**STAYWELL BLDG., 430 W. SOLEDAD AVENUE, HAGATNA, GUAM 96910**
**TELEPHONE: (671) 477 - 5091 Ext.320 - 324  FACSIMILE: (671) 477 - 2464**
**SAIPAN OFFICE: FLAME TREE TERRACE BLDG. SUITE 200**
**LOWER CAPITOL HILL SAIPAN, MP 96950 TEL.# (670) 323-4260 FAX# (670) 323-4263**

# OFF ISLAND DENTAL CLAIM FORM

| PATIENT COVERAGE INFORMATION | |
|---|---|
| Patient Name: | Patient Birthdate: |
| Subscriber Name: | Subscriber Birthdate: |
| Mailing Address: | Subscriber SS #: |
| Employer (Company): | |

| BILLING DENTIST | |
|---|---|
| Name of Billing Dentist: | Address: |
| Dentist Phone Number: | Fax Number: |

**TREATMENT/ACTUAL SERVICES**

| TOOTH # | SURFACE | DESCRIPTION OF SERVICE | DATE OF SERVICE | FEE |
|---|---|---|---|---|
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| Signed (Treating Dentist) | License Number | Date |
|---|---|---|
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NOTE: This form is applicable for off - island dental treatment except U.S. Countries.