


Denex Dental Claim Form

 <small>deneX Plans underwritten by Group Dental Service of Maryland Inc.</small>		Send Claim To: deneX P.O. Box 3827 Houston TX 77253	<input type="checkbox"/> Pre-Determination of Benefits <input type="checkbox"/> Claim for Actual Services
Employee ID Number:		Employer Group Number:	
Employee Last Name:	MI:	Employee First Name:	
Employee Street Address:		Apt:	
City:		State:	Zip Code:
Employee Home Phone:	Employee Work Phone:	Employee Other Phone:	
Patient Last Name:		MI:	Patient First Name:
Patient Street Address:		Apt:	
City:		State:	Zip Code:
Patient Home Phone:	Patient Work Phone:	Relationship:	
Dentist Last Name:	Dentist First Name:		Provider TIN
Dentist Street Address:		Suite:	
City:		State:	Zip Code:
Dentist Phone:		Dentist Fax:	
I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize release of any information relating to this claim.			
Reimbursement Check will be sent to: Provider <input type="checkbox"/> Employee <input type="checkbox"/> Patient <input type="checkbox"/>			
X _____ Signed (Patient/Guardian)		_____ Date	
Please enclose provider's invoice			