DENTAL CLAIMS ADMINISTERED BY

PART A - MEMBER STATEMENT - Failure to Answer All Questions May Delay Payment

1. Member's Name	Street Address	City or Town	ZIP Code

2. Plan Number	Social Security #	Are you still employed? ☐ Yes ☐ No	If no, enter date last worked
3. Date of Birth	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Name of Your Employer	Occupation
4. Spouse's Date of Birth	Is your spouse employed? ☐ Yes ☐ No	If yes, enter the name and address of spouse's employer	

5. Are you or your dependents covered under another group insurance or government plan such as Medicare, an HMO or automobile no fault coverage, which will also cover any of the dental expenses on the claim? ☐ Yes ☐ No — If yes, enter name and address: Policy # / ID #: Family Member Holding Policy:

6. Is claim for a dependent? ☐ Yes ☐ No	If yes, enter dependent name (first, last)	Sex ☐ Male ☐ Female	Date of Birth	Relationship to Member	If dependent is a child, are you entitled to a tax exemption? ☐ Yes ☐ No
6a. If child, is he/she married? ☐ Yes ☐ No	Is child over 19? ☐ Yes ☐ No	If yes, is child a full-time student? ☐ Yes ☐ No	If yes, enter name of school		
7. Is claim for an accident? ☐ Yes ☐ No	Date: Time:	Where did it occur?	While working? ☐ Yes ☐ No	How did it occur?	

8. SIGN HERE IF YOU WANT BENEFITS PAID TO DOCTOR/HOSPITAL — DATE:

9. SIGN HERE FOR ALL CLAIMS — DATE:

I hereby authorize any insurance company, hospital, or physician to release all information which may have a bearing on benefits payable under this plan of benefits.

PART B - DENTIST'S STATEMENT

Check One ☐ Dentist's Pretreatment Estimate ☐ Dentist's Statement of Actual Services

Patient's Name	Date of Birth	Has any other group insurance carrier been billed for these services? ☐ Yes ☐ No

Question		Details
Is treatment result of occupational illness or injury?	☐ Yes ☐ No	If yes, advise date and details
Is treatment result of automobile or other accident?	☐ Yes ☐ No	If yes, advise date and details
If prosthesis, is this initial placement?	☐ Yes ☐ No	If no, reason for replacement — Prior placement date
Is treatment for orthodontics?	☐ Yes ☐ No	Date appliances placed

Examination and treatment plan - List in order from tooth No.1 to 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	Procedure Number	Fee
		1			
		2			
		3			
		4			
		5			
		6			
		7			
		8			
		9			

Signature of Dentist

Signed — Date:

Total Charges	Amount Paid	Balance Due

X-rays Enclosed ☐ Yes ☐ No	Provider's Social Security # / Tax ID #	Dentist's Name, Address, ZIP Code	Telephone (Include Area Code)

Group Dental Claim - HOW TO FILE A CLAIM

Member

1. Complete Part A - One for each family member
2. If claim is for a dependent, also complete lines 6 & 6a
3. If claim is for an accident, complete line 7
4. For all claims, sign line 9
5. If you want benefits paid to doctor/hospital, sign form on line 8
6. Enclose a copy of other carriers' payment worksheet when you have other insurance.
7. Ask your doctor to provide itemized bills with diagnosis for care

Dentist

1. Complete Part B
2. Or, attach itemized Bill which includes Diagnosis for care
3. Sign form - return to patient

Forward Completed Claim Forms To:

P.O. Box 11111
Fort Scott, KS 66701

NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against a claims administrator or payer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. Such action is considered to be a felony in some states.