AmeriHealth Administrators

GROUP DENTAL CLAIM FORM

EMPLOYEE INSTRUCTIONS

1. Complete a separate form for each family member.
2. Complete Part A in full.
3. Give the claim form to your dentist, who will complete Part B and send the completed form and all bills to:

AmeriHealth Administrators
PO Box 21545
Eagan, MN 55121

PART A FAILURE TO ANSWER ALL QUESTIONS MAY CAUSE DELAY IN PAYMENT

EMPLOYEE'S NAME (First Name, Middle, Last Name)	STREET ADDRESS	CITY OR TOWN	ZIP CODE

ARE YOU STILL EMPLOYED? ❑ YES ❑ NO	IF NO, LAST DATE WORKED	OCCUPATION

NAME OF YOUR EMPLOYER	GROUP NUMBER	AGREEMENT NUMBER

DATE OF BIRTH	SOCIAL SECURITY NO.	MARITAL STATUS (Check one.) ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

IS YOUR SPOUSE EMPLOYED? ❑ YES ❑ NO	IF YES, NAME AND ADDRESS OF EMPLOYER

IF DEPENDENT CLAIM DEPENDENT'S NAME	SEX ❑ MALE ❑ FEMALE	DATE OF BIRTH	RELATIONSHIP	ARE YOU ENTITLED TO INCOME TAX EXEMPTION FOR THIS DEPENDENT? ❑ YES ❑ NO

MARITAL STATUS OF DEPENDENT ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED	IS DEPENDENT FULL-TIME STUDENT? ❑ YES ❑ NO	IF YES, NAME AND ADDRESS OF SCHOOL

EMPLOYED WITHIN THE LAST YEAR? ❑ YES ❑ NO	IF YES, NAME AND ADDRESS OF EMPLOYER

IF ACCIDENT, GIVE DATE / / TIME ❑ AM ❑ PM	WHERE DID IT OCCUR?	WHILE WORKING? ❑ YES ❑ NO	HOW DID IT OCCUR?

ARE YOU OR YOUR DEPENDENTS ENTITLED TO BENEFITS UNDER:

- ANY OTHER GROUP HEALTH OR WELFARE PLAN? ❑ YES ❑ NO
- MEDICARE ❑ YES ❑ NO
- HEALTH MAINTENANCE ORGANIZATION (HMO) ❑ YES ❑ NO
  ❑ GROUP ❑ INDIVIDUAL
- NO FAULT AUTOMOBILE INSURANCE ❑ YES ❑ NO

IF YES, NAME OF FAMILY MEMBER HOLDING POLICY — POLICY NO.

NAME AND ADDRESS OF EMPLOYER, UNION ASSN., SCHOOL, ETC. CARRYING OTHER PLAN

NAME OF OTHER INSURANCE COMPANY	ADDRESS OF OTHER INSURANCE COMPANY

AUTHORIZATION TO PAY BENEFIT TO PROVIDER:
I hereby authorize payment directly to the Provider of Service for any benefits otherwise payable to me for such services, but not to exceed the usual and customary charge or policy limitations for these services.

➤ SIGNED (INSURED PERSON)

DATE

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any Insurance Company, Prepayment Organization, Employer, Hospital, or Physician to release all information with respect to me or my dependents that may have a bearing on the benefits under this or any other plan providing benefits or services.

➤ SIGNED (PATIENT, OR PARENT IF A MINOR)

DATE

NOTICE — Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered a felony in some states.

For Charges Exceeding $250.00

1. Prior to commencement of treatment compile a Treatment Plan describing Treatment and Corresponding Fees.
2. If Treatment Plan includes crowns or bridgework, please include mounted x-rays.

CHECK ONE:

❑ DENTIST'S PRE-TREATMENT ESTIMATE
❑ DENTIST'S STATEMENT OF ACTUAL SERVICES

DOCTOR: PLEASE

1. COMPLETE PART B THEN SEND FORM TO:

AmeriHealth Administrators
PO Box 21545
Eagan, MN 55121

DOCTOR: Please Note:

1. IF EMPLOYEE HAS AUTHORIZED PAYMENT OF BENEFITS TO PHYSICIAN (SEE REVERSE) BENEFIT PAYMENTS OFFICE WILL SEND CHECKS FOR SERVICES DIRECTLY TO YOU.
2. BENEFIT PAYMENTS OFFICE WILL SEND DIRECTLY TO EMPLOYEE AT HIS HOME ADDRESS A STATEMENT SHOWING DATES OF SERVICE, AMOUNT OF YOUR BILL, AMOUNT PAID AND BALANCE DUE IF ANY.

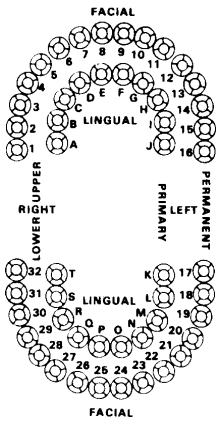
PART B — DENTIST'S STATEMENT

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED NAME (First name, middle initial, last name)

4. PATIENT'S RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER	5. PATIENT'S SEX ❑ MALE ❑ FEMALE	6. INSURED GROUP NO.	7. ARE OTHER INSURANCE BENEFITS AVAILABLE FOR THESE SERVICES? ❑ YES ❑ NO

8. DENTIST NAME	16. Is Treatment Result of Occupational Illness or Injury?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
9. MAILING ADDRESS	17. Is Treatment Result of Auto Accident?			
	18. Other Accident?			
CITY, STATE, ZIP	19. Are Any Services Covered By Another Plan?			
10. DENTIST SOC. SEC. OR T.I.N. 11. DENTIST LICENSE NO. 12. DENTIST PHONE NO.	20. If Prosthesis, Is This Initial Placement?			(IF NO, REASON FOR REPLACEMENT). DATE OF PRIOR REPLACEMENT
13. FIRST VISIT DATE CURRENT SERIES / 14. PLACE OF TREATMENT OFFICE HOSP ECF OTHER / 15. RADIOGRAPHS OR MODELS ENCLOSED? ❑ YES ❑ NO / HOW MANY?	21. Is Treatment For Orthodontics?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



23. REMARKS FOR UNUSUAL SERVICES

22. EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 – USE CHARTING SYSTEM SHOWN

TOOTH OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS PROPHYLAXIS MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO	DAY	YEAR	PROCEDURE NUMBER		FEE		FOR ADMINISTRATIVE USE ONLY
		1								
		2								
		3								
		4								
		5								
		6								
		7								
		8								
		9								
		10								
		11								
		12								
		13								
		14								
		15								

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) _____ DATE _____

TOTAL FEE CHARGED	
MAX ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	