**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**
   - ☐ MALE
   - ☐ 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)

<table>
<thead>
<tr>
<th>DATE SERVICE PERFORMED MONTH/DAY/YEAR</th>
<th>TOOTH # OR LETTER</th>
<th>SURFACE</th>
<th>DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)</th>
<th>ADA PROCEDURE CODE</th>
<th>FEE FOR CARRIER USE ONLY</th>
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**INDICATE MISING TEETH WITH AN “X”**

**PROVIDER’S NAME:**

**PROVIDER’S ADDRESS:**

**OFFICE PHONE NUMBER**

**PROVIDER’S TAX IDENTIFICATION NUMBER**

**PROVIDER’S NPI**

**PROVIDER’S ADDRESS:**

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**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.