

GROUP DENTAL CLAIM FORM

SUBMIT CLAIMS TO:



Assured Access Health Systems Management

1742 Georgetown Road Suite E, Hudson, Ohio 44236

Phone: (330)528-3929

Fax: (330) 342-1642

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 <input type="checkbox"/>	NO <input type="checkbox"/>	IF YES, ENTER BRIEF DESCRIPTION AND DATES:	
2) MAILING ADDRESS		11) IS TREATMENT RESULT OF AUTO ACCIDENT?		YES <input type="checkbox"/>	NO <input type="checkbox"/>		
3) CITY, STATE ZIP		OTHER ACCIDENT?		YES <input type="checkbox"/>	NO <input type="checkbox"/>		
4) DENTIST SS# OR TIN		5) DENTIST LISCENSE #	6) DENTIST PHONE #	12) IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO, REASON FOR REPLACEMENT)	DATE OF PRIOR PLACEMENT
7) FIRST VISIT DATE CURRENT SERIES		8) PLACE OF TREATMENT Office Hosp ECF Other		9) RADIOGRAPHS OR MODELS ENCLOSED? <input type="checkbox"/> YES <input type="checkbox"/> NO		14) DOES PATIENT HAVE OTHER DENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
						13) IS TREATMENT FOR ORTHODONICS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	
						IF YES, PLEASE IDENTIFY	

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 (<input type="checkbox"/> WILL BE <input type="checkbox"/> 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 AUTHORIZATION.	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