 Fixed, unilateral type<br/>1515 Fixed, bilateral type<br/>1520 Removable, unilateral type<br/>1525 Removable, bilateral type</p>  | <p><b>IV. ENDODONTICS</b></p> <p><b>Pulpotomy (excluding restoration)</b></p> <p>3220 Therapeutic pulpotomy</p> <p><b>Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes restoration)</b></p> <p>3310 One canal<br/>3320 Two canals<br/>3330 Three canals</p> <p><b>Periapical Services</b></p> <p>3410 Apicoectomy, performed as a separate surgical procedure</p>   | <p><b>VII. PROSTHODONTICS-FIXED</b></p> <p><b>Fixed Bridges</b></p> <p><b>Bridge Pontics</b></p> <p>6210 Cast gold<br/>6211 Cast-non-precious<br/>6212 Cast-semi-precious<br/>6240 Porcelain fused to gold<br/>6241 Porcelain fused to non-precious metal<br/>6242 Porcelain fused to semi-precious metal<br/>6250 Plastic processed to gold<br/>6251 Plastic processed to non-precious metal<br/>6252 Plastic processed to semi-precious metal</p> <p><b>Abutments</b></p> <p>6520 Two surface gold inlay<br/>6530 Three or more surface gold inlay<br/>6540 Gold inlay, (overlaying cusps)</p> <p><b>Crowns</b></p> <p>6710 Plastic (acrylic)<br/>6720 Plastic processed to gold<br/>6721 Plastic processed to non-precious metal<br/>6722 Plastic processed to semi-precious metal<br/>6750 Porcelain fused to gold<br/>6751 Porcelain fused to non-precious metal<br/>6752 Porcelain fused to semi-precious metal</p>  | <p><b>VIII. ORAL SURGERY</b></p> <p>(All procedures include local anesthesia and postoperative care)</p> <p><b>Simple extractions</b></p> <p>7110 Single tooth<br/>7120 Each additional tooth</p> <p><b>Surgical Extractions</b></p> <p>7210 Erupted tooth<br/>7220 Soft tissue impaction<br/>7230 Partial bony impaction<br/>7240 Complete bony impaction<br/>7241 Complete bony impaction presenting unusual difficulty and circumstances</p> <p><b>Alveoplasty (surgical preparation of ridge for dentures), per quadrant:</b></p> <p>7310 In conjunction with extractions<br/>7320 Not in conjunction with extractions</p> |
| <p><b>III./RESTORATIVE</b></p> <p><b>Amalgam Restorations (deciduous teeth)</b></p> <p>2110 Amalgam-one surface<br/>2120 Amalgam-two surfaces<br/>2130 Amalgam-three surfaces</p> <p><b>Amalgam Restorations (permanent teeth)</b></p> <p>2140 Amalgam-one surface<br/>2150 Amalgam-two surfaces<br/>2180 Amalgam-three surfaces<br/>2181 Amalgam-four surfaces</p> <p><b>Silicate Restorations</b></p> <p>2210 Silicate cement-per restoration</p> <p><b>Filled or Unfilled Resin Restorations</b></p> <p>2320 Composite resin-one surface<br/>2331 Composite resin-two surfaces<br/>2332 Composite resin-three surfaces<br/>2335 Composite resin, involving incisal angle</p> <p><b>Gold Inlay Restorations</b></p> <p>2520 Inlay, gold-two surfaces<br/>2530 Inlay, gold-three surfaces</p> | <p><b>V. PERIODONTICS</b></p> <p><b>Surgical Services</b></p> <p>4210 Gingivectomy or gingivoplasty, per quadrant<br/>4260 Osseous surgery, per quadrant</p> <p><b>Adjunctive Services</b></p> <p>4330 Occlusal adjustment (limited; not involving restoration)<br/>4331 Occlusal adjustment (complete; not involving restoration)<br/>4340 Root Planing, entire mouth<br/>4341 Root Planing, per quadrant</p> <p><b>Miscellaneous Services</b></p> <p>4910 Periodontal prophylaxis (periodontal maintenance procedures following active periodontal therapy)</p>   | <p><b>VI. PROSTHODONTICS-REMOVABLE</b></p> <p><b>Complete Dentures</b></p> <p>5110 Complete upper<br/>5120 Complete lower<br/>5130 Immediate upper<br/>5140 Immediate lower</p>  | <p><b>IX. ORTHODONTICS</b></p> <p><b>Comprehensive Full Banded Treatment</b></p> <p>8020 Preliminary Study (including cephalometric radiographs, diagnostic casts and treatment plan) and first month of active treatment including all active and retention appliances<br/>8030 Active treatment, per month after first month</p> <p><b>Other Orthodontic Treatment</b></p> <p><b>Appliances for Tooth Guidance</b></p> <p>8110 Removable<br/>8120 Fixed or cemented</p> <p><b>Appliances to Control Harmful Habits</b></p> <p>8210 Removable<br/>8220 Fixed or cemented</p>  |
|  |   |  | <p><b>X. ADJUNCTIVE SERVICES</b></p> <p><b>Emergency Treatment</b></p> <p>9110 Palliative (emergency) treatment of dental pain, minor procedures<br/>9220 General anesthesia</p>   |