Office 229-225-9943
Fax 229-225-9945
Toll Free 888-35-CLAIM

TBR
Taylor Benefit Resource

104 Commercial Drive
P. O. Box 6580
Thomasville, GA 31758

Dental Claim Form

GROUP No.

Patient's Name (First, Middle initial, Last)	Patient's Sex	Patient's Birthdate
Patient's relationship to Employee: _____Self _____Spouse _____Child _____Other		
Employee		
Employee Address (street)	City	State & Zip
If patient has other dental insurance, enter its Name, Address, and Policy Nu,ber		
Was Illness or injury connected with patient's employment		
Patient's or authorized person's signature I authorize the release of any medical information necessary to process this claim. **Signed**	I authorize payment of benefits to undersigned physician or supplier of service described below **Signed**	

Name of Billing Dentist or Dental Entity	Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief desription and dates
Address where payment should be remitted	Is treatment result of auto accident?			
City, State, Zip	Other Accident?			

First visit date current series: If prosthesis, is this initial placement?	If no, reason for replacment	Date of prior placement
Dentist Soc Sec or T.I.N		
Dentist Licence No		
WHEN COMPLETE, PLEASE MAIL TO: **Taylor Benefit Resource, Inc.** **P. O. Box 6580** **Thomasville, GA 31758** **888-35-CLAIM**		

Signed by (Treating Dentist)	Date