TruScan Body Claim Form

Referring Lab Name:_____ **Phone Number:** _____

Please select 5 TruScan bodies from the list below:

Implant Brand/Size	Quantity
☐ Astra Tech EV 3.0 (AE30-SB)	_____
☐ Astra Tech EV 3.6 (AE36-SB)	_____
☐ Astra Tech EV 4.2 (AE42-SB)	_____
☐ Astra Tech EV 4.8 (AE48-SB)	_____
☐ Astra Tech EV 5.4 (AE54-SB)	_____
☐ Astra Tech TX 3.0 (AS3-SB)	_____
☐ Astra Tech TX 3.5/4.0 (AS4-SB)	_____
☐ Astra Tech TX 4.5/5.0 (AS5-SB)	_____
☐ BioHorizons 3.0 (BHN-SB)	_____
☐ BioHorizons 3.5 (BH35-SB)	_____
☐ BioHorizons 4.5 (BH45-SB)	_____
☐ BioHorizons 5.7 (BH57-SB)	_____
☐ Biomet 3i Certain 3.4 (BC34-SB)	_____
☐ Biomet 3i Certain 4.1 (BC41-SB)	_____
☐ Biomet 3i Certain 5.0 (BC50-SB)	_____
☐ Biomet 3i Certain 6.0 (BC60-SB)	_____
☐ Dentium Superline (DSU-SB)	_____
☐ DIO UF Narrow (DUN-SB)	_____
☐ DIO UF Regular (DUR-SB)	_____
☐ Hiossen ET Mini (OTM-SB)	_____
☐ Hiossen ET Regular (OTR-SB)	_____
☐ Keystone Prima SD (KPS-SB)	_____
☐ Keystone Prima RD (KPR-SB)	_____
☐ Keystone Prima WD (KPR-SB)	_____

Implant Brand/Size	Quantity
☐ MIS C1 NP (MCN-SB)	_____
☐ MIS C1 SP (MCS-SB)	_____
☐ MIS C1 WP (MCW-SB)	_____
☐ Megagen AnyRidge (MRD-SB)	_____
☐ Neodent GM (NDG-SB)	_____
☐ Neoss ProActive Narrow (NSN-SB)	_____
☐ Neoss ProActive Regular (NSR-SB)	_____
☐ Nobel Active 3.0 (NA3-SB)	_____
☐ Nobel Active NP (NAN-SB)	_____
☐ Nobel Active RP (NAR-SB)	_____
☐ Nobel Active WP (NAW-SB)	_____
☐ Nobel Replace NP (NRN-SB)	_____
☐ Nobel Replace RP (NRR-SB)	_____
☐ Nobel Replace WP (NRW-SB)	_____
☐ Nobel Replace 6.0 (NR6-SB)	_____
☐ Straumann BLX RB/WB (SXR-SB)	_____
☐ Straumann Bone Level SC (SBS-SB)	_____
☐ Straumann Bone Level NC (SBN-SB)	_____
☐ Straumann Bone Level RC (SBR-SB)	_____
☐ Straumann Tissue Level RN (STR-SB)	_____
☐ Straumann Tissue Level WN (STW-SB)	_____
☐ URIS OMNI Narrow (UNSB45105H)	_____
☐ URIS OMNI Regular (URSB50103H)	_____
☐ Zimmer Eztetic 2.9 (ZVN-SB)	_____
☐ Zimmer TSV 3.5 (ZV3-SB)	_____
☐ Zimmer TSV 4.5 (ZV4-SB)	_____
☐ Zimmer TSV 5.7 (ZV5-SB)	_____

Please sign on the next page

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TruScan Body Claim Form

Please ship this promotional order to:

Doctor's Full Name: _____ *Limit 1 offer per doctor

Dental Office Name: _____ Phone Number: _____

Shipping Address: _____

Credit Card Payment Authorization Form:

*I understand that TruAbutment will send me TruScan Bodies according to the quantity and the brand of the scan bodies listed above.

*I acknowledge that I'm responsible for a $10 (domestic) FedEx 2nd day shipping charge. Please charge my credit card with the information below.

Cardholder Name: _____ **Card Number:** _____

Expiration Date: _____ **CVV*:** _____

*3 digits on back of VISA/MasterCard/Discover & 4 digits on front of AMEX

By my signature above, I certify that I have signatory capacity with this credit card company to authorize charges on this credit card on behalf of my company. If the charges are declined, I personally and individually guarantee the payment of the above charges. I acknowledge that future orders may be authorized to this card – subject to the same terms and conditions as this authorization, and a confirmation provided if I request it.

Name _____ Signature _____ Date _____

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