PAI
Planned Administrators Incorporated

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Claim for Dental Expense Benefits

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF / SPOUSE / CHILD / OTHER	3. SEX M / F	4. PATIENT BIRTHDATE MO / DAY / YEAR	5. IF FULL TIME STUDENT SCHOOL / CITY

6. EMPLOYEE NAME First / Middle / Last	7. EMPLOYEE SOC. SEC. NO.	SPOUSE'S NAME	SPOUSE'S BIRTHDATE Mo. / Day / Yr.

8. EMPLOYEE MAILING ADDRESS	10. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY, STATE, ZIP	

11. GROUP NO.	13. ARE OTHER FAMILY MEMBERS EMPLOYED? YES NO Employee Name / Birthdate Mo. / Da. / Yr. / Soc. Sec. No.	14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.

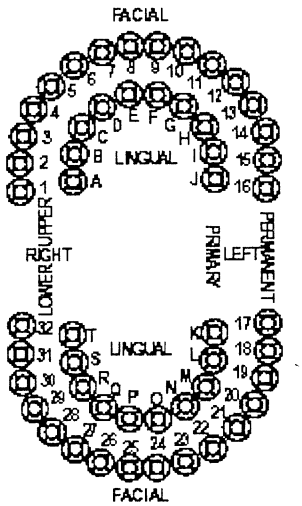
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	GROUP NO.	NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	I HEREBY CERTIFY TO THE ABOVE STATEMENTS.	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME. THIS AUTHORIZATION IS INVALID UNLESS THE TAX I.D. OF THE PROVIDER IS GIVEN BELOW.
Signed (Patient or Parent if Minor) / Date	Employee Signature / Date	Employee Signature / Date

16. DENTIST NAME	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT? 26. OTHER ACCIDENT?			
CITY, STATE, ZIP	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
18. DENTIST SOC. SEC. OR EIN / 19. DENTIST LICENSE NO. / 20. DENTIST PHONE NO.	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) / 29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE CURRENT SERIES / 22. PLACE OF TREATMENT Office / Home / Hos. / Other	23. RADIOGRAPHS OR MODELS ENCLOSED? YES / NO / HOW MANY?			30. TREATMENT FOR ORTHODONTICS? IF SERVICES ALREADY COMMENCED. ENTER DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

DENTIST'S
- Pre-Treatment Estimate
- Statement of Actual Services

Identify missing teeth with "x"



32. REMARKS FOR UNUSUAL SERVICES

31. Examination and Treatment Plan—List in Order Tooth No. 1 through Tooth No. 32
Use Charting System Shown

Tooth # or letter	Surfaces	DESCRIPTION OF SERVICE (including X-Rays, Prophylaxis Materials Used, Etc.)	Date Service Performed Mo. / Da / Yr.	ADA Procedure Number	Fee	For Carrier Use Only

Total Fee Actually Charged

I hereby certify that the procedures as indicated by date have been completed.

Date_____

* Signed (Dentist)