ALLIED

AS CLAIMS ADMINISTRATOR
PO Box 909786-60690
Chicago, IL 60690
TEL: (312) 906-8080 FAX: (312) 906-8359

214

DENTAL CARE CLAIM FORM

INSTRUCTIONS: Complete the applicable items in Part 1. Give the form to your Provider to complete Part 2. Return the completed form to **ALLIED BENEFIT SYSTEMS, INC.**

PART 1: TO BE COMPLETED BY EMPLOYEE

1. CLAIMS BEING MADE FOR
   - Employee
   - Spouse
   - Unmarried Child. If child is over 19, benefits continued as:
     - Full Time Student, attending
     - Other

2. PATIENTS NAME DATE OF BIRTH: SEX:

3. IS THIS CLAIM DUE TO AN ACCIDENT? YES NO
   IF YES, WHERE DID THE ACCIDENT OCCUR?
   DATE OF ACCIDENT: DESCRIBE ACCIDENT:

4. IS THIS CLAIM AS A RESULT OF A WORK RELATED ILLNESS OR INJURY? YES NO

5. ARE YOU (EMPLOYEE) MARRIED? YES NO
   IF YES, IS YOUR SPOUSE EMPLOYED? YES NO
   IF YES, PLEASE PROVIDE:

   NAME OF SPOUSE

   EMPLOYER OF SPOUSE

   ADDRESS OF EMPLOYER

   IF CLAIM IS FOR DEPENDENT CHILD, IS YOUR CHILD EMPLOYED? YES NO
   IF YES, PLEASE PROVIDE:

   NAME OF DEPENDENT

   EMPLOYER OF DEPENDENT

   ADDRESS OF EMPLOYER

6. IS THE PATIENT COVERED UNDER ANY OTHER PLAN PROVIDING DENTAL BENEFITS? YES NO
   IF "YES", PROVIDE THE NAME AND ADDRESS OF THE COMPANY OR INSURANCE CARRIER PROVIDING BENEFITS

   NAME OF COMPANY OR INSURANCE CARRIER

   STREET NUMBER CITY STATE ZIP

7. EMPLOYEE NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER (Area) TELEPHONE NUMBER

   STREET NUMBER CITY STATE ZIP

8. AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to my illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective as the original.

   PATIENT'S SIGNATURE (If other than Employee, omit if patient is a minor) DATE

   EMPLOYEE'S SIGNATURE DATE

9. ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to the provider of dental services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the plan.

   EMPLOYEE'S SIGNATURE DATE

10. **THSD 214** — EMPLOYER
    A06157 — GROUP NUMBER

    2121 S. Goeberrt — STREET NUMBER
    Arlington Heights — CITY
    IL — STATE
    60005 — ZIP

PART 2: TO BE COMPLETED BY BILLING DENTIST

1.

NAME OF BILLING DENTIST OR DENTAL ENTITY (Area) TELEPHONE NUMBER

ADDRESS WHERE PAYMENT SHOULD BE REMITTED CITY STATE ZIP CODE

DENTIST SSN OR TAX ID DENTIST LICENSE NUMBER

2. FIRST VISIT DATE:

3. PLACE OF TREATMENT OFFICE HOSPITAL ECF OTHER

4. RADIOGRAPH OR MODELS ENCLOSED? YES NO IF YES, HOW MANY?

5. IS TREATMENT FOR ORTHODONICS? YES NO

IF SERVICE ALREADY COMMENCED, PLEASE PROVIDE

DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING

6. EXAMINATION AND TREATMENT PLAN:

LIST IN ORDER FROM TOOTH NUMBER 1 THROUGH TOOTH NUMBER 32. USE CHARTING SYSTEM BELOW

Identify missing tooth with 'x'

FACIAL

6 7 8 9 10 11 5 12 4 13 3 14 2 15 1 16

D E F G C H B I A J

LINGUAL

UPPER RIGHT LOWER PRIMARY LEFT PERMANENT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

T S R Q P O N M L K

LINGUAL

FACIAL

Tooth	Surface	Description of Services (including x-rays, prophylaxis, materials used, etc.)	Date of Service	Procedure Number	Fee

7. ADDITIONAL NOTATIONS:

TOTAL FEE CHARGED $

8. I HEREBEY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

TREATING DENTIST SIGNATURE DATE

FOR ADMINISTRATIVE USE ONLY

MAX. ALLOWABLE

DEDUCTIBLE

CARRIER %

CARRIER PAYS

PATIENT PAYS