ADC

Associated Dental Consultants

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CLAIM REFERRAL FORM

ADC # A ________________

Company: ___________________________

Address: ___________________________

City, State, Zip: ______________________

Claim Examiner: ______________________

Tel No.: _______________________ Fax No.: ______________________

Claimant's Name: ___________________________

Insured: ___________________________

Claim No. ___________________________

Date of Loss: ___________________________

1. Are x-rays enclosed / attached? ❑ **Yes** ❑ **No**

Was this claim reviewed previously? ❑ **Yes** ❑ **No**

If yes, the ADC number is: __________________

2. Check type of claim:

❑ W/C ❑ PIP ❑ TMJ
❑ Med / Pay ❑ G.L. ❑ Dental (Teeth)
❑ U.M. ❑ Other: _____________

3. Total fees asked: $ _____________

4. Please send the following: (✓ enclosed items)

❑ Attending dentist treatment plan and itemized fees / narrative *

❑ X-rays from attending dentist after trauma, before dental work started

❑ Physician's first report of injury / emergency room reports *

❑ Accident report / employer's first report / notice of loss *

*** PLEASE SEND COPIES ONLY**

ADC USE ONLY	