

Rate of Service	Procedure Code	Dental Code	Dental Surfaces	Provider's Fee	Laboratory Charges	Total Charges	Allowed Amount	Cost
This is an accurate statement of services rendered and the total fee due and payable.				O A F, S B Provider Signature _____ Date _____				

SSQ C O S F O C A I S B S S O

Please carefully fill in all pertinent areas and sign the copy. Return to SSQ Identification Card or correct patient information. Incorrect data or signatures will be returned or rejected and will result in a delay in reimbursement.

<b>PA - PA C PA</b>		All claims must be submitted within 1 month of the date of service.	
Participant's Name Please Print		SSQ Certificate Number	Participant's Date of Birth
_____	_____	_____	____/____/____
Last Name	First Name		

<b>PA - PA I F O I A I O</b>		<input type="checkbox"/> <input type="checkbox"/>	
Patient's Name Please Print		Patient's Date of Birth	
_____	_____	____/____/____	
Last Name	First Name		<input type="checkbox"/>