



**HAREL**  
insurance company

Clarification  Pre-treatment Estimate  Dentist's Statement of Actual Services

Do Not Copy

**DENTAL CLAIM FORM**

Dentist With Agreement  NO  YES   
(Mark X Where Suitable)

P.O.B. 1952, Ramat Gan 52118  
Tel. 03-7547222 Fax. 03-7388102  
www.harel-ins.co.il

LAST REFERENCE NUMBER _____ _____	DENTIST DETAILS THE NAME _____ THE INSURANCE NUMBER _____ THE LICENCE NUMBER _____ / _____ / _____
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DENTIST ADDRESS AND PHONE \_\_\_\_\_

COPY THE DATA FROM THE DENTAL CARD ID

I CERTIFY THAT THE STATEMENTS APPLY TO THI BILL AND ARE MADE A PART HERE OF \_\_\_\_\_  
 DENTIST'S STAMPLE AND SIGNATURE \_\_\_\_\_

ID NUMBER _____	POLICY NUMBER _____	EMPLOYEE'S NUMBER _____
FIRST NAME _____	FAMILY NAME _____	PHONE NUMBER _____

WRITE THE TREATMENT CODES AND THE REASONS - BRIDGE AND GUM TREATMENT WRITE FROM TOOTH TO TOOTH NO.

CODE NUMBER	PAYMENT AMOUNT INCLUDING VAT	TREATMENT DATE DD / MM / YY	BIG X-RAY FILM WAS SENT SEPARATELY	ENCLOSED BIG X-RAY FILM OR DOCUMENTS	THE PLACE OF SMALL X-RAY FILM	X- WRITE THE SURFACE BY						TOOTH	FROM TOOTH	REASON CODE	TREATMENT CODE
						M	O	D	L/P	B	CL-V				
____	____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____	____	____	1			
____	____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____	____	____	2			
____	____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____	____	____	3			
____	____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____	____	____	4			

THIS DATA IS RELEVANT ONLY FOR PROSTHODONTIC/GUM TREATMENT

BY SIGNING ON THIS FORM I AM GIVING PERMISSION TO GIVE TO THE INSURER ANY DATA AND X RAY'S FOR CLAIMS RESOLVING. I WILL NOT HAVE ANY COMPLAINS OR LEGAL DEMANDS ABOUT TRANSFERING THE DATA FROM ALL INVOLVED IN MY DENTAL OR ADMINISTRATIVE TREATMENT  TTH SIGNATURE OF THE INSURED _____  <input type="checkbox"/> MARK X IF YOU WANT TO CHANGE THE BANK DATA THAT THE INSURANCE COMPENSATION WILL BE PAID  BANK NAME _____ BRANCH NUMBER _____ ACCOUNT NUMBER _____ EMPLOYEE'S SIGNATURE _____	<input type="checkbox"/> PLEASE MARK X IF YOU HAVE ANY REMARKS _____ _____ _____
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ATTACH THE X-RAY FILM TO ITS PLACE IN THE BOTTOM AND WRITE THE NUMBER AT " THE PLACE OF SMALL X-RAY FILM"

X-RAY FILM NUMBER 1	X-RAY FILM NUMBER 2	X-RAY FILM NUMBER 3	X-RAY FILM NUMBER 4
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Treatment Code	Diagnostic Code	Treatment	Photograph		Treatment Code	Treatment	Photograph	
			before	after			before	after
Diagnostic					Prosthodontic Treatment			
100		periodic oral evaluation			1102	prefabricated post and core	X	
240		bitewing film	X		1103	cast post and core	X	
230		periapical film	X		1111	crown- resin with metal	X	X
210		panoramic film	X		1116	crown- porcelain	X	X
220		status film (intraoral-complete series)	X		Reasons for prosthodontic treatment			
270		parallel status film (intraoral-complete series)	X		10a	crown/post following r.ct		
200		cephalometric film	X		11a	crown/post due to esthetics		
250		occlusal film	X		12a	crown/post following coronal destruction		
272		c.t. film	X		13a	bridge following extraction		
274		tomographic survey	X		14a	redoing restoration due to r.ct./r.c.r		
286		"photo" film	X		15a	redoing restoration due to esthetics		
285		computerized analysis	X		16a	redoing restoration due to caries		
280		study models			17a	redoing restoration following extraction		
Preventive					Prosthodontic (removable) and repairs			
310		prophylaxis			1200	partial denture resin base	X	
730		sealant- per tooth			1201	partial denture cast metal framework	X	
					1220	complete denture	X	
					1240			
Restorative					1250	add clasp to existing denture		
710		amalgam			1300	repair broken denture base		
714		resin-based composite			1310	replace broken or missing teeth		
Endodontics					1330	repair cast framework		
621		root canal treatment	X	X	1340	rebase denture		
641		root canal re-treatment	X	X	1342	refine denture soft		
					1344	refine denture hard		
					1346	repairing of crown facing	X	
					1367	precision attachment	X	X
					1203	cap (under structure)	X	X
					Implant services			
					2301	implant surgical placement	X	X
					1105	implant abutment	X	X
					1146	implant supported crown	X	X
Surgery					Orthodontics			
400		tooth removal	X		3801	limited orthodontic treatment	X	
510		surgical removal - exposed tooth	X		3802	partial (interceptive) orthodontic treatment	X	
530		impacted tooth in soft tissue-surgical removal	X		3803	orthodontic treatment with headgear brackets	X	X
531		impacted in bone tooth-surgical removal	X		3810	headgear brackets +orthopedic instrument	X	
					3821	orthodontic retention (removable appliances)		
					Periodontics			
					2000	periodontal evaluation		
					2130	periodontal abscess drainage	X	
					2141	provisional splinting composite/amalgam	X	
					2187	ridge atveoloplasty	X	
540		apicoectomy	X		2188	root lengthening	X	
545		hemisection	X		2208	periodontal scaling and root planning- hygiene		
550		surgical abscess drainage	X		2209	periodontal scaling and root planning-periodontit		
551		abscess drainage by tooth opening	X		2221	conservative supplementary treatment	X	
Other treatments					2231	soft tissue surgery	X	
900		firs aid	X		2241	flap and hard tissue surgery	X	
1260		space maintainer to kid	X					
720		prefabricated crown to kid	X		8888	unspecified treatment		
meaning of "photograph" is x-ray film or photographic film or photograph of laboratory study models								