



Mail Form to: EBS Benefit Solutions, Inc.
 P.O. Box 4863
 Syracuse, NY 13221-4863

For information please call:
 1-800-803-5773 Toll Free
 (315) 671-7074

- Pre-Treatment Estimate
- Statement of Actual Services

GROUP DENTAL CLAIM FORM

1. Patient Name		2. Relationship to Employee Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		3. Sex M <input type="checkbox"/> F <input type="checkbox"/>		4. Patient Birth Date Mo Day Year		5. If Full Time Student - School City			
6. Employee / Member / Subscriber Name (First, Middle, Last)						7. Member Identification No.		Employee Birth Date Mo Day Year			
8. Employee Mailing Address				9. Company (Employer) Name & Address and/or Division and Plant Location							
10. Group #	11. Is Spouse or Other Family Member Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Member's Name Social Security #		12. Name and Address of Spouse's or Other Family Member's Employer in Item 11			Spouse Birth Date Mo Day Year					
13. Is Patient Covered by Another Dental Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, indicate Dental Plan Name			Group #	Name & Address of Carrier					
AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature.						Signed (Patient or Parent if Minor)		Date			
AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.						Signed (Employee)		Date			
CERTIFICATION - I certify that the foregoing information is true and correct.						Signed (Employee)		Date			
Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.											
14. Dentist Name				22. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter brief description and dates					
15. Mailing Address				23. Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No							
				24. Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No							
16. Tax I.D. # to be used for tax reporting		Tax I.D. #	Soc. Sec #	25. Are any services covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of other plan:					
17. Dentist License No.		18. Dentist Phone No.		26. If prosthesis, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, reason for placement:		27. Date of prior placement			
19. First Visit Date Current Series		20. Place of Treatment Office/Hosp/ECF/Other	21. Radiographs or Models Encl. Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many?		28. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No	If services already commenced enter date appliances placed:		Number of months of treatment remaining			
Indicate missing teeth with a "X" 				29. Examination and Treatment Plan – List in order from tooth No. 1 through tooth No. 32 – Use Charting system shown							
				Tooth # or Letter	Surface (i.e., M, O, D, B, L.)	Description of Service (incl. X-rays, Prophylaxis, Materials Used, Etc.)		Date of Service Mo Day Year	Procedure # CDT-2/CPT4	Fee	
30. Remarks for unusual services											
I hereby certify that the procedures as indicated by date have been completed and the fees indicated are those actually charged to the patient regardless of the existence of insurance coverage.						Signed (Dentist)		Date	Total Fee Charged		