State Insurance Corporation

Redcliffe Street, P.O. Box 290, St. John's, Antigua, W.I.
Tel: (268) 481-7800/7804 Fax: (268) 481-7860 E-Mail: stateins@candw.ag

DENTAL CLAIM FORM

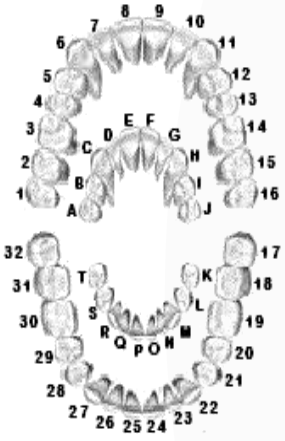
PART I: **TO BE COMPLETED BY DENTIST**

(Original receipts are required for all incurred expenses)

1. NAME OF PATIENT:				
2. Type of Treatment:			3. Name of referring doctor, if any:	
4. Is Treatment a result of Occupational Illness or Injury?	**Yes**	**No**	**If Yes, enter brief description and dates**	
5. Is Treatment a result of Auto Accident?				
6. Other Accident?				
7. Is Treatment for Orthodontics?				
8. If Prosthesis, is this initial placement?			**If No, reason for replacement**	Date of prior placement / /

Identify Mission Tooth with an "X"

FACIAL



EXAMINATION AND TREATMENT PLAN

9. List in order from Tooth #1 through Tooth #32 (Use charting system of primary or permanent teeth shown)

Date Service Performed	Tooth # or Letter	Description of Services (including x-rays, extractions, prophylaxis and examinations)	Procedure Number		Fees	State Insurance Corporation OFFICE USE ONLY	
						Total	
						Deduct	
					TOTAL	**Total Payable**	**$**

Signature of Dentist .....

Address .....Date .....

.....Telephone # ..... Dentist's Stamp

PART II: **TO BE COMPLETED BY INSURED** (***Claim form must be fully completed and signed in order to avoid delay in settlement***)

10. Name of Insured:	11. Name of Group Scheme:
12. Address:	13. Contact Number: Home Work
14. Name of covered Dependant (*if patient is a dependant*)	15. Gender: Male ☐ Female ☐
16. Date of Birth of Patient: D / M / Y/	17. Relationship to Insured: Self ☐ Spouse ☐ Son ☐ Daughter ☐
18. Is patient covered by any other dental plan? Yes ☐ No ☐ If Yes, give name and address of other Insurance Provider-	19. If #18 is (YES), Do you intend to make a claim with any other Insurance Provider? Yes ☐ No ☐

Signature of Insured ..... **Date** .....

I hereby request and authorize the attending dentist to disclose, whenever requested to do so, all information concerning my medical condition or treatment.

Signature of Patient .....

(If patient is a minor, insured signs on their behalf)

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