GUARDIAN℠ The Guardian Life Insurance Company of America

Guardian
Group Dental Claims
PO Box 2459
Spokane WA 99210-2459

Attending Dentist's Statement

Patient Section

Check one: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

1. Patient name first m.i. last	2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____	3. Sex M F	4. Patient birthdate MM DD YYYY	5. If full time student school city

6. Employee's name and mailing address	7. Employee Social Security Number	8. Employee birthdate MM DD YYYY	9. Employer (company) name and address	10. Group number

11. Is patient covered by another dental plan? ☐ Yes ☐ No If yes, indicate:	12-a. Name and address of carrier(s).	12-b. Group no.(s)	13. Name and address of employer

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer, or other Organization to release any information regarding any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.	Signed (Patient or parent if minor)	Date
AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named dentist of the dental benefits otherwise payable to me.	Signed (Employee)	Date
CERTIFICATION - I certify that the foregoing information is true and correct.	Signed (Patient or parent if minor)	Date

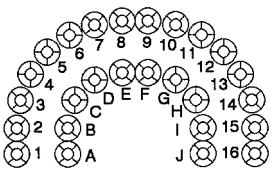
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Dentist Section

14. Dentist name	22. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.
15. Mailing address	23. Is treatment a result of auto accident?			
	24. Other accident?			
City, State, Zip	25. Are any services covered by another plan?			
16. Dentist Soc. Sec. or T.I.N. 17. Dentist license no. 18. Dentist phone no.	26. If prosthesis, is this initial placement?			(If no, reason for replacement) 27. Date of prior placement
19. First visit date current series; 20. Place of treatment: Office, Hosp, ECF, Other; 21. Radiographs or models enclosed? No Yes How many?	28. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed Mos. treatment remaining

Identify missing teeth with an "x"

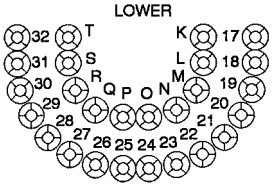
FACIAL



UPPER

RIGHT LINGUAL LEFT

LOWER



FACIAL

30. Remarks for unusual services

29. Examination and treatment plan: List in order from tooth no. 1 through tooth no. 32 - Use the charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, material used, etc.) Line No.	Date service performed mo. day year	Procedure number	Fee	For administrative use only
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

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 _____

Total Fee Charged	
Max allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

INSTRUCTIONS

FOR THE EMPLOYEE

1. Please answer all questions in Part I entitled "TO BE COMPLETED BY EMPLOYEE".
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 Benefit's to Dentist".

   If authorized, payment will be made directly to your Dentist. A copy of the payment will be sent to you for your records. Otherwise, payment will be made directly to you.
4. If the patient has coverage under any other group or Government plan, submit the same bills to the other plan at the same time.

FOR THE DENTIST

For claims involving Predetermination of Benefits:

1. Complete the section "TO BE COMPLETED BY ATTENDING DENTIST'S". Be sure to itemize charges for each proposed procedure.
2. Guardian will review the treatment plan and will provide the estimate of benefits payable.
3. Review the form and benefit estimates with your patient before the work is done.
4. When you complete treatment, return the form with the treatment dates completed and your signature.

For claims not involving Predetermination of Benefits:

1. Complete Part II. Be sure to date and itemize charges. Send this form with Pre-treatment X-rays to Guardian.
2. Sign and date bottom of claim form when work is completed.

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

DENTAL PROCEDURE REFERENCE LIST

I. DIAGNOSTIC/GENERAL

Examinations
0110 Initial Oral Examination
0120 Periodic Oral Examination

Radiographs
0210 Intraoral-complete series (including bitewings)
0220 Intraoral-single, first film
0230 Intraoral-each additional film
0272 Bitewing, two films
0274 Bitewing, four films
0330 Panoramic-maxiliary and mandibular-single film

II. PREVENTIVE

Dental Prophylaxis (including scaling and polishing)
1110 Adults
1120 Children under 14

Fluoride Treatments
Topical application of sodium fluoride, four treatments
1210 Excluding prophylaxis

Topical application of stannous fluoride, one treatment
1220 Excluding prophylaxis

Space Maintainers
1510 Fixed, unilateral type
1515 Fixed, bilateral type
1520 Removable, unilateral type
1525 Removable, bilateral type

III. RESTORATIVE

Amalgam Restorations (deciduous teeth)
2110 Amalgam-one surface
2120 Amalgam-two surfaces
2130 Amalgam-three surfaces

Amalgam Restorations (permanent teeth)
2140 Amalgam-one surface
2150 Amalgam-two surfaces
2160 Amalgam-three surfaces
2161 Amalgam-four surfaces

Silicone Restorations
2210 Silicate cement-per restoration

Filled or Unfilled Resin Restorations
2330 Composite resin-one surface
2321 Composite resin-two surfaces
2332 Composite resin-three surfaces
2335 Composite resin,involving incisal angle

Gold Inlay Restorations
2520 Inlay, gold-two surfaces
2530 Inlay, gold-three surfaces

III. RESTORATIVE (Con't)

Crowns-Single Restorations Only
2710 Plastic (acrylic)
2711 Plastic-prefabricated
2720 Plastic with gold
2721 Plastic with non-precious metal
2722 Plastic with semi-precious metal
2750 Porcelain with gold
2751 Porcelain with non-precious metal
2752 Porcelain with semi-precious metal
2790 Gold (full cast)
2791 Non-precious metal - full cast
2792 Semi-precious metal - full cast
2810 Gold (3/4 cast)
2830 Stainless steel
2891 Post and core — in addition to above per tooth
2892 Steel post and composite or amalgam — in addition to above per tooth

Other Restorative Services
2910 Recement inlays
2920 Recement crowns

IV. ENDODONTICS

Pulpotomy (excluding restoration)
3220 Therapeutic pulpotomy

Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes restoration)
3310 One canal
3320 Two canals
3330 Three canals

Periapical Services
3410 Apicoectomy, performed as a separate surgical procedure

V. PERIODONTICS

Surgical Services
4210 Gingivectomy or gingivoplasty, per quadrant
4260 Osseous surgery per quadrant

Adjunctive Services
4330 Occlusal adjustment (limited: not including restoration)
4331 Occlusal adjustment (complete, not involving restoration)
4340 Root Planing, entire mouth
4341 Root Planing, per quadrant

Miscellaneous Services
4910 Periodontal prophylaxis (periodontal maintenance procedures following active periodontal therapy)

VI. PROSTHODONTICS-REMOVABLE

Complete Dentures
5110 Complete upper
5120 Complete lower
5130 Immediate upper
5140 Immediate lower

VI. PROSTHODONTICS-REMOV. (Con't)

Partial Dentures

Acrylic Base
5211 Upper without clasps
5212 Lower without clasps
5216 Upper with two chrome clasps, with rests
5218 Lower with two chrome clasps, with rests
5231 Lower with chrome lingual bar and two clasps, acrylic base
5241 Lower with chrome lingual bar and two clasps, cast base
5251 Upper with chrome palatel bar and two clasps, acrylic base
5261 Lower with chrome palatel bar and two clasps, cast base

Adjustments to dentures (6 mos. after installation or by dentist other than dentist providing appliances)
5410 Complete denture
5421 Partial denture (upper)
5422 Partial denture (lower)

Repair broken complete or partial denture
5610 No teeth damaged
5620 Replace one broken tooth
5630 Replace additional teeth, each tooth
5640 Replace broken tooth on denture, no other repairs

Adding teeth to partial to replace extracted tooth
5650 Each tooth not involving clasp
5660 Each tooth involving clasp
5730 Relining upper or lower complete denture (office reline)
5740 Relining upper or lower partial denture (office reline)
5750 Relining upper or lower complete denture (laboratory)
5760 Relining upper or lower partial denture (laboratory)

VII. PROSTHODONTICS-FIXED

Fixed Bridges

Bridge Pontics
6210 Cast gold
6211 Cast-non-precious
6212 Cast-semi-precious
6240 Porcelain fused to gold
6241 Porcelain fused to non-precious metal
6242 Porcelain fused to semi-precious metal
6250 Plastic processed to gold
6251 Plastic processed to non-precious metal
6252 Plastic processed to semi-precious metal

Abutments
6520 Two surface gold inlay
6530 Three or more surface gold inlay
6540 Gold inlay, (onlaying cusps)

Crowns
6710 Plastic (acrylic)
6720 Plastic processed to gold
6721 Plastic processed to non-precious metal
6722 Plastic processed to semi-precious metal

VII. PROSTHODONTICS-FIXED (Con't)

6750 Porcelain fused to gold
6751 Porcelain fused to non-precious metal
6752 Porcelain fused to semi-precious metal
6780 Gold (3/4 cast)
6790 Gold (full cast)
6791 Non-precious metal (full cast)
6792 Semi-precious metal (full cast)

Other services
6930 Recement bridge

VIII. ORAL SURGERY

(All procedures include local anesthesia and postoperative care)

Simple extractions
7110 Single tooth
7120 Each additional tooth

Surgical Extractions
7210 Erupted tooth
7220 Soft tissue impaction
7230 Partial bone impaction
7240 Complete bony impaction
7241 Complete bony impaction presenting unusual difficulty and circumstances

Alveoloplasty (surgical preparation of ridge for dentures), per quadrant
7310 In conjunction with extractions
7320 Not in conjunction with extractions

IX. ORTHODONTICS

Comprehensive Full Banded Treatment
8020 Preliminary Study (including cephalometric radiographs, diagnostic casts and treatment plan) and first month of active treatment including all active and retention appliances
8030 Active treatment, per month after first month

Other Orthodontic Treatment

Appliances for Tooth Guidance
8110 Removable
8120 Fixed or cemented

Appliances to Control Harmful Habits
8210 Removable
8220 Fixed or cemented

X. ADJUNCTIVE SERVICES

Emergency Treatment
9110 Palliative (emergency) treatment of dental pain, minor procedures
9220 General anesthesia