AS CLAIMS ADMINISTRATOR
PO Box 909786-60690
Chicago, IL 6090
TEL: (312) 906-8080 FAX: (312) 906-8359

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

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 ______