CLAIM FORM

1. COMPLETE THIS FORM IN FULL AND SIGN BELOW.
2. ATTACH ALL BILLS.
3. MAIL TO:

Fringe Benefit Coordinators
P O BOX 771
Kathleen, FL 33849

FRINGE BENEFIT COORDINATORS

P O Box 771
Kathleen, FL 33849
(352) 377-1239 Fax (352) 372-9805
WWW.FBC-INC.COM

PART 1 EMPLOYEE STATEMENT — PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME	SOCIAL SECURITY #	NAME OF DISTRICT GILCHRIST	
EMPLOYEE MAILING ADDRESS	EMPLOYEE BIRTH DATE	OCCUPATION	GROUP NUMBER _____
CITY STATE ZIP	PHONE NO.	EMAIL ADDRESS (OPT)	NAME OF SCHOOL

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? ☐ YES ☐ NO
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? ☐ YES ☐ NO
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? ☐ YES ☐ NO

IS THE PATIENT A FULL TIME STUDENT? YES ☐ NO ☐ IS THE PATIENT HANDICAPPED? YES ☐ NO ☐

NAME OF SPOUSE	SOC. SEC. # OF SPOUSE	BIRTHDATE	SPOUSE EMPLOYER

IS THE PATIENT COVERED BY ANY OTHER DENTAL / VISION / DISABILITY PLAN? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

MEMBER NAME: RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ OTHER ☐ _____ SOCIAL SECURITY # OF MEMBER:	PLAN NAME AND ADDRESS: GROUP PLAN #: EFFECTIVE DATE:

PATIENT OR PARENT MUST SIGN AND DATE BELOW | **IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW**

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X_____
Patient, or Parent if minor Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):
I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X_____
Employee Date

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
   - Questions regarding other coverage you or your dependents are eligible for must be answered.
   - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
   - If payment is to be made to the provider of services, you should sign that section.

2. **When not accompanied by an itemized bill** have your doctor or dentist complete PART 2 for each dental or vision claim

3. Attach all itemized bills relating to the claim to PART 1 of the Claim Form.
   - Make sure all bills identify the patient.
   - All bills should show the date of treatment, type of service, and amount of charges.

4. If you have other coverage (including Medicare), make sure you attach all Payment Statements, Explanations of Benefits or declination letters.

PART 2 TO BE COMPLETED BY DENTIST

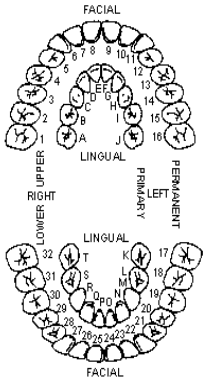
PATIENT'S NAME	BIRTH DATE OF PATIENT	RELATIONSHIP TO MEMBER SELF ☐ SPOUSE ☐ CHILD ☐

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE ☐ OTHER ☐ _____	RADIOGRAPHS OR MODELS ENCLOSED ☐ NO ☐ YES	HOW MANY?	IF PROSTHESIS, IS THIS AN INITIAL PLACEMENT? ☐ YES ☐ NO IF NO, PROVIDE THE REASON FOR REPLACEMENT: DATE OF PRIOR PLACEMENT:

IS TREATMENT FOR ORTHODONTICS? ☐ YES ☐ NO	IF "YES" AND SERVICES ALREADY COMMENCED, GIVE DATE APPLIANCES PLACED: _____ ENTER MONTHS OF TREATMENT REMAINING: _____

IS TREATMENT THE RESULT OF ILLNESS OR ACCIDENTAL INJURY? ☐ YES ☐ NO WORK RELATED? ☐ YES ☐ NO	IF YES TO EITHER, ENTER A BRIEF EXPLANATION INCLUDING DATES

CHECK ONE ☐ **DENTIST'S PRE-TREATMENT EVALUATION** ☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**



EXAMINATION TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THRU TOOTH NO. 32 USING CHARTING SYSTEM SHOWN

TOOTH #	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED			PROCEDURE CODE	FEE	ADMINISTRATIVE USE
		TOTAL CHARGE						

REMARKS FOR UNUSUAL SERVICES

DENTIST'S NAME DEGREE ADDRESS	TAX I.D. # or SSN	ACCEPT ASSIGNMENT? ☐ YES ☐ NO
CITY STATE ZIP CODE	PHONE NUMBER	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ☐ WILL BE PERFORMED ☐ HAVE BEEN PERFORMED

DENTIST'S SIGNATURE X _____

PATIENT ACCOUNT #