

**DENTAL CLAIM FORM**

1. COMPLETE THIS FORM  
2. ATTACH ALL BILLS  
3. MAIL TO \_\_\_\_\_

FOR PROMPT PAYMENT  
COMPLETE REVERSE SIDE



Pursuant to Section 817.234, FLORIDA Statutes...Any person who knowingly and with intent to injure defraud, or deceive any employer or employee, Insurance Company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony of the third degree.

13080 Belcher Road South, Suite A Largo, Florida 33773  
(727) 530-4144 Fax (727) 535-3977 (800) 571-4144  
www.firstbenefitadmin.com

**GROUP NO.**

Dentist's Treatment Estimate

Dentist's Statement of Actual Services

**PART 1 MUST BE COMPLETED BY EMPLOYEE  
(Please Print)**

Employee Name		Date of Birth	Employer Name		FBA ID Number
Address: Number and Street		City	State	Zip Code	Phone: Work Home
Dependent Name (If Patient)	Relationship to Dependent <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		If over 19 & full time student / Name of School		Date of Birth
Date of Injury	Is Claim Being Made For Workman's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No		Physician Name		
Nature Injury			How, When and Where Did Injury happen?		
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse Name		Name and Address of Spouse Employer (If not Employed Write "Not Employed")		
Are you or your dependent covered by any other Group Insurance, Health Maintenance Organization, Federal Plan or Union Welfare Plan which may also pay for any of the expenses of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete all information below:					
Name and Address of Ins. Co.		Policy / Contract #	Name of Policyholder	Parties Covered under Plan	Effective Date
IF PAYMENT IS TO BE MADE TO DENTIST SIGN BELOW			PATIENT OR PARENT MUST SIGN BELOW		
AUTHORIZATION TO PAY BENEFITS TO DENTIST. I hereby authorize payment directly to the undersigned Dentist, otherwise payable to me for his services, but not to exceed the reasonable and customary charge for those services or the contracted network fees.			AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize any Dentist to release any information acquired in the course of my examination or treatment.		
SIGNED (Patient or Parent) Sign Only If Payment is to Go to Dentist.			SIGNED (Patient or Parent if Minor)		
X _____ Date			X _____ Date		

**PART 2 MUST BE COMPLETED BY DENTIST  
(Please Print)**

Patient Name		Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Patient Date of Birth Mo Day Year		Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No Name of School				
Employee Name First Middle Last				FBA or Dental Plan #								
Employee Mailing Address						Employer (Company) Name and Address						
City			State		Zip Code							
Are Other Family Members Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Employee Name Soc. Sec. No.				Name and Address of their Employer								
Is Patient Covered by Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			Group No.		Name and Address of Carrier							
Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, enter brief description and dates								
Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, enter brief description and dates								
Is treatment result of any other type of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, enter brief description and dates								
Are any services covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, enter brief description and dates								
If Prosthesis, is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No				If No, reason for replacement				Date of prior placement?				
First Visit Date Current Series		Place of Treatment Off Hosp ECF Other		Radiographs Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No		How Many?		Is treatment for Orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No		If services already commenced enter date:	Date appls placed	Mos. treatment remain
Explanation and Treatment Plan – List in order from Tooth No. 1 through No. 32												
Remarks for Unusual Services		Tooth # or Letter	Surfaces	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis Materials Used, Etc.)				Date Service Performed Mo. Day Yr.		ADA Procedure Number	Fee	CLAIMS OFFICE USE ONLY
ORTHODONTICS: (Give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)									TOTAL FEE ACTUALLY CHARGED			
									MAX ALLOWABLE			
									DEDUCTIBLE			
									PLAN %			
									PLAN PAYS			
I hereby certify that the services listed above <input type="checkbox"/> will be <input type="checkbox"/> have been performed												
Dentist Name (Print)						License # / Degree						
Mailing Address				City				State		Zip Code		
Telephone				Fax				E-mail				
Signature						Date			SS# or TIN#			
X												

**INSTRUCTIONS FOR FILING**

1. Complete the employee's portion – Part 1
2. Have your Dentist complete the Attending Dentist Statement – Part 2, and attach x-rays on major work only.
3. Have your Dentist return the form to you or forward to Florida Benefit Administrators