



Allied Benefit Systems, Inc.
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Dental Claim Form

Part 1: To be completed by Employee/Patient

Employer Information	
Employer Name	Group Number

Employee Information			
Employee Name	Social Security Number	Birthdate	
Employee Address	City	State	Zip

Do you or any of your dependents have other group dental coverage?
 Yes (please provide information below) No

Name of Individual with other coverage	Other Insurance Carrier or TPA		
Address of Carrier or TPA	City	State	Zip

Patient Information		
Patient Name	Gender	Birthdate
Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:		

Employee Authorization	
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.	
Employee Signature	Date
ASSIGNMENT OF BENEFITS: I hereby authorize payment 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 benefit plan.	
Employee Signature	Date

Part 2: To be completed by Dentist

Please select one: <input type="checkbox"/> Dentist's Pre-Treatment Estimate <input type="checkbox"/> Dentist's Statement of Actual Services	
Provider Name	Provider TIN and License Number
Provider Address	City State Zip

Claim Information					
Was this claim due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, what was the date of the accident?		
Where did the accident occur?			Is this claim the result of a work related illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Service		Place of Treatment <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____			
Radiographs of Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many?			
If treatment is for Orthodontia, date the appliances were placed		If treatment is for Orthodontia, how many months of treatment remain?			
Provider Name	Patient Name	Date of Service	Provider TIN	ADA Dental Code	Total Charge

I hereby 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 these procedures.

Provider Signature _____

Date _____