SUTTON
SPECIAL RISK

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DENTIST STATEMENT OF CLAIM

Insured Information

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

Name of Policyholder	Policy no.
Name of Insured	Email Address
Name of Patient (If other than above)	Relationship to Insured
Address	Telephone no.
Is patient covered by another plan? ☐ NO ☐ YES	If yes, state dental plan name, group no. and name and address of carrier.

Dentist Information

Dentist's Name, Address, Phone No. and Social Security No. or TIN							
First visit date for current series	Place of Treatment	Office	Hosp	ECF	Other	Radiographs or model enclosed? ☐ NO ☐ YES	How many?
Is treatment result of occupational illness or injury? ☐ NO ☐ YES	If yes, enter brief description and dates						
Is treatment result of an auto accident or other accident? ☐ NO ☐ YES	If yes, enter brief description and dates						
If prosthesis, is this an initial placement? ☐ NO ☐ YES	If no, reason for replacement and date of prior placement						
Is treatment for orthodontics? ☐ NO ☐ YES	Enter date of initial placement and months of treatment remaining						

Date	Tooth No.	Surface	Description Of Service Including X-Rays, Prophylaxis, materials used etc. Line No.	Procedure No.	Fee	For admin use
				Total Fee Submitted		

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

Reimbursement

How do you wish reimbursement to be made? Cheque ☐ Direct Deposit ☐ Wire Transfer ☐

If Direct Deposit:

Name of Bank _____ Bank Number _____

Branch Address _____ Transit Number _____

Name of Account Holder _____ Account Number _____

If Wire Transfer:

Name of Bank _____ Bank I.D. (Swift Code) _____

Branch Address _____

Account Number _____ Currency of Account _____

Name of Claimant _____ Account Number (IBAN) _____

Residence Address of Account Holder _____

Signature and Authorization

I have reviewed the following treatment plan and I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signature (Patient or parent if minor) Date

I hereby assign my benefits payable from this claim to the named Dentist and authorize payment directly to him/her.

Signature (Insured Person) Date