DENTAL CLAIM FORM

BeniComp Inc.
8310 Clinton Park Dr.,
Ft. Wayne. IN 46825
(260) 482-7400 ■ 1-800-837-7400

EMPLOYER _____

PATIENT

Check One: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services	Carrier name and address
Patient's Name Last First Middle Initial	Relationship To Employee Sex ☐ Male ☐ Female
Is Patient Full Time Student? ☐ Yes ☐ No Is YES, Please give School and Address:	Patient's Date of Birth / / Month Day Year
Employee/Subscriber Name Last First Middle Initial	Employee/Subscriber Social Security Number
Employee/Subscriber Date of Birth / / Month Day Year	Employer (company) name and address Group Number

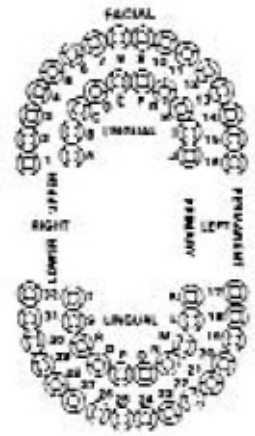
Is Patient covered by another plan of benefits?	Name and Address of Carrier(s)	Group Number	Name and Address of Employer
Dental_____ Medical_____			

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 if minor)	I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me. _____ _____ Signed (insured person Date

DENTIST

Dentist's Name Last First Middle Initial		Dentist's Social Security or TIN
Mailing Address	Dentist's License #	Dentist's Phone #
First Visit Date Current Series / Place of Treatment		Radiographs or Models Enclosed? How Many? ☐ Yes ☐ No
Is Treatment result of occupational illness or injury? If yes, please explain. ☐ Yes ☐ No	Is treatment result of Auto accident? ☐ Yes ☐ No	Other Accident? ☐ Yes ☐ No
Are any Services Covered under another Plan? If so, Explain. ☐ Yes ☐ No	If Prosthesis, is this initial placement? ☐ Yes ☐ No	
	If no, reason for replacement.	Date of prior placement.
Is treatment for Orthodontics? ☐ Yes ☐ No	If services already commenced enter: / Date appliances place.	Mos. Treatment remaining

IDENTIFY MISSING TEETH WITH X



Tooth # or letter	Surface	Description of service	Date service preformed	Procedure #	Fee	For Administrative Use only

I hereby certify that the procedures as indicated by data have been completed and that the fees submitted are the actual fees I have charged and intended to collect for those procedures.

_____ _____
Signed (Dentist) Date

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

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Group Dental Insurance ■ Employee Statement

This form must be completed by the employee and the patient's dentist whenever a claim is made for reimbursement for dental expenses.
ALSO, if the claim is for

1. Prosthetic Treatment (crowns, inlays, bridges or dentures), or
2. Any Other Proposed Dental Treatment Expense requiring a Dentist's Pre-treatment Estimate as described in the policy, or
3. Expenses incurred during the Dental Health Insurance Extension provisions of the policy,

a **Dentist's Pre-treatment Estimate** of cost and a description of the treatment must be submitted to the administrator (B) for approval **prior** to the commencement of the proposed dental treatment and within 20 days from the date of the examination showing the need for such dental treatment. Failure to comply with this requirement could result in a reduction in benefits or cause a delay in service.

Return form and attachments to: **BeniComp Inc.**

EMPLOYEE

Employee Name	Employee's Date of Birth: / / Month Day Year
Employee Social Security Number	Are you currently working? ☐ Yes ☐ No If no, give last day worked:
Are you married? ☐ Yes ☐ No If Yes, complete shaded boxes.	Spouse's Name Spouse's Date of Birth / / Month Day Year
Spouse's Employer:	Spouse's Occupation:

PATIENT

For whose expenses do you make claim? ☐ Self ☐ Wife ☐ Husband ☐ Son ☐ Daughter	Patient's Date Of Birth: / / Month Day Year Patient's Occupation:
Date Treatment Began: / / Month Day Year	Did Condition Result from Employment? ☐ Yes ☐ No
Is Condition Due To Injury? ☐ Yes ☐ No If Yes, Describe Accident, Including Date and Place:	Is Patient Covered by any other Group Policy or Prepayment Plan? ☐ Yes ☐ No If Yes, complete shaded boxes.
Name of Person Carrying The Other Coverage:	Name of Group (Employer, Association, etc.)
Name of Insurance Company or Plan:	Policy or Plan Number:

These statements are true and complete to the best of my knowledge. I authorize any insurer, or dentist to disclose information regarding my (or my dependent's) insurance coverage or dental history, and agree to reimburse the Administrator named above, if this claim for dental benefits is compensable under Workmen's Compensation Act or similar law or such claim is settled or compromised, or if benefits, reduced by the coordination of benefits provision of the contract, are paid or are payable. A copy of this authorization shall be as valid as the original.

Signature of Insured Employee_____ Date_____

Signature of Patient_____

Address of Insured_____
Street City State Zip