

DENTAL CLAIM FORM

INSTRUCTIONS: Please complete the "PATIENT SECTION". Your dentist must complete all other sections or attach an itemized statement.

DENTIST PLEASE CHECK ONE: PRE-TREATMENT ESTIMATE or STATEMENT OF ACTUAL SERVICES
PLEASE SUBMIT X-RAYS IF PRE-TREATMENT OR SERVICE EXCEED \$250.00
PLEASE COMPLETE ONE CLAIM FORM PER PATIENT

P A T I E N T S E C T I O N	EMPLOYER NAME				GROUP NO AS SHOWN ON YOUR ID CARD						
	EMPLOYEE'S NAME LAST		FIRST		MIDDLE INITIAL		EMPLOYEE'S SOCIAL SECURITY NO.				
	EMPLOYEE'S ADDRESS		STREET BOX		CITY		STATE		ZIP		
	PATIENT NAME LAST		FIRST		SS #:		RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD		PATIENT BIRTHDATE MO. DAY YEAR		
	IS PATIENT COVERED BY OTHER GROUP DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, INSURANCE CO. NAME		STREET		CITY		STATE ZIP		
	IS PATIENT FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF FULL TIME STUDENT, SCHOOL NAME		CITY		STATE		ZIP		
	SPOUSE'S EMPLOYER		SPOUSE'S D.O.B.		DOES SPOUSE HAVE OTHER GROUP DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE CO. NAME		STREET CITY STATE ZIP		
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.					I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.						
SIGNED (PATIENT OR PARENT IF PATIENT IS A MINOR) _____ DATE _____					SIGNED (EMPLOYEE) _____ DATE _____						
D E N T I S T S E C T I O N	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?						
	CITY STATE ZIP				OTHER ACCIDENT?						
	DENTIST SOC. SEC. NO. OR T.I.N. DENTIST LICENSE NO. DENTIST PHONE NO. ()				ARE ANY SERVICES COVERED BY ANOTHER PLAN?						
	FIRST VISIT DATE PLACE OF TREATMENT OFFICE HOSP ECF OTHER RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?				IF PROSTHESIS, IS THIS INITIAL PLACEMENT?				(IF NO REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT		
	IS TREATMENT FOR ORTHODONTICS?				IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED				MOS. TREATMENT REMAINING		
	IDENTIFY MISSING TEETH WITH "X"		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.) LINE NO.	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE				
REMARKS FOR UNUSUAL SERVICES		TOTALS									
I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.											
DENTIST SIGNATURE _____				DATE _____		TAX I. D. NO. _____					

Please send the completed claim form and appropriate statements to:

First Administrators, Inc.

P.O. Box 9900, Sioux City, Iowa 51102-0479

Tollfree 1- 800/526-5710 Local (712) 233-5400