# GROUP DENTAL CLAIM FORM

SUBMIT CLAIMS TO:

ASSURECARE®
Assured Access Health Systems Management
340 Quadrangle Drive
Bolingbrook, IL 60440
Phone: (630) 759-1311 Fax: (630) 759-5219

**Check one:** ☐ DENTISTS PRE-TREATMENT ESTIMATE ☐ DENTISTS STATEMENT OF ACTUAL SERVICES

## PART A - TO BE COMPLETED BY EMPLOYEE

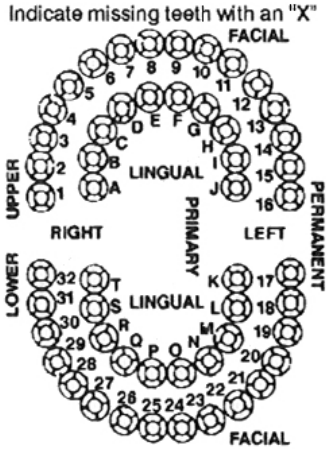
| 1) EMPLOYEES NAME (Last, First, Middle) | | | 2) EMPLOYEES SOCIAL SECURITY NUMBER |
|---|---|---|---|
| 3) EMPLOYEES ADDRESS | CITY | STATE | ZIP CODE |
| 4) PATIENTS NAME (If a Dependent) | 5) RELATIONSHIP TO EMPLOYEE | | 6) BIRTH DATE |
| 7) PATIENTS SOCIAL SECURITY NUMBER | 8) EMPLOYERS NAME | | |

## PART B - TO BE COMPLETED BY DENTIST

| 1) DENTISTS NAME | 10) IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | YES ☐ | NO ☐ | IF YES, ENTER BRIEF DESCRIPTION AND DATES: | |
|---|---|---|---|---|---|
| 2) MAILING ADDRESS | 11) IS TREATMENT RESULT OF AUTO ACCIDENT | ☐ | ☐ | | |
| | OTHER ACCIDENT? | ☐ | ☐ | | |
| 3) CITY, STATE ZIP | 12) IF PROSTHESIS, IS THIS INITIAL PLACEMENT? | ☐ | ☐ | (IF NO, REASON FOR REPLACEMENT) | DATE OF PRIOR PLACEMENT |
| 4) DENTIST SS# OR TIN 5) DENTIST LISCENSE # 6) DENTIST PHONE # | 13) IS TREATMENT FOR ORTHODONICS | ☐ | ☐ | IF SERVICES ALREADY COMMENCED, ENTER: / DATE APPLIANCES PLACED | MOS. TREATMENT REMAING |

| 7) FIRST VISIT DATE CURRENT SERIES | 8) PLACE OF TREATMENT | 9) RADIOGRAPHS OR MODELS ENCLOSED? | HOW MANY? | 14) DOES PATIENT HAVE OTHER DENTAL COVERAGE? | If YES, PLEASE IDENTIFY |
|---|---|---|---|---|---|
| | *Office* *Hosp* *ECF* *Other* | ☐ YES ☐ NO | | ☐ YES ☐ NO | |

Indicate missing teeth with an "X"




**EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN**

| TOOTH # OR LETTER | SURFACE (ie., M,O, D, B, L, LA, I) | DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPI-IYLAXISMATERIALS USED, ETC. | DATE SERVICE PERFORMED MO. DA. YR | PROCEDURE NUMBER | FEE | FOR OFFICE USE ONLY |
|---|---|---|---|---|---|---|
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REMARKS FOR UNUSUAL SERVICES:

| | | |
|---|---|---|
| **TOTAL FEE CHARGED** | | |
| **PATIENT PAYS** | | |
| **BALANCE** | | |
| **PLAN %** | | |
| **PLAN PAYS** | | |

| | | |
|---|---|---|
| I HEREBY CERTIFY THE SERVICES LISTED ABOVE ( ☐ **WILL BE** ☐ **HAVE BEEN** ) PERFORMED. | SIGNED (DENTIST) | DATE |
| I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP PLAN BENEFITS NOT OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATON. | SIGNED (EMPLOYEE) | DATE |
| I HAVE REVIEWED THE FOREGOING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. | SIGNED (PATIENT, OR PARENT IF MINOR) | DATE |



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