## **Dental Claim Form**

| Check one:  Dentist's pre-treatment estimate Dentist's statement of actual services  |  |                     |                             |              |             |                         |   |             |            |             | Return this form to:  Return this form to:  GROUP ADMINISTRATORS, L. 915 National Parkway, Suite F Schaumburg, IL 60173 Fax: 847-519-1979 |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
|--|--|---------------------|-----------------------------|--------------|-------------|-------------------------|---|-------------|------------|-------------|---|-------------------|---|--------------|--|--------|---|--------------|------------------|--------------|-------------------------------------|----------|-----|--|
|  | 1. Patient Name 2. Relationship to   |                     |                             |              |             |                         |   |             |            |             | 3. Sex 4. Pa  |                   |   | tient birtl  | е  | 5 If   | full                                      | time student | 19-191           | <del>-</del> |                                     |          |     |  |
| P<br>A<br>T<br>I   | first  |                     | self child spouse other     |              |             |                         |   |             |            | MM DD YYYY  |   |                   | school                                      |              |  |        | city                                      |              |                  |              |                                     |          |     |  |
| ENT COVERAGE   | 6. Employee/subscriber   | 7                   | soc. sec. or I.D. number bi |              |             |                         | Employee/subscriber 9.<br>oirthdate<br>MM DD YYYY |             |            |             | 9. Employer (compar   |                   |   |              | ne and address   | 10. Gr | 10. Group number                          |              |                  |              |                                     |          |     |  |
| INFORMATI  | dental plan?  yes no  If yes, complete 12-a.  Is patient covered by a medical plan? no  14-a. Employee/subscriber name  (if different than patient's)  |                     |                             |              |             |                         | ier(s)  14-b. Employe soc. sec                    |             |            |             |   |                   |   |              | 13. Name and address of other employer(s)  15. Relationship to patient self parent |        |   |              |                  |              |                                     |          |     |  |
|  |  |                     |                             |              |             |                         |   |             |            |             | I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.                      |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
| 5  | bigned (Patient, or parent of minor)  Date   |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   |              |                  | Date         |                                     |          |     |  |
| B<br>!   | 17 Address where permant should be remitted  |                     |                             |              |             |                         |   |             |            |             | 24. Is treatment result of occupational illness or injury?     25. Is treatment result.   |                   |   |              |  |        | If yes, enter brief description and dates |              |                  |              |                                     |          |     |  |
| LLIN   | -<br>-<br>-  |                     |                             |              |             |                         |   |             |            |             | of auto accident  |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
| G<br>D   | G City, State, Zip   |                     |                             |              |             |                         |   |             |            |             | 26. Other accident?   |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
| ENTI   |  |                     |                             |              |             | 20.                     | . Dentist phone no.                               |             |            |             | 27. If prosthesis, is the initial replacement   |                   |   |              |  |        |   | easo         | on for replaceme | ent)         | 28. Date of prior placement         |          |     |  |
| S<br>T   | 21. First visit date current series  | 22. Place<br>Office | of treatm<br>Hosp.          | ent<br>ECF   | Other       |                         | ographs or<br>els endosed?                        | No          | Yes Ho     | w<br>any?   | 29. Is tre<br>ortho   | eatmer<br>odontic |   | 0            |  |        |   |              |                  |              | appliances Mos. treatment remaining |          |     |  |
| lde  | ntify missing teeth with "x  | 27                  | 30. Exar                    | mination and | d treatment | plan – Li               | - List in order from to                           |             | no. 1 thro | 1 through t | tooth no. 32 – Use ch   |                   | lse ch                                      | arting syste |  | n show | ın.                                       |              |                  |              |                                     |          | For |  |
| FACIAL   |  |                     | Tooth<br># or<br>letter     | Surface      |             | tion of se<br>ng x-rays | rvice<br>, prophylaxis, m                         | als used, e | etc.)      |             |   |                   | Date of service<br>performed<br>Mo. Day Yea |              |  |        | Procedure<br>number                       | F            | ee               |              | administrative<br>use only          |          |     |  |
| Ç  |  |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   | 1            |                  |              |                                     |          |     |  |
| Ç  |  | ,                   |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
|  | LOWER TUPE TOWER T |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
| 0  | 2)<br>2)32 (C)1   K(E)<br>2)31 (C)6   LINGUAL L(E)   | EFT PROMINENT       |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
| (  |  |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   | 1            |                  |              |                                     |          |     |  |
|  | FACIAL   | y                   |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   | 1            |                  |              |                                     |          |     |  |
| 31. Remarks for unusual services   |  |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        | l   |              |                  |              |                                     |          |     |  |
|  |  |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   |              |                  |              |                                     |          |     |  |
| I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. |  |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        | Total Fee<br>Charged                      |              |                  |              |                                     |          |     |  |
| ▶_   |  |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        | -  -                                      | _            |                  |              |                                     | <u> </u> |     |  |
| Signed (Treating Dentist) License Number Date  |  |                     |                             |              |             |                         |   |             |            |             |   | Max. Allowable    |   |              |  |        |   |              |                  |              |                                     |          |     |  |
|  |  |                     |                             |              |             |                         |   |             |            |             |   |                   |   |              |  |        |   |              | luctible         |              |                                     |          |     |  |
|  |  | S                   | ee Re                       | everse       | Side F      | or C                    | laim Fili   | ng          | Instr      | ucti        | ons   |                   |   |              |  |        |   | Carrier %    |                  |              |                                     |          |     |  |

Patient pays

## INSTRUCTIONS TO THE EMPLOYEE (Use this form for both Employee and Dependent Claims)

- 1. Complete Questions 1 through 15 on the reverse side. Have Patient's Dentist complete Questions 16 through 31.
- 2. If you want benefits paid directly to the dentist, complete the Authorization to Pay on the reverse side following **Question 15**.
- 3. If charges exceed \$200.00, a treatment plan should be submitted prior to continuation of treatment.

## **INSTRUCTIONS TO THE DENTIST**

FOR CHARGES LESS THAN \$200.00

- 1. Show the date the work was completed for each service and the corresponding fee.
- 2. Return the completed form to the Group Administrators, Ltd. address given below.

FOR CHARGES EXCEEDING \$200.00

- Prior to the continuation of treatment describe procedures necessary to fully complete the treatment plan. State you fees, enclose x-rays (these will be returned to you)\*and return the form to Group Administrators, Ltd. (address below).
- The amount payable per procedure will be predetermined and you will be advised of the benefits payable for the procedures indicated.
- After the work is completed, enter the dates that the service was completed and return the pre-treatment estimate form to the Group Administrators, Ltd. address given below

## NOTICE!!

THE PRE-DETERMINED BENEFITS APPLY ONLY TO EXPENSES INCURRED WHILE EMPLOYEE'S COVERAGE IS IN FORCE.

\* X-RAYS WILL BE RETURNED ONLY IF A SELF-ADDRESSED, STAMPED ENVELOPE IS INCLUDED WITH THE SUBMISSION OF YOUR CLAIM!!

PLEASE MAIL COMPLETED FORM TO:

GROUP ADMINISTRATORS, LTD.
915 NATIONAL PARKWAY, SUITE F
SCHAUMBURG, IL 60173
847-519-1880
Fax: 847-519-1979