DENTAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO →

FOR PROMPT PAYMENT
COMPLETE REVERSE SIDE

FBA
FIRST BENEFIT ADMINISTRATORS

Pursuant to Section 817.234. FLORIDA Statutes…Any person who knowingly and with intent to injury defraud, or deceive any employer or employee, Insurance Company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony of the third degree.

9455 Koger Blvd. N. Suite 100, St. Petersburg, FL 33702
(727) 530-4144 Fax (727) 532-9602 (800) 571-4144
www.firstbenefitadmin.com

GROUP NO.

☐ **Dentist's Treatment Estimate** ☐ **Dentist's Statement of Actual Services**

PART 1 MUST BE COMPLETED BY EMPLOYEE
(Please Print)

Employee Name	Date of Birth	Employer Name	FBA ID Number

Address: Number and Street / City / State / Zip Code	Phone: Work / Home

Dependent Name (If Patient)	Relationship to Dependent ☐ Spouse ☐ Child ☐ Other _____	If over 19 & full time student / Name of School	Date of Birth

Date of Injury	Is Claim Being Made For Workman's Comp? ☐ Yes ☐ No	Physician Name

Nature Injury	How, When and Where Did Injury happen?

Are you married? ☐ Yes ☐ No	Spouse Name	Name and Address of Spouse Employer (If not Employed Write "Not Employed")

Are you or your dependent covered by any other Group Insurance, Health Maintenance Organization, Federal Plan or Union Welfare Plan which may also pay for any of the expenses of this claim?
☐ Yes ☐ No If Yes, complete all information below:

Name and Address of Ins. Co.	Policy / Contract #	Name of Policyholder	Parties Covered under Plan	Effective Date

IF PAYMENT IS TO BE MADE TO DENTIST SIGN BELOW	PATIENT OR PARENT MUST SIGN BELOW
AUTHORIZATION TO PAY BENEFITS TO DENTIST. I hereby authorize payment directly to the undersigned Dentist, otherwise payable to me for his services, but not to exceed the reasonable and customary charge for those services or the contracted network fees.	AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize any Dentist to release any information acquired in the course of my examination or treatment.
SIGNED (Patient or Parent) Sign Only If Payment is to Go to Dentist. X Date	SIGNED (Patient or Parent if Minor) X Date

PART 2 MUST BE COMPLETED BY DENTIST
(Please Print)

Patient Name	Relationship to Employee ☐ Self ☐ Spouse ☐Child ☐ Other _____	Sex ☐ Male ☐Female	Patient Date of Birth Mo Day Year	Full-Time Student ☐ Yes ☐ No Name of School

Employee Name First Middle Last	FBA or Dental Plan #
Employee Mailing Address	Employer (Company) Name and Address

City	State	Zip Code	
Are Other Family Members Employed? ☐ Yes ☐ No Employee Name Soc. Sec. No.			Name and Address of their Employer
Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No	Group No.		Name and Address of Carrier

Is treatment result of occupational illness or injury? ☐ Yes ☐ No	If yes, enter brief description and dates	
Is treatment result of auto accident? ☐ Yes ☐ No	If yes, enter brief description and dates	
Is treatment result of any other type of accident? ☐ Yes ☐ No	If yes, enter brief description and dates	
Are any services covered by another plan? ☐ Yes ☐ No	If yes, enter brief description and dates	
If Prosthesis, is this initial placement? ☐ Yes ☐ No	If No, reason for replacement	Date of prior placement?

First Visit Date Current Series	Place of Treatment Off	Hosp	ECF	Other	Radiographs Models Enclosed? ☐ Yes ☐ No	How Many?	Is treatment for Orthodontics? ☐ Yes ☐ No	If services already commenced enter date:	Date appls placed	Mos. treatment remain

Explanation and Treatment Plan – List in order from Tooth No. 1 through No. 32

Remarks for Unusual Services	Tooth # or Letter	Surfaces	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis Materials Used, Etc.)	Date Service Performed Mo. Day Yr.	ADA Procedure Number	Fee	CLAIMS OFFICE USE ONLY

ORTHODONTICS: (Give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)	TOTAL FEE ACTUALLY CHARGED	
	MAX ALLOWABLE	
	DEDUCTIBLE	
	PLAN %	
	PLAN PAYS	

I hereby certify that the services listed above ☐ will be ☐ have been performed

Dentist Name (Print)	License # / Degree		
Mailing Address	City	State	Zip Code
Telephone	Fax	E-mail	
Signature X	Date	SS# or TIN#	

INSTRUCTIONS FOR FILING

1. Complete the employee's portion – Part 1
2. Have your Dentist complete the Attending Dentist Statement – Part 2, and attach x-rays on major work only.
3. Have your Dentist return the form to you or forward to Florida Benefit Administrators