GROUP DENTAL INSURANCE CLAIM FORM

EMPLOYEE: We may not be able to identify this claim without your correct social security number or identification number.

EMPLOYEE'S STATEMENT (DO **NOT** COMPLETE THIS STATEMENT UNTIL YOU VERIFY THE ACCURACY OF ALL CHARGES RECORDED IN THE HOSPITAL'S AND ATTENDING PHYSICIAN'S REPORTS)

EMPLOYEE'S NAME →

NAME OF EMPLOYER

S.S. NO. OR IDENTIFICATION NO.

EMPLOYEE'S ADDRESS

CITY

STATE

ZIP CODE

PHONE #

EMPLOYEE'S MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐

NAME OF SPOUSE

IS SPOUSE EMPLOYED: YES ☐ NO ☐

NAME AND ADDRESS OF SPOUSE'S EMPLOYER

ARE YOU OR YOUR DEPENDENT INSURED UNDER ANY OTHER GROUP HEALTH INSURANCE PLAN OFFERED THROUGH ANOTHER JOB, YOUR SPOUSE'S EMPLOYER, A UNION OR ASSOCIATION, OR THROUGH ANY GOVERNMENT PLAN? YES ☐ NO ☐

IF YES GIVE NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS.

PHONE NUMBER

NAME

ADDRESS

POLICY NUMBER

THIS CLAIM IS FOR: ☐ MYSELF ☐ MY DEPENDENT (COMPLETE SECTION 3 ONLY IF PATIENT IS A DEPENDENT)

NATURE OF ILLNESS:

DATE OF FIRST TREATMENT

1

NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED THIS CONDITION

IF CLAIM IS BASED ON ACCIDENT:

2

DATE OCCURRED TIME ☐ A.M. ☐ P.M.

WHERE DID ACCIDENT OCCUR?

WAS ACCIDENT DUE TO PATIENT'S OCCUPATION? YES ☐ NO ☐

HOW DID ACCIDENT HAPPEN?

IF CLAIM IS FOR A CHILD AND YOU ARE DIVORCED OR SEPARATED, COMPLETE SUPPLEMENTAL CLAIM FORM G-997

3

PATIENT'S NAME

RELATIONSHIP

DATE OF BIRTH ,19

IS PATIENT LIVING WITH AND WHOLLY DEPENDENT ON YOU? YES ☐ NO ☐

SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐

IF CLAIM IS FOR CHILD OVER AGE 18, IS THE CHILD A FULL-TIME STUDENT? YES ☐ NO ☐

NAME AND LOCATION OF SCHOOL

WAS THIS DEPENDENT EMPLOYED WHEN THIS CLAIM WAS INCURRED? YES ☐ NO ☐

IF YES, GIVE NAME AND ADDRESS OF EMPLOYER.

IF NO, GIVE NAME OF EMPLOYER AND DATE CEASED WORK.

The above answers are true and complete to the best of my knowledge and belief. Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Florida Health Administrators, Inc. FHA-PTA Division or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care or treatment provided the patient, Insured Person or deceased named below, or information relating to the death of such person, including information relating to mental illness, use of drugs or use of alcohol. I also authorize my employer, group policyholder or benefit plan administrator to provide Florida Health Administrators, Inc. FHA-PTA with any financial or employment-related information which may be pertinent to the claim. I understand that such information will be used by Florida Health Administrators, Inc. FHA-PTA or its authorized representative for the purpose of evaluating my claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of coverage under the policy.

Signature of Patient _____ *Signature of Employee* _____ *Date Signed (Mo. / Day / Year)* _____

(If Patient / Employee is a minor or is incapacitated, Parent or Guardian must sign. If Patient / Employee is deceased, Personal Representative or next of kin must sign.)

WHEN COMPLETE, PLEASE MAIL TO:

FHA-TPA
Benefit Administrators
PO Box 327810 • Fort Lauderdale, FL 33332-9998
TEL: 954-366-0111 • TOLL FREE: 800-707-0501 • FAX: 954-366-0133

HEALTH INSURANCE CLAIM
GROUP OR INDIVIDUAL

ATTENDING DENTIST'S STATEMENT

PART A *Spaced for Typewriter - Marks for Tabulator Appear on this Line*

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH

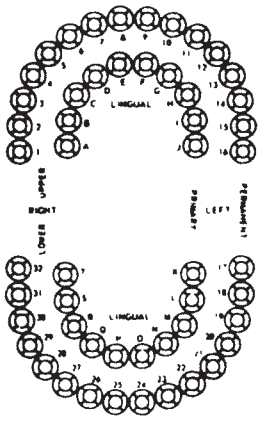
INSURED'S NAME IF PATIENT IS A DEPENDENT

NAME OF INSURANCE COMPANY	POLICY NUMBER	INSURED'S SOCIAL SECURITY NUMBER

IF GROUP INSURANCE, NAME OF POLICY HOLDER *(i.e. Employer , Unions or Associations through whom insured)*

DENTIST NAME			IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES.
MAILING ADDRESS			IS TREATMENT RESULT OF AUTO ACCIDENT?			
			OTHER ACCIDENT?			
CITY STATE ZIP			ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
DENTIST SOC. SEC. OR T.I.N.	DENTIST LICENSE NO.	DENTIST PHONE NO.	IF PROSTHESIS IS THIS INITIAL PLACEMENT?			(IF NO REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT: OFFICE / HOSP / ECF / OTHER	RADIOGRAPHS OR MODELS ENCLOSED? NO / YES / HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED; MOS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X" FACIAL



FACIAL REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MONTH	DAY	YEAR	PROCEDURE NUMBER	FEE	
						TOTAL FEE CHARGED		

I HEREBY CERTIFY THAT I HAVE EXAMINED AND DIAGNOSED THIS PATIENT AND THAT THE ABOVE TREATMENT PLAN IS MEDICALLY/DENTALLY NECESSARY AND INDICATED, AND THAT THE PATIENT HAS BEEN ADVISED REGARDING ALTERNATIVE TREATMENT PLANS.

DATE _____ SIGNED (Dentist) _____

PATIENT CERTIFICATION

I hereby certify that to the best of my knowledge all of the above listed services have been performed.

Date _____ Signed (Participant) _____

DENTIST CERTIFICATION

I hereby certify that the procedures as indicated by date have been completed and Prosthetics inserted.

Date _____ Signed (Dentist) _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charges for these services.

SIGNED (INSURED PERSON)

DATE

INSTRUCTIONS TO DENTIST

All Treatment must be Pre-Authorized except Emergency Treatment Including Root Canal, if charges exceed $200. Mounted Full Mouth X-rays identified by Right and Left must accompany all Pre-Treatment Plans.

For Removable Dentures a copy of the numbered Florida State Board of Dentistry Laboratory slip must be submitted. On any Treatment Plan that includes Prosthetics the "Date Service Performed" is the date of insertion in the mouth. Any changes in an Authorized Pre-Treatment Plan requires additional certification before treatment can be rendered.

NOTICE

Any person who knowingly and willfully seeks to have an employee benefit plan pay a wrongful claim may be fined as much as $10,000, or imprisoned not more than five years, or both. 18 United States Code Section 664.

The State of Florida (Fl. Statutes, Section 817.234) requires us to inform you that "any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree."