CLAIM FORM

PART 1 EMPLOYEE STATEMENT			PLEASE REFER TO INSTRUCTIONS BELOW	
EMPLOYEE NAME		SOCIAL SECURITY#	Date of Birth	
EMPLOYEE STREET ADDRESS		CITY & STATE & ZIP CODE		
GROUP NUMBER 0100	Daytime Phone #	Is The Patient A Full Time Student? YES ☐ NO ☐ HANDICAPPED? YES ☐ NO ☐	Name And Address Of School	
PATIENT (IF OTHER THAN EMPLOYEE) NAME	☐ MALE ☐ FEMALE	PATIENT RELATIONSHIP TO EMPLOYEE	Patient Birth Date	IS PATIENT MARRIED ☐ YES ☐ NO
Is The Claim Due To An Accident YES ☐ NO☐	DATE OF ACCIDENT		IS CONDITION WORK RELATED? ☐ YES ☐ NO	
IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?				
NAME AND SOC. SEC. # OF SPOUSE	BIRTHDATE	IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME AND ADDRESS OF SPOUSE'S EMPLOYER	

IS THE PATIENT COVERED UNDER ANY OTHER MEDICAL OR DENTAL PLAN? ☐ YES ☐ NO
IF YES, COMPLETE THE FOLLOWING:

PLAN NAME AND ADDRESS:

SOCIAL SECURITY # OF PATIENT:
GROUP PLAN #: EFFECTIVE DATE:

PATIENT OR PARENT MUST SIGN AND DATE BELOW	IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW
AUTHORIZATION TO RELEASE INFORMATION I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge. X_______________ Patient, or Parent if minor Date	AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization. X _______________ Employee Date

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
   - Questions regarding other coverage you or your dependents are eligible for must be answered.
   - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
   - If payment is to be made to the provider of services, you should sign that section.
2. If you have other coverage (including Medicare), make sure you attach all payment statements or declination letters.
3. Attach all bills relating to the claim.
   - Make sure all bills identify the patient.
   - All bills should show the date of treatment, type of service, and amount of charges.
   - Prescription drug bills should be original receipts, showing name and address of pharmacy, name of patient, date of purchase, prescription number, nature of medication, and charge.

MAIL COMPLETED MEDICAL/DENTAL/VISION CLAIMS AND ITEMIZED BILLS TO:

UNITED BENEFITS, INC. a division of FBMC
P.O. Box 730561 Ormond Beach, FL. 32173-0561
(386) 676-5760 8:00 a.m. to 5:00 p.m. EST.
1-800-323-4890

PART 2 — TO BE COMPLETED BY PHYSICIAN

PATIENT'S NAME	BIRTH DATE OF PATIENT	DOES PATIENT HAVE OTHER COVERAGE? ☐ YES ☐ NO	IF YES, PLEASE IDENTIFY

DIAGNOSIS AND CURRENT CONDITIONS

HAS THE PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? ☐ YES ☐ NO
IF "YES", WHEN AND DESCRIBE.

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED, YOU ONLY NEED DATES AND SERVICES SINCE LAST REPORT) OR ATTACH ITEMIZED BILL.

CLAIMS OFFICE USE ONLY

DATE OF SERVICES	**PLACE OF SERVICES**	**DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED**	**PROCEDURE CODE USED**	**CHARGES**
			TOTAL CHARGES	$
			AMOUNT PAID	$
			BALANCE DUE	$

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

LAST DAY WORKED DATE

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM THROUGH

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

DATE EMPLOYEE RETURNED TO WORK

TYPE OR PRINT
PHYSICIAN'S NAME

ADDRESS

CITY, STATE, ZIP CODE

PHONE

TAX ID NUMBER | SOCIAL SECURITY NUMBER

(DIRECT PAYMENT CANNOT BE MADE IF NOT PROVIDED.)

DEGREE

PHYSICIAN'S SIGNATURE X ______________________________

PART 3 — TO BE COMPLETED BY DENTIST

PATIENT'S NAME	BIRTH DATE OF PATIENT	DOES PATIENT HAVE OTHER COVERAGE? ☐ YES ☐ NO	IF YES, PLEASE IDENTIFY

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER ☐	RADIOGRAPHS OR MODELS ENCLOSED ☐ NO ☐ YES	HOW MANY?	IF PROSTHESIS, IS THIS AN INITIAL PLACEMENT? IF NO, ENTER THE REASON FOR REPLACEMENT. ☐ YES ☐ NO	DATE OF PRIOR PLACEMENT

IS TREATMENT FOR ORTHODONTICS? ☐ YES ☐ NO
IF "YES" AND SERVICES ALREADY COMMENCED, GIVE DATE APPLIANCES PLACED.
ENTER MONTHS OF TREATMENT REMAINING.

IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY? ☐ YES ☐ NO
IF YES, ENTER A BREIF DESCRIPT ION AND DATES

CHECK ONE ☐ **DENTIST'S PRE-TREATMENT EVALUATION** ☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

FACIAL
UPPER RIGHT LINGUAL LEFT
PRIMARY PERMANENT
LOWER LINGUAL
FACIAL
(Tooth chart: 1–32 permanent, A–T primary)

EXAMINATION TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THRU TOOTH NO. 32 USING CHARTING SYSTEM SHOWN

TOOTH	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED	PROCEDURE NUMBER	FEE	ADMINISTRATIVE USE

DENTIST'S NAME
ADDRESS
CITY, STATE, ZIP CODE
DEGREE
PHONE
SOCIAL SECURITY #
TAX I.D. #

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ☐ WILL BE PERFORMED ☐ HAVE BEEN PERFORMED

DENTIST'S SIGNATURE X ______________________________