CORESOURCE
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DENTAL CLAIM STATEMENT

(See reverse side for instructions)

Pre-Determination ☐ Yes ☐ No

PART I TO BE COMPLETED BY EMPLOYEE

PATIENT NAME	RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER	SEX M F	PATIENT BIRTH DATE MO DAY YEAR	IF FULL-TIME STUDENT SCHOOL CITY

EMPLOYEE NAME First Middle Last	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE Mo. Day Year

EMPLOYEE MAILING ADDRESS STREET CITY STATE ZIP

EMPLOYER NAME	GROUP NO.
The Cooper Union for the Advancement of Science and Art	CN0000

ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO IF YES, MEMBER NAME SOC. SEC. NO.	NAME AND ADDRESS OF EMPLOYER

IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO | IF YES, DENTAL PLAN NAME | GROUP NO. | NAME AND ADDRESS OF CARRIER

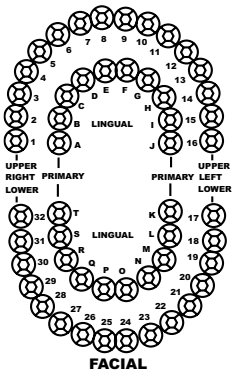
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.	I AUTHORIZE PAYMENT DIRECTLY OF DENTAL BENEFITS TO UNDERSIGNED DENTIST OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED _____ DATE _____	SIGNED (EMPLOYEE OR AUTHORIZED PERSON) _____

PART II TO BE COMPLETED BY ATTENDING DENTIST (OR ATTACH AN ITEMIZED STATEMENT)

DENTIST NAME			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
CITY, STATE, ZIP			ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF YES, NAME OF OTHER PLAN
DENTIST SOC. SEC. OR T.I.N.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE HOSP. SNF OTHER	RADIOGRAPHS OR MODELS ENCLOSED NO YES HOW MANY	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

CHECK ONE: ☐ DENTIST'S PRETREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



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, MATERIAL USED, ETC.)	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATOR USE ONLY

Remarks for Unusual Services

TOTAL FEE CHARGED

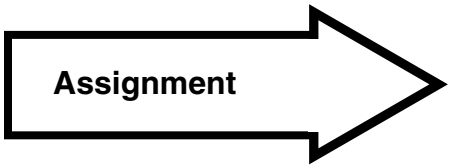
I certify that the procedures indicated by date have been completed and the fees shown are not greater than those usually accepted by me as payment in full for each procedure. No copayment provisions and/or deductibles of this plan will be forgiven. (Any exceptions require a full explanation.)

Dentist's Signature _____ Date _____

MAXIMUM BENEFIT:

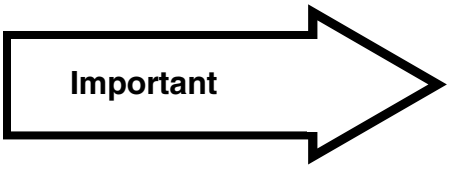
PLEASE NOTE: PRETREATMENT REVIEW IS NOT A GUARANTEE OF BENEFITS PAYABLE. This estimate advises you in advance of the amount of insurance benefits payable if the described procedures are performed during a period of the patient's eligibility.

PLEASE READ BEFORE FILING YOUR DENTAL CLAIM

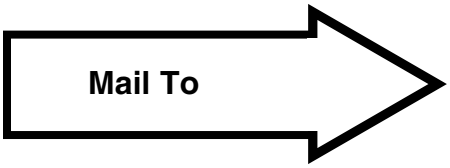


FOR THE EMPLOYEE

1. PLEASE ANSWER ALL QUESTIONS IN PART I.
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.** A COPY OF THE PAYMENT WILL BE SENT TO YOU FOR YOUR RECORDS. NON-ASSIGNED BENEFITS PAYMENT WILL BE MADE DIRECTLY TO YOU.
4. IF THE PATIENT HAS COVERAGE UNDER ANY OTHER GROUP OR GOVERNMENT PLAN, SUBMIT THE BILLS TO THE PRIMARY PAYER FIRST, THEN, SUBMIT THE PRIMARY PAYER'S EXPLANATION OF BENEFITS STATEMENT TO THE SECONDARY PAYER.



IF THE CLAIM IS NOT COMPLETED IN FULL AND/ OR SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING OF THE PAYMENT WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED.



MAIL TO:

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