One Health Cayman

Dental Claim Form

SECTION A: CLAIMANT INFORMATION

Patient Name

Date of Birth

Sex: ☐ Male ☐ Female

Patient Insured Status: ☐ Self ☐ Dependant

Patient's Physical Address

Group Number

Subscriber Name

Member ID

Group Name

Claimant's Authorization
I authorize One Health Cayman to obtain medical records from any medical service provider, insurer, employer, or other source deemed necessary to settle this claim.

Signature　　Date

Payment Assignment
I authorize One Health Cayman to pay the proceeds of this claim to the undersigned Dental Care Provider.

Signature　　Date

SECTION B: DENTAL CARE SERVICES/TREATMENT PROVIDER

Dental Provider Name

Phone Number

Dental Provider Address

Date of first visit for current series

Is treatment for orthodontics? ☐ YES ☐ NO

For current series, months of treatment remaining

Date of Service	Tooth Letter	Tooth Surface	Dental Service	Dental Code	Fee	Currency
				TOTAL FEES		
				PAID BY PATIENT		
				BALANCE DUE		

BANK DETAILS:

If you would like to be reimbursed by EFT direct deposit, please provide your Cayman banking details.

Bank Name	Account Name	Account Number	Account Type	Account Currency

I hereby certify that this is a true statement of treatment and services rendered

Signature of Dental Care Provider or Member　　Date

Once complete, please email this form and itemized receipts to **claims@onehealth.ky**