



Administered by
Principal Life
Insurance Company
Des Moines, Iowa

Attending Dentist's Statement - CA
Check one:
 Dentist's pre-treatment estimate
 Dentist's statement of actual services

See Page 2 for Claim Filing Instructions.

Employee Statement

1. Patient name _____

2. Relationship to employee
self wife husband domestic partner son daughter stepchild foster child

3. M F | 4. Patient birth date _____ | 5. If full-time student School _____ City _____

6. Employee name (first, middle, last) _____

7. Employee social security number _____ Spouse's or domestic partner's social security number _____ 8. Plan and ID numbers (printed on employee's ID card)
Plan _____ I.D. _____

9. Employee/mailling address _____ Is this a new address?
yes no

City _____ State _____ ZIP _____ 10. Employer (company name and address) _____

City _____ State _____ ZIP _____

11. Is employee
single married domestic partner divorced widowed

12. Spouse's or domestic partner's name and birth date _____ 13. Is spouse or domestic partner employed?
yes no

14. If "yes", give name, address and telephone number of spouse's or domestic partner's employer _____

15. Is patient covered by another plan of benefits? If "yes", give name of person carrying the other coverage Dental plan name
Dental yes no **Medical** yes no _____

Group number _____ Name and address of carrier _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed (patient or parent if minor) _____ Date _____
I hereby authorize payment directly to the below-named dentist of the dental benefits otherwise payable to me.
Signed (employee) _____ Date _____

Attending Dentist's Statement

16. Dentist name _____

17. Mailing address _____

City _____ State _____ ZIP _____ 18. Dentist T.I.N. _____

19. Dentist license number/anesthesia license number _____ 20. Dentist phone number _____ 21. First visit date current series _____

22. Place of treatment office hosp. ECF other 23. Radiographs or models enclosed? How many?
 office hosp. ECF other no yes _____

24. Is treatment result of occupational illness or injury? If "yes", enter brief description and dates:
 no yes _____

25. Is treatment result of auto accident? If "yes", enter brief description and dates:
 no yes _____

26. Other accident? If "yes", enter brief description and dates:
 no yes _____

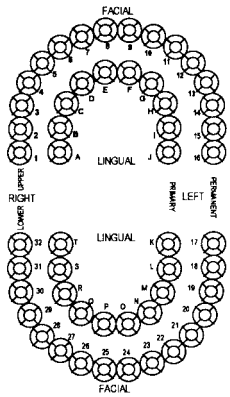
27. Are any services covered by another plan? If "yes", enter brief description:
 no yes _____

Attending Dentist's Statement (continued)

28. If prosthesis, is this first placement of any type? no yes If "no", reason for replacement _____ 29. Date of prior placement _____

30. Is treatment for orthodontics? no yes If services already commenced, enter date appliances placed _____ Mos. treatment remaining _____

Identify missing teeth with "X"



32. Remarks for unusual services _____

31. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32. - Use charting system shown.

Tooth number or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.) line number	Date service performed mo/day/year	Procedure number	Fee	FOR ADMINISTRATIVE USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				

* This is an **estimate only**, and does not guarantee payment. Actual payment will depend on the plan provisions in effect when the services are performed. This coverage is subject to coordination with other insurance.

By: _____ Date: _____

TOTAL FEE CHARGED _____

Covered charges _____

Less deductible _____

_____ @ _____ %

_____ @ _____ %

_____ @ _____ %

Total estimated benefits _____ *

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 (dentist) _____ Date _____

Use this form for both employee and dependent claims.

Statement of Employer

Employee's name _____ I.D. number _____ Division _____

Date employed _____ Employee's med plan _____ Effective date in plan _____

Is employee's coverage still in force? yes no If "no", give termination date. _____

Employer _____ Plan number _____

Date _____ Signature _____ Title _____

Instructions to the Employee

1. Complete questions 1 through 15 on Page 1. Have patient's dentist complete questions 16 through 32 on Page 1 & 2.
2. If you want benefits paid directly to the dentist, complete the Authorization to Pay on Page 1 following question 15.
3. If charges exceed \$200.00 or \$300.00 (or as specified in your benefit plan booklet), a treatment plan must be submitted prior to continuation of treatment.

Instructions to the Dentist

For charges less than amount specified in your benefit plan booklet.

1. Show the date the work was completed for each service and the corresponding fee.
2. Return this form to Principal Life Insurance Company (address printed on your ID card).

For charges exceeding amount specified in your benefit plan booklet.

1. Prior to the continuation of treatment, describe procedures necessary to fully complete the treatment plan. State your fees, enclose x-rays (these will be returned to you) and return the form to Principal Life (address printed on your ID card).
2. Principal Life will pre-determine the amount payable per procedure and return this form to you.
3. After the work is completed, enter the dates that the service was completed and return this form to Principal Life (address printed on your ID card).

Notice!!

The pre-determined benefits apply only to expenses incurred while employee's coverage is in force.

Pre-determination of dental services is intended to avoid any misunderstandings between the dentist, employee, and Principal Life. Patient waives advanced knowledge when not obtaining a pre-determination and is liable if the plan doesn't pay or partially pays for treatment.

Please mail completed form to the address printed on your ID card.

For Questions: Please refer to the toll free number printed on your ID card.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.