

**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

1. 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).
2. The amount payable per procedure will be pre-determined and you will be advised of the benefits payable for the procedures indicated.
3. 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.
953 American Lane, Suite 100
SCHAUMBURG, IL 60173
847-519-1880
Fax: 847-519-1979**

Dental Claim Form

Check one:

- Dentist's pre-treatment estimate
 Dentist's statement of actual services



Return this form to: **GROUP ADMINISTRATORS, LTD.**
 953 American Lane, Suite 100
 Schaumburg, IL 60173
 Fax: 847-519-1979

P A T I E N T C O V E R A G E I N F O R M A T I O N	1. Patient Name first _____ m.i. _____ last _____		2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other		3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school _____ city _____				
	6. Employee/subscriber name and mailing address			7. Employee subscriber soc. sec. or I.D. number		8. Employee/subscriber birthdate MM DD YYYY		9. Employer (company) name and address		10. Group number	
	11. Is patient covered by another dental plan? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, complete 12-a. Is patient covered by a medical plan? <input type="checkbox"/> yes <input type="checkbox"/> no		12-a. Name and address of carrier(s)			12-b. Group no.(s)		13. Name and address of other employer(s)			
	14-a. Employee/subscriber name (if different than patient's)			14-b. Employee/subscriber soc. sec. or I.D. number		14-c. Employee/subscriber birthdate MM DD YYYY		15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____			

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.

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

Signed (Patient, or parent of minor) _____ Date _____				Signed (Insured person) _____ Date _____							
16. Name of Billing Dentist or Dental Entity				24. Is treatment result of occupational illness or injury?		No	Yes	If yes, enter brief description and dates			
17. Address where payment should be remitted				25. Is treatment result of auto accident?							
City, State, Zip				26. Other accident?							
18. Dentist Soc. Sec. or T.I.N.		19. Dentist license no.		20. Dentist phone no.		27. If prosthesis, is this initial replacement?		(If no, reason for replacement)		28. Date of prior placement	
21. First visit date current series	22. Place of treatment Office Hosp. ECF Other			23. Radiographs or models enclosed?	No	Yes	How many?	29. Is treatment for orthodontics?	If services already commenced enter:	Date appliances placed	Mos. treatment remaining

Identify missing teeth with "X"		30. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Use charting system shown.						For administrative use only	
		Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date of service performed Mo. Day Year	Procedure number	Fee		

31. Remarks for unusual services									

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 Charged			
Signed (Treating Dentist) _____				License Number _____		Date _____		Max. Allowable	
								Deductible	
								Carrier %	
								Carrier pays	
								Patient pays	

See Reverse Side For Claim Filing Instructions