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BENEFIT ADMINISTRATORS

DENTAL CLAIM FORM

EMPLOYEE INFORMATION

Employer's Name: **Occupation:**

Employee's Name: **Social Security #:**

Sex:

Marital Status: Single Married Head of Household

Date of Birth: **Date of Hire:**

Employee's Home Address: (Street) **(City)** **(State)** **(Zip)**

COMPLETE IF YOU ARE MARRIED OR IF CLAIM IS FOR A DEPENDENT

Name of Your Spouse:

Is your spouse employed?
No
Yes - Name of Employer:___

The expenses included in this claim were for medical services rendered solely to:

Self

Eligible Dependent - Name:___

Relationship:___

Social Security #:___

Date of Birth:___

Sex: Male Female

If the claimant is a dependent child:

Is the dependent employed?	Yes	No
Is the dependent claimed for tax purposes?	Yes	No
Is the dependent handicapped?	Yes	No
Is the dependent over age 18?	Yes	No
Is the dependent a full-time student?	Yes	No

School name/location:___

COMPLETE IF CLAIM IS THE RESULT OF A DENTAL ACCIDENT

Where did the accident happen? **Date:**

Describe the accident. Include how it happened.

OTHER INSURANCE

THIS PORTION MUST BE ANSWERED BEFORE THE CLAIM CAN BE PROCESSED.

Is the expense of this claim covered by any other group insurance, or any other arrangement of coverage for individuals in a group? Yes No

Name of Insurance Company:___ Policy Number:___

Address of Insurance Company:___

Name of Insured:___

EMPLOYEE'S STATEMENT

I AUTHORIZE any physician, dental practitioner, hospital, clinic, other dentally related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer, having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental condition and/or treatment of me, or my minor children, and any non-medical information of me, or my minor children, to give Centrix Benefit Administrators (CBA), the insurance company, or their legal representative any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by CBA to determine eligibility for benefits under an existing policy. Any information obtained will not be released by CBA to any person or organizations performing business or legal services in connection with the claim, or as maybe otherwise lawfully required or as I may further authorize.

I KNOW that I may request that CBA send me a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for one year from the date it is signed.

I AGREE to reimburse the Plan for any over-payment made to me in my behalf due to error.

___ ___

SIGNATURE OF EMPLOYEE/CLAIMANT Date

(If this claim concerns a dependent age 18 or over, dependent should sign as the claimant.)
ATTACH ALL BILLS AND PRESCRIPTION RECEIPTS INCLUDING DRUG NAME.

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ATTENDING DENTIST'S STATEMENT

PATIENT SECTION

1. Patient's Name :
2. Relationship to employee:
3. Sex:
4. Patient Birthdate: MM DD YY
5. If full-time student:
School:
City:
6. Employee/subscriber name and mailing address:
7. Employee/subscriber social security #:
8. Patient Birthdate: MM DD YY
9. Employer (company):
10. Group number, name, and address:
11. Is patient covered by another plan of benefits?
Dental Yes No
Medical Yes No
12A. Name and address of carrier(s):
12B. Group number(s):
13. Name and address of employer:
14A. Employee/subscriber name (if different than patient's):
14B. Employee/subscriber social security #:
14C. Employee/subscriber birthdate: MM DD YY
15. Relationship to patient:

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (employee or spouse if dependent is a minor) Date

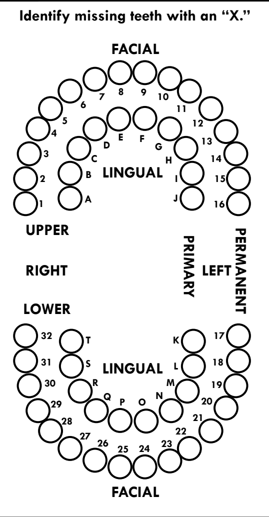
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (employee or spouse if dependent is a minor) Date

DENTIST SECTION

16. Dentist name:
17. Mailing address:
City, state, zip:
18. Dentist social security # or T.I.N.:
19. Dentist license #:
20. Dentist phone #:
21. First visit date (current series):
22. Place of treatment: Office Hospital ECF Other
23. Radiographs or models enclosed? If yes, how many?
24. Is this the result of an occupational illness/injury? (If yes, enter brief description and dates.)
25. Is this the result of an automobile accident? 26. Other accident?
27. Are the services covered by another plan?
28. If for a prosthesis, is this the initial placement? (If no, enter reason for replacement):
29. Date of prior placement:
30. Is this treatment for orthodontics? (If services have commenced, enter date appt. placed and mos. remaining.)

Identify missing teeth with an "X."



31. Examination and treatment plan - list in order from tooth no. 1 through tooth no. 32. Use charting system shown.

Tooth # and Surface	Description of Service (incl. x-rays, prophylaxis, materials used, etc.)	Date Performed (Mo./Day/Year)	Procedure Number	Fee	For Administrative Use Only

32. Remarks for unusual services:

I hereby certify that the procedure as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

Signed (dentist) Date

TOTAL FEE CHARGED	
Max Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	