Superior Dental	l Care	?		. (	CLAIM	FORM								
6683 Centerville Busine Dayton, Ohio 45459 (513) 438-0283 (800) 762-3159	ss Park	way			Jamy Celve	1 011111					FOR O	FFICE	USE ONLY	
1. EMPLOYEE SOCIAL SECURITY NO	UMBER	2. 1	EMPLOYER/GROUP	NUMBER		1								12
						X-RAYS R	ETO							
3. PATIENT NAME FIRST MIDDLE LAST						4. RELATIONSH SELF SPOU	5. SE							
						SELF SPOU	SE CI	HILD OTHE	В М	F	МО	1	DATE	YEAR
7. EMPLOYEE NAME						THESE QUES	TIONS	First Nam	ne of Spous	i se		0	Patient overed by ther Group	
8. EMPLOYEE MAILING ADDRESS	***************************************					Is Spouse Emple	oyed?		YES	Does S Group	Spouse have Dental Cov	e e	ental Plan?	☐ YE
9. CITY, STATE, ZIP								***************************************	□ NO	<u></u>		<u>-</u>		□ NC
S. OTT, STATE, ZIF						Spouse's Insu	urance (	Company Nam	e	Group 1	Vumber	-	Policy Nu	umber
10. DENTIST NAME						<u> </u>			If YES e	nter a hris	of description	on and	dates:	
						is treatment res of occupational illness or injury		☐ YES	1. 100, 0	mer a one	эг осаснулс	JII au	uaics.	
11. MAILING ADDRESS						Is treatment result YES of auto accident NO								
12. CITY, STATE, ZIP						Are any services YES covered by NO								
13. SUPERIOR DENTAL CARE I.D. NUMBER										Date of prior placement acement.				
First visit date current series Place of Treatmer Office Hosp.		Other	Radiographs or Models enclosed?	☐ YES	How many?	Is treatment for orthodontics?		☐ YES	If service : enter date	already cor appliance	mmenced s placed.		Mos. treatn remaining.	nent
	Tooth	EXAMIN	NATION and TREA	ATMENT -	List in order for	rom tooth no. 1			e Charting	System	shown.		For	SDC
CHECK ONE:  Pre-determination Estimate		Surface	(Including X-	DESCRIPTIO Rays, Proph	N OF SERVIC sylaxis, material	E s used, etc.)	MO	te Service Completed DAY YEAR	Procedure Number ADA Code			: .	Use Only	
Statement of Actual														
TOOTH CHART														
LABIAL				****										
3 C LINGUAL H 14														
GS GF LINGUAL HO 15 GO														
DISCONDING PERMANENT PRODUCE TO THE				<u> </u>							****************			
ARY (						***************************************						:		
0 32 0 1 K 0 170 1 0 31 0 S LINGUAL M 0 18 0												<del> </del>		
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66 3 3 3 3 3 3 3 3 5 5 5 5 5 5 5 5 5 5 5				<del></del>						-	· · · · · · · · · · · · · · · · · · ·	1		
LABIAL												!		
Indicate Teeth being Replaced by Partial(s)												:		
INDICATE MISSING TEETH WITH AN X							l				•	:		
TELLI WILLIAM V												1 1 1 1		
									TOTAL	FEE :	\$	:		

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In order to expedite processing of this claim, include periapical x-rays for any inlays, crowns, bridgework, and root canals. Please attach page with additional information regarding any unusual dental services.