CAPROCK HEALTH GROUP
A Healthcare Services Organization

FORMERLY MAXOR® ADMINISTRATIVE SERVICES

Dental Claim Form

To Be Completed by Employee

1. Patient First Name Middle Last

2. Relationship to Employee O Self O Spouse O Child O Other

3. Sex O Male O Female

4. Married? O Yes O No

5. EMPLOYEE Social Security / ID Number

6. Patient Date of Birth Mo. / Day / Year

7. Name of Group

8. Employee First Name Middle Last

9. Employee Date of Birth

10. Office Phone (Area Code)

11. Employee Residence Mailing Address

12. City, State, Zip

13. Are other Family Members Employed? O Yes O No
Name Social Security / ID Number

14. Date of Birth

15. Name and Address of Employer for Item 16

16. Is Patient Covered by Another Dental Plan? O Yes O No (If Yes, complete the following:)
Dental Plan Name Group No. Name and Address of Carrier

17. I Authorize Release of any Information Relating to this Claim
(Signature of Patient or Signature of Authorized Representative if Minor) Date
If Authorized Representative, Relationship to Minor

18. I Certify that the Above Information is Correct.
Employee Signature Date

19. I Authorize Payment Directly to the Bebw Named Dentist.
Employee Signature Date

To Be Completed by Dentist

20. Dentist Name

21. Mailing Address City State Zip

22. Dentist Social Security Number or T.I.N.

23. Dentist License Number

24. Dentist Phone Number

25. First Visit Date Current Series

26. Place of Treatment
O Office O Hospital O ECF O Other ____________________

27. Radiographs or Models Enclosed?
O Yes O No How Many?__________

28. Is Treatment Result of Occupational Illness or Injury? O Yes O No
(If Yes, Enter Brief Description and Dates)

29. Is Treatment Result of Auto Accident? O Yes O No
(If Yes, Enter Brief Description and Dates)

30. Other Accident? O Yes O No
(If Yes, Enter Brief Description and Dates)

31. Are any Services Covered by Another Plan? O Yes O No
(If Yes, Enter Brief Description and Dates)

32. If Prosthesis, is this Initial Placement? O Yes O No (If No, Reason for Replacement)

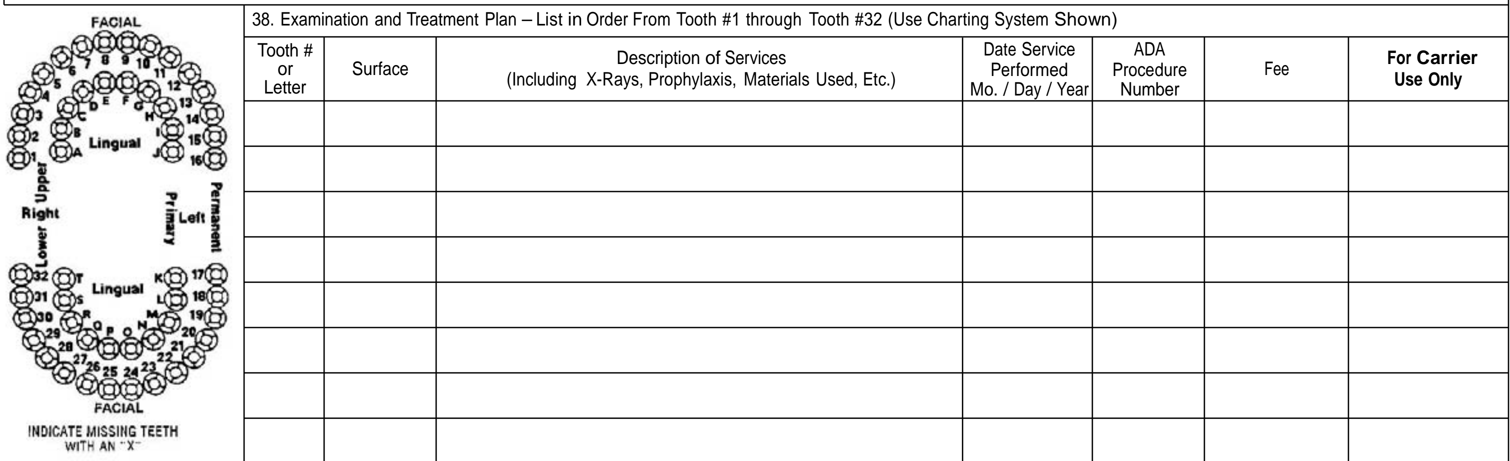
33. Date of Prior Replacement?

34. Is Treatment for Orthodontics?
O Yes O No

If Services Already Commenced, Enter Date Appliance Placed

Months of Treatment Remaining

Dentist's — O Pretreatment Estimate O Statement of Actual Services (Please sign below)*



38. Examination and Treatment Plan – List in Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo. / Day / Year	ADA Procedure Number	Fee	**For Carrier Use Only**

35. I Hereby Certify That The Services Listed Above O Will Be O Have Been Performed

* Signature of Dentist ______________________________ Date ______________

Total Fee Actually Charged

36. Address where treatment was performed

Street ______________________________ City ____________________ State __________ Zip ______________