



Administered by

Principal Life Insurance Company
Des Moines, Iowa

Attending Dentist's Statement

Check One:

- Dentist's Pre-Treatment Estimate
Dentist's Statement of Actual Services

Employee Statement

See Page 2 for Claim Filing Instructions.

Employee Statement form with fields for patient name, relationship, birthdate, employee name, social security numbers, addresses, marital status, and dental plan information.

Attending Dentist's Statement

Attending Dentist's Statement form with fields for dentist name, address, license number, phone number, and treatment details.

Table for dental examination and treatment plan with columns for tooth number, surface, description of service, date performed, procedure number, and fee.

* This is an estimate only, and does not guarantee payment. Actual payment will depend on the plan provisions in effect when the services are performed. This coverage is subject to coordination with other insurance.
By: _____ Date _____

Summary table for fees and charges including Total Fee Charged, Covered Charges, Less Deductible, and Total Estimated Benefits.

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
Signed (Dentist) _____ Date _____

See Page 2 for Statement of Employer Information

USE THIS FORM FOR BOTH EMPLOYEE AND DEPENDENT CLAIMS.

Statement of Employer

Employee's name		I.D. number	Division
Date employed	Employee's med plan	Effective date in plan	
Is employee's coverage still in force?		If no, give termination date.	
<input type="checkbox"/> yes <input type="checkbox"/> no			
Employer			Plan number
Date	Signature	Title	

Instructions to the Employee

1. Complete questions 1 through 15 on Page 1. Have patient's dentist complete questions 16 through 31.
2. If you want benefits paid directly to the dentist, complete the Authorization to Pay on Page 1 following question 15.
3. If charges exceed either \$200.00 or \$300.00 (as specified in your Benefit Plan Booklet), a treatment plan must be submitted prior to continuation of treatment.

Instructions to the Dentist

FOR CHARGES LESS THAN AMOUNT SPECIFIED IN YOUR BENEFIT PLAN BOOKLET.

1. Show the date the work was completed for each service and the corresponding fee.
2. Return this form to Principal Life Insurance Company (The Principal®) (address printed on your ID card.)

FOR CHARGES EXCEEDING AMOUNT SPECIFIED IN YOUR BENEFIT PLAN BOOKLET.

1. Prior to the continuation of treatment describe procedures necessary to fully complete the treatment plan. State your fees, enclose x-rays (these will be returned to you) and return the form to The Principal (address printed on your ID card.)
2. The Principal will pre-determine the amount payable per procedure and return this form to you.
3. After the work is completed, enter the dates that the service was completed and return this form to The Principal (address printed on your ID card.)

Notice!!

THE PRE-DETERMINED BENEFITS APPLY ONLY TO EXPENSES INCURRED WHILE EMPLOYEE'S COVERAGE IS IN FORCE.

PRE-DETERMINATION OF DENTAL SERVICES IS INTENDED TO AVOID ANY MISUNDERSTANDINGS BETWEEN THE DENTIST, EMPLOYEE, AND THE PRINCIPAL. PATIENT WAIVES ADVANCED KNOWLEDGE WHEN NOT OBTAINING A PRE-DETERMINATION AND IS LIABLE IF THE PLAN DOESN'T PAY OR PARTIALLY PAYS FOR TREATMENT.

Please mail completed form to the address printed on your ID card.

For Questions: Please refer to the Toll Free number printed on your ID card.

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