DENTAL CLAIM FORM

Professional Benefit Administrators, Inc.

All Providers send bills to:
Professional Benefit Administrators, Inc.
P.O. Box 4687
Oak Brook, IL 60522-4687
(800) 435-5694

INSTRUCTIONS TO EMPLOYEE FOR COMPLETING THIS CLAIM FORM

- Complete all sections in full (please type or print). Incomplete information may delay processing your claim.
- Give this form to your dentist. If you wish to have your benfits paid directly to your dentist, please sign part D below.
- If services will exceed $300, have your dentist submit a Pre-Treatment Estimate to PBA. PBA will advise your dentist and you what the plan will pay.

Part A - Employee Information

Employee name:	Date of birth:	ID#:
Home Address:		Phone:
Sex: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed	
Spouses Name:	Date of birth:	ID#:
Is Spouse Employed? ☐ Yes ☐ No	If yes, Company Name:	
Address:		Phone:

Part B – Dependent Information

Name:	Relationship:	Date of birth:
Home address if different from employee:		
Is dependent employed? ☐ Yes ☐ No	Name of Employer:	
Address:		Phone:

If claim is for child over 18 indicate:
A. **Student** ☐ Full-time ☐ High School ☐ Vocational ☐ College
Credit hours of study: _____ Name & Address of School: _____

B. **Handicapped**, Please Explain: _____

Are you or your dependents entitled to benefits from any other group insurance plan or Group Dental Plan? ☐ Yes ☐ No
If "Yes", please identify:

A. Identify Family members insured under other plan:

B. Name(s) and addresses of other insurance company and/or organization:

C. Group policy number:

Part C – Complete If Claim is For an Accident

Was dental treatment required because of injury? ☐ Yes ☐ No

Date/Time of Accident: Location:

Explain what happened:

Did injury arise out of or in the course of any employment? ☐ Yes ☐ No

If yes, explain (include employer's name):

CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION: I certify that these statements and answers are true to the best of my knowledge and belief. I hereby agree to reimburse this plan to the extent that benefits are provided under any Workers' Compensation law, similar legislation, and/or any settlement related to such coverages.

I hereby authorize any insurance company, provider, or any other organization to release all information to PBA, Inc., which may have a bearing on the benefits payable under this plan. A photocopy of this authorization will be considered as effective and valid as the original, and will be valid for one year from the date below.

Date:	Employee Signature:	Spouse Signature (if claim is on spouse):

Part D – Assignment Authorization

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Dental Benefits, if any to the provider of services on the reverse side of this form and for those providers whose billings are attached to this form.

Signed (Employee):	Date:
Spouse Signature (if claim is on spouse):	

INSTRUCTIONS TO DENTIST'S OFFICE

1. Complete the dentist's portion of the claim form.
2. Have the employee sign the assignment authorization, Part D, if payment is to be made directly to your office.
3. If you are requesting a Pre-Treatment Estimate of plan benefits, retain a copy of the Dental Claim Form you have forwarded to the claim paying office. Your office and the employee will receive an explanation of benefits from the claim department. After the services have been performed, forward a copy of the Dental Claim Form to the address shown on the reverse side of this form, indicating the dates of service and any changes in the treatment plan originally reported.

Part D – Assignment Authorization

(Check One)

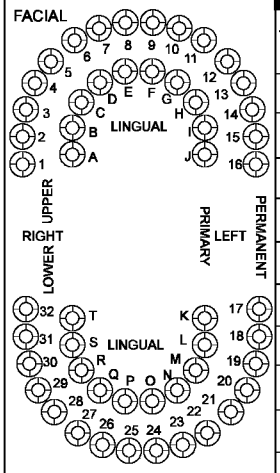
☐ Pre-Treatment Estimate (optional)
OR
☐ Statement of Actual Services

DENTIST'S NAME		
First	M.I.	Last
Street Address		
City, State		Zip
If Specialist Show Specialty	Soc. Sec. or Tax ID # Required Under Federal Law	Phone #

	Yes	No
Is any treatment for Orthodontic purposes?		
Is treatment the result of an accident?		
Is treatment the result of an occupational injury?		
Are X-Rays included? If yes, how many _____		

Date of Patient's first visit	Mo.	Day	Yr.

If Prosthesis, Crown, Inlay or Bridge, is this initial placement?
☐ Yes ☐ No. If no, give procedure number, date of prior placement and reason to replace.



Facial
Ⓐ
Indicate Missing Teeth with an "X"
Ⓑ
Make a Schematic Drawing of Crowns, Bridges and Partial Dentures

Remarks
Unusual Services

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN

Tooth # or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Procedure Number ADA	Date Service Performed Mo.	Da.	Yr.	FEE	FOR ADMINISTRATIVE USE ONLY 100%	80%	____%

ORTHODONTICS: (Five diagnosis, class of malocclusion and describe appliance(s) in above treatment section)
Date first appliance inserted _____
Date last appliance removed _____
Treatment period (Number Months _____
Total Fee $_____

TOTAL FEE $

Benefits will be subject to plan provisions if the procedures described are performed during a period of the patient's eligibility.

Deductible			
Balance			
% Pay			
Amt. Pay			
Plan Pays			
Patient Pays			

I hereby certify that services listed above have been performed on the named patient on the dates indicated and that the fees shown are those currently charged to the majority of my patients.

Signed (Dentist) X_____ Date _____

PLEASE NOTE: PRETREATMENT ESTIMATE OF BENEFITS DOES NOT GUARANTEE PAYMENT.
This estimate of benefits has been calculated based on current available benefits and employee eligibility. This estimate is subject to modification based upon remaining benefits available and eligibility which applies at the time services are completed and a claim is submitted for payment.