Date_____
Eff. Date_____
Can. Date_____
Div. Code_____

Return Original Of This Form To:
CoreSource, Inc.
P.O. Box 2821
Clinton, IA 52733-2821

ATTENDING DENTIST'S STATEMENT

PART I — TO BE COMPLETED BY THE EMLOYEE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child ☐ Other
3. SEX ☐ M ☐ F
4. PATIENT BIRTH DATE Mo. Day Year
5. IF FULL TIME STUDENT School City
6. EMPLOYEE/MEMBER/SUBSCRIBER NAME (FIRST, MIDDLE, LAST)
7. EMPLOYEE SOCIAL SECURITY NO.
EMPLOYEE BIRTH DATE Mo. Day Year
8. EMPLOYEE MAILING ADDRESS
CITY, STATE, ZIP
9.
10. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION
11. IS SPOUSE COVERED WITH CoreSource, Inc.?
12. IF SO, WHAT IS GROUP ACCT. NO?
13. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED ☐ Yes ☐ No
If yes, Member's Name SOC. SEC. NO.
14. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 13
SPOUSE BIRTH DATE Mo. Day Year
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ Yes ☐ No If yes, indicate
DENTAL PLAN NAME UNION LOCAL GROUP NO. NAME AND ADDRESS OF CARRIER

AUTHORIZATION TO RELEASE INFORMATION — I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable
SIGNED (PATIENT OR PARENT, IF MINOR) DATE

AUTHORIZATION TO PAY BENEFITS TO DENTIST — I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.
SIGNED (EMPLOYEE) DATE

CERTIFICATION — I certify that the foregoing information is true and correct.
SIGNED (PATIENT OR PARENT, IF MINOR) DATE

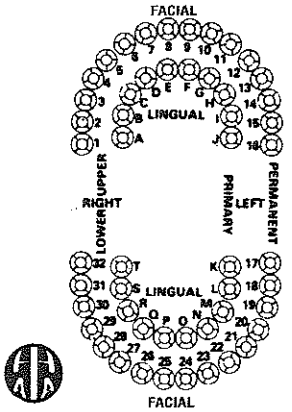
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRADULENT INSURANCE ACT WHICH IS A CRIME.

PART II — TO BE COMPLETED BY ATTENDING DENTIST

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

CHECK ONE:
☐ Dentist's Pre-treated Estimate (date) _____
☐ Statement of Actual Services

Indicate missing teeth with an "X"



31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO 32 — USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE (i.e. M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE COMPLETED MO DAY YEAR	PROCEDURE NUMBER (See Reverse)	FEE

32. Remarks for unusual services.

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTANCE OF INSURANCE COVERAGE
SIGNED (DENTIST) DATE TOTAL FEE CHARGED

INSTRUCTIONS

FOR THE EMPLOYEE

1. Please answer all questions in Part I entitled "TO BE COMPLETED BY EMPLOYEE".
2. Sign and Date the "Authorization to Release Information."
3. If you wish to have your benefits paid directly to the Dentist, sign and date the "Authorization to pay Benefits to Dentist".

   If authorized, payment will be made directly to your Dentist. A copy of the payment will be sent to you for your records. Otherwise, payment will be made directly to you.
4. If the patient has coverage under any other group or Government plan, submit the same bills to the other plan at the same time.

FOR THE DENTIST

For claims involving Predetermination of Benefits:

1. Complete the section "TO BE COMPLETED BY ATTENDING DENTIST". Be sure to itemize charges for each proposed procedure.
2. CoreSource, Inc. will review the treatment plan and will provide the estimate of benefits payable.
3. Review the form and benefit estimates with your patient before the work is done.
4. When you complete treatment, return the form with the treatment dates completed and your signature.

For claims not involving Predetermination of Benefits:

1. Complete Part II. Be sure to date and itemize charges.
2. Sign and date bottom of claim form when work is completed.

PLEASE NOTE: IF THE CLAIM FORM IS NOT COMPLETED IN FULL AND SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING OF PAYMENT WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED

DENTAL PROCEDURE REFERENCE LIST

I. DIAGNOSTIC/GENERAL

Examinations

0110 Initial Oral Examination
0120 Periodic Oral Examination

Radiographs

0210 Intraoral-complete series (including bitewings)
0220 Intraoral-single, first film
0230 Intraoral-each additional film
0272 Bitewing, two films
0274 Bitewing, four films
0330 Panoramic-maxillary and mandibular-single film

II. PREVENTIVE

Dental Prophylaxis (including scaling & polishing)

1110 Adults
1120 Children under 14

Fluoride Treatments

Topical application of sodium fluoride, four treatments
1210 Excluding prophylaxis

Topical application of stannous fluoride, one treatment
1220 Excluding prophylaxis

Space Maintainers

1510 Fixed, unilateral type
1515 Fixed, bilateral type
1520 Removable, unilateral type
1525 Removable, bilateral type

III. RESTORATIVE

Amalgam Restorations (deciduous teeth)

2110 Amalgam-one surface
2120 Amalgam-two surfaces
2130 Amalgam-three surfaces

Amalgam Restorations (permanent teeth)

2140 Amalgam-one surface
2150 Amalgam-two surfaces
2160 Amalgam-three surfaces
2161 Amalgam-four surfaces

Silicate Restorations

2210 Silicate cement-per restoration

Filled or Unfilled Resin Restorations

2330 Composite resin-one surface
2331 Composite resin-two surfaces
2332 Composite resin-three surfaces
2335 Composite resin, invoving incisal angle

Gold Inlay Restorations

2620 Inlay, gold-two surfaces
2630 Inlay, gold-three surfaces

III. Restorative (Con't)

Crowns - Single Restorations Only

2710 Plastic (acrylic)
2711 Plastic - prefabricated
2720 Plastic with gold
2721 Plastic with non-precious metal
2722 Plastic with semi-precious metal
2750 Porcelain with gold
2751 Porcelain with non-precious metal
2752 Plastic with semi-precious metal
2790 Gold (full cast)
2791 Non-precious metal - full cast
2792 Semi-precious metal - full cast
2810 Gold (3/4 cast)
2830 Stainless steel
2891 Post and core
2892 Steel Post and composite or amalgam
(In addition to above per tooth)

Other Restorative Services

2910 Recement inlays
2920 Recement crowns

IV. ENDODONTICS

Pulpotomy (excluding restoration)

3220 Therapeutic pulpotomy

Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes restoration)

3310 One Canal
3320 Two Canals
3330 Three Canals

Periapical Services

3410 Apicoectomy, performed as a separate surgical procedure

V. PERIODONTICS

Surgical Services

4210 Gingivectomy or gingivoplasty, per quadrant
4260 Osseous surgery, per quadrant

Adjunctive Services

4330 Occlusal adjustment (limited; not involving restoration)
4331 Occlusal adjustment (complete; not involving restoration)
4340 Root Planing, entire mouth
4341 Root Planing, per quadrant

Miscellaneous Services

4910 Periodontal prophylaxis (periodontal maintenance) procedures following active periodontal therapy)

VI. PROSTHODONTICS-REMOVABLE

Complete Dentures

5110 Complete upper
5120 Complete lower
5130 Immediate upper
5140 Immediate lower

VI. Prosthodontics-Remov. (Con't)

Partial Dentures

Acrylic Base

5211 Upper without clasps
5212 Lower without clasps
5216 Upper with two chrome clasps, with rests
5218 Lower with two chrome clasps, with rests
5231 Lower with chrome lingual bar and two clasps, acrylic base
5241 Lower with chrome lingual bar and two clasps, cast base
5251 Upper with chrome palatal bar and two clasps, acrylic base
5261 Upper with chrome palatal bar and two clasps, cast base

Adjustments to dentures (6mos. after installation or by dentist other than dentist providing appliances)

5410 Complete denture
5421 Partial denture (upper)
5422 Partial denture (lower)

Repair broken complete or partial denture

5610 No teeth damaged
5620 Replace one broken tooth
5630 Replace additional teeth, each tooth
5640 Replace broken tooth on denture, no other repairs

Adding teeth to partial to replace extracted tooth

5650 Each tooth not involving clasp
5660 Each tooth involving clasp
5730 Relining upper or lower complete denture (office reline)
5740 Relining upper or lower partial denture (office reline)
5750 Relining upper or lower complete denture (laboratory)
5760 Relining upper or lower partial denture (laboratory)

VII. PROSTHODONTICS-FIXED

Fixed Bridges

Bridge Pontics

6210 Cast gold
6211 Cast-non-precious
6212 Cast-semi-precious
6240 Porcelain fused to gold
6241 Porcelain fused to non-precious metal
6242 Porcelain fused to semi-precious metal
6250 Plastic processed to gold
6251 Plastic processed to non-precious metal
6252 Plastic processed to semi-precious metal

Abutments

6520 Two surface gold inlay
6530 Three or more surface gold inlay
6540 Gold Inlay, (onlaying cusps)

Crowns

6710 Plastic (acrylic)
6720 Plastic processed to gold
6721 Plastic processed to non-precious metal
6722 Plastic processed to semi-precious metal
6750 Porcelain fused to gold
6751 Porcelain fused to non-precious metal
6752 Porcelain fused to semi-precious metal

VII. PROSTHODONTICS-FIXED (Con't)

6780 Gold (3/4 cast)
6790 Gold (full cast)
6791 Non-precious metal (full cast)
6792 Semi-precious metal (full cast)

Other services

6930 Recement Bridge

VIII. ORAL SURGERY

(All procedures include local anesthesia and postoperative care)

Simple extractions

7110 Single tooth
7120 Each additional tooth

Surgical extractions

7210 Erupted tooth
7220 Soft tissue impaction
7230 Partial bony impaction
7240 Complete bony impaction
7241 Complete bony impaction presenting unusual difficulty and circumstances

Alveoloplasty (surgical preparation of ridge for dentures), per quadrant:

7310 In conjunction with extractions
7320 Not in conjunction with extractions

IX. ORTHODONTICS

Comprehensive Full Banded Treatment

8020 Preliminary Study (including cephalometric radiographs, diagnostic casts and treatment plan) and first month of active treatment including all active and retention appliances
8030 Active treatment, per month after first month

Other Orthodontic Treatment

Appliance for Tooth Guidance

8110 Removable
8120 Fixed or cemented

Appliances to Control Harmful Habits

8210 Removable
8220 Fixed or cemented

X. ADJUNCTIVE SERVICES

Emergency Treatment

9110 Palliative (emergency) treatment of dental pain, minor proceduces
9220 General anesthesia