PRM PROFESSIONAL RISK MANAGEMENT
P.O. Box 1049 • Youngstown, Ohio 44501
(330) 726-5666 • OHIO WATS 1-800-331-7620

PRM-0003-0796

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PROFESSIONAL RISK MANAGEMENT
USE ONLY

PLEASE **PRINT** IN BLOCK LETTERS

DENTAL CLAIM FORM

1. EMPLOYEE NAME
FIRST MIDDLE LAST

2. HOME PHONE NO.
AREA

3. CONTRACT / CERTIFICATE NO.

4. EMPLOYEE HOME ADDRESS
NUMBER AND STREET

5. BUSINESS PHONE
AREA

6. SOCIAL SECURITY NO.

7.
CITY STATE ZIP CODE

8. EMPLOYER & LOCATION

9. GROUP NO. IF SHOWN ON YOUR I.D. CARD -

10. PATIENT NAME
FIRST MIDDLE LAST

11. PATIENT BIRTHDATE

12. AGE

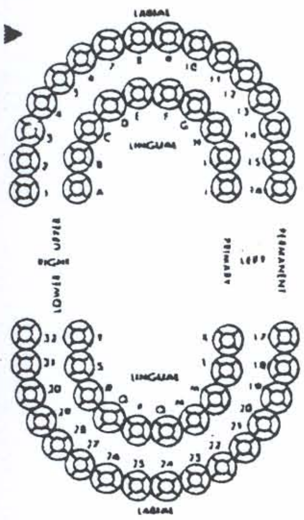
13. RELATION TO EMPLOYEE

14. DO YOU OR YOUR SPOUSE HAVE OTHER DENTAL INSURANCE?
☐ YES ☐ NO IF YES - IS THE PATIENT COVERED UNDER YOUR DENTAL INSURANCE? ☐ YES ☐ NO ☐ FAMILY COVERAGE ☐ SINGLE COVERAGE
POLICY HOLDER'S NAME ______
OTHER INSURANCE CO. ______
POLICY HOLDER'S EMPLOYER AND CONTRACT/SOC. SEC. NUMBER ______

I AUTHORIZE PRM, INC., AT IT'S OPTION, TO ISSUE PAYMENT TO THE PROVIDER DESCRIBED ON THIS CLAIM.

EMPLOYEE OR SPOUSE SIGNATURE DATE

16.



17. Examination and treatment record — List in order from Tooth No. 1 through Tooth No. 32

a. Tooth No. or Letter	b. Surfaces	c. DESCRIPTION OF SERVICES (Including X-Rays, prophylaxis, materials used, etc.)	d. Date Service Performed Mo. Day Yr.	e. Fee for Each Service Performed	f. Procedure Code No.
			TOTAL:		

Reserved for Processing Use

18. PLEASE INDICATE IF SERVICE WAS PROVIDED:
a. FOR ORTHODONTIC PURPOSES? ☐
b. IN PATIENT'S HOME; OR HOSPITAL? ☐
c. AS AS RESULT OF OCCUPATIONAL INJURY? ☐
d. AS RESULT OF ACCIDENT? ☐
DATE OF ACCIDENT ______

19. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO
IF YES, DATE LAST TOOTH EXTRACTED? ______
IF NO, AGE OF EXISTING PROSTHESIS & REASON FOR REPLACEMENT ______
19a. BOTH THE IMPRESSION DATE & INSERTION DATE.
______ IMPRESS ______ INSERT

20. ARE X-RAYS ENCLOSED? (NOT NECESSARY IF TOTAL DENTAL FEE IS LESS THAN $100)
☐ YES INDICATE NUMBER: ______ ☐ NO

21. DENTIST NAME/ADDRESS
FIRST MIDDLE LAST
NUMBER AND STREET
CITY STATE ZIP

22. OFFICE PHONE NO.
AREA

23. IRS OR SOCIAL SECURITY NO.

24. PRACTICE SPECIALTY

25. STAMP

26. ADDITIONAL REMARKS — UNUSUAL SERVICES OR CIRCUMSTANCES
(ADDITIONAL SPACE ON BACK OF THIS PAGE — PLEASE REMOVE CARBON)

27.
I CERTIFY THAT THE SERVICES SHOWN ABOVE ARE PLANNED OR HAVE BEEN PERFORMED.