Dental Care Plan Claim Form

Patient Information:

Full Name: ____

Date of Birth: ________________ Gender: ____________________________________

Address: ____

City: __________________________ State: ____________ PIN Code: ________________

Mobile/ Phone Number: ______________________ Email id: ______________________________

Dental Care Plan Information:

Plan Name: ________________________________

Plan ID Number: _____________________________

Policy Holder Name: __________________________

Policy Holder Date of Birth: ______________________

Adhar No____________________________________

Dental Provider Information (Clinic/Dental Hospital) Details

Dental Provider Name: (Clinic/Hospital) __________________________________

Dental Provider Phone Number: ____

Complete Address ____

Treatment Information:

Date of Treatment: __________________

Procedure Code: ______________________Diagnosis Code: ___________________

Treatment Description: ____

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Cost of Treatment: INR ___________________

Payment Information:

Please select the payment method you would like:

☐ Cashless

Authorization:

I authorize cashless treatment services of dental care plan to provide cashless services to the dental clinic /Hospital (partnered) for the services described above. I certify that the information provided is true and correct to the best of my knowledge.

Patient Signature/Policy holder: _________________________ Date: _____________________

Note –Only Cashless services is provided .No reimbursement scheme is applicable