care@care
Insurance Company, Inc.

# DENTAL BENEFITS CLAIM FORM

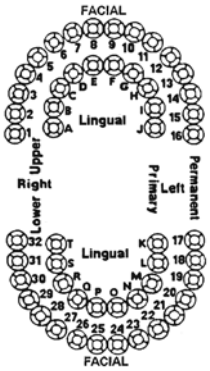
PLEASE BE AS THOROUGH AND ACCURATE AS POSSIBLE WHEN COMPLETING THIS FORM. ERRORS OR OMISSIONS MAY DELAY CLAIM PAYMENTS.

## TO BE COMPLETED BY THE MEMBER/PATIENT

| | | |
|---|---|---|
| 1. PATIENT'S NAME *(Last, First, Middle)* | | |
| 2. PATIENT'S BIRTH DATE | 3. PATIENT'S SEX<br>❑ MALE<br>❑ FEMALE | 4. PATIENT'S ID NUMBER |
| 5. MEMBER'S ADDRESS (No., Street, City, State and Zip Code) | | 6. CONTACT PHONE NUMBER |
| 18. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO FIRST CONTINENTAL LIFE AND ACCIDENT INSURANCE COMPANY (FCL DENTAL) ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION PROVIDED BY ME IN SUPPORT OF THIS CLAIM IS COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE ABOVE NAMED PATIENT. | | |

SIGNATURE OF MEMBER_____ DATE SIGNED _____

## TO BE COMPLETED BY THE DENTAL PROVIDER - EXAMINATION & TREATMENT PLAN (USE CHARTING SYSTEM BELOW)




INDICATE MISSING TEETH WITH AN "X"

| DATE SERVICE PERFORMED MONTH/DAY/YEAR | TOOTH # OR LETTER | SURFACE | DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) | ADA PROCEDURE CODE | FEE | FOR CARRIER USE ONLY |
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|---|---|
| PROVIDER'S NAME: | PROVIDER'S ADDRESS: |
| OFFICE PHONE NUMBER | PROVIDER'S TAX IDENTIFICATION NUMBER |
| PROVIDER'S NPI | PROVIDER'S ADDRESS: |

## PLEASE SUBMIT THIS FORM WITH YOUR ITEMIZED RECEIPT(S) OR SUPERBILL WITH A $0 BALANCE CONFIRMING CHARGES PAID IN FULL TO THE FOLLOWING

First Continental Life and Accident Insurance Company (FCL Dental)
Attention: Claims Department
101 Parklane Boulevard, Suite 301
Sugar Land, TX 77478

Should you have any questions or require further assistance, please call the FCL Dental toll free number at (833)492-9866.