# 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


## *DENTAL CLAIM FORM*

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 # XXX-XX- | NAME OF DISTRICT Bradford |
|---|---|---|

| EMPLOYEE MAILING ADDRESS | EMPLOYEE BIRTH DATE | OCCUPATION | GROUP NUMBER 7033 |
|---|---|---|---|

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

**PATIENT OR PARENT MUST SIGN AND DATE 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

**IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW**

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

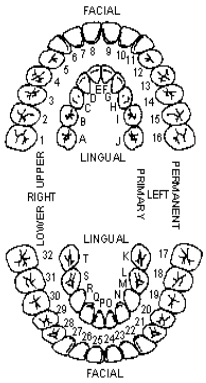
| PATIENT'S NAME | BIRTH DATE OF PATIENT | RELATIONSHIP TO MEMBER<br>SELF ☐ SPOUSE ☐ CHILD ☐ |
|---|---|---|

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

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

| IS TREATMENT THE RESULT OF ILLNESS OR ACCIDENTAL INJURY?<br>☐ 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 |
|---|---|---|---|---|---|---|---|---|
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| | | **TOTAL CHARGE** | | | | | | |

REMARKS FOR UNUSUAL SERVICES

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

| I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ☐ WILL BE PERFORMED ☐ HAVE BEEN PERFORMED<br>DENTIST'S SIGNATURE X _____ | PATIENT ACCOUNT # |
|---|---|