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.
20 NORTH MARTINGALE RD., SUITE 290
SCHAUMBURG, IL 60173
847-519-1880
Fax: 855-978-2331

Dental Claim Form

Check one:
- ☐ **Dentist's pre-treatment estimate**
- ☐ **Dentist's statement of actual services**

Return this form to:

GROUP ADMINISTRATORS, LTD.
20 North Martingale Rd., Suite 290
Schaumburg, IL 60173
Fax: 855-978-2331

PATIENT COVERAGE INFORMATION

1. Patient Name first m.i. last	2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ 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? ☐ yes ☐ no If yes, complete 12-a. Is patient covered by a medical plan? ☐ yes ☐ 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 ☐ self ☐ parent ☐ spouse ☐ 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.

▶ _____ _____
Signed (Patient, or parent of minor) Date

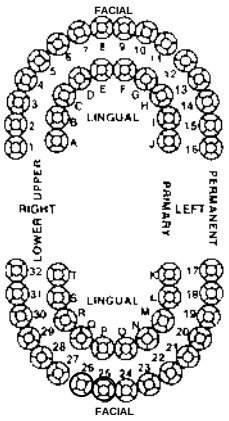
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ _____ _____
Signed (Insured person) Date

BILLING DENTIST

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.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date of service performed Mo. Day Year	Procedure number		Fee

For administrative use only

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.

▶ _____ _____ _____
Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

See Reverse Side For Claim Filing Instructions