



**LAKE ERIE REGIONAL COUNCIL
EMPLOYEE PROTECTION PLAN**

**1885 Lake Avenue
Elyria, Ohio 44035
(440) 324-5777
(440) 244-1659**

DENTAL CLAIM FORM

Please Print or Type

Employee completes this section.

Last	First	M.I.	Employer			SS#
Subscriber's Address		City		State	Zip Code	
Patient's Last Name	First	M.I.	Sex	Birth Date Mo. Day Yr.		Relationship of Patient to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Dependent Child (Dependent child age 19 and over) <input type="checkbox"/> Spouse <input type="checkbox"/> Full-time Student <input type="checkbox"/> Handicapped
Other Dental Insurance? No <input type="checkbox"/> Yes <input type="checkbox"/>	Other Insurance Company Name		Accident? NO YES	Date of Accident Mo. Day Yr.		If accidental did it occur on the job? NO YES
Policy Holder of Other Insurance	Authorization to pay Dentist					If accident, was another person involved? NO YES
Employer of Other Policyholder						
Claimant's Signature _____						Date _____

DENTIST COMPLETES THIS SECTION

Dentist completes this section.

Are X-Rays Enclosed? YES <input type="checkbox"/> If Yes, Indicate Number _____	Line No.	Tooth No.	Sur-faces	Description of Services (Including X-Rays, Prophylaxis, materials used, etc.)	Date Services Performed Mo. Day Yr.	Fee for each Service Performed	Procedure Code Number
	01						7
	02						7
	03						7
	04						7
	05						7
	06						7
	07						7
	08						7
	09						7
	10						7

PLACE OF SERVICE
 In-Patient Office
 Out-Patient Home

Were services indicated rendered for orthodontic purposes? YES NO

Page Total Fee >>

If Prosthesis, Yes If No, Date of Prior Placement and Reason to Replace
 is this initial placement? No

Grand Total Fee >>

Additional Remarks for Unusual Services

Provider Name, Address and Phone Number

I certify that the above services are submitted for predetermination of benefits, or have been personally performed by me, or are approved dental hygienist services supervised by me.

Federal Tax ID#

Signature _____

Date _____