



DENTAL CLAIM FORM

Please Check Reason For Submission

- Predetermination of Benefits
- All Listed Services Complete

SELF-FUNDED PLANS, INC.
 1432 Hamilton Avenue
 Cleveland, Ohio 44114-1146
 (216) 566-1455
 1-800-722-7374

HOW TO FILE A CLAIM

1. Complete Part I and IV below. A separate Part I Section is required for each family member. To insure payment, be sure to answer each question completely.
2. Have your dentist complete Parts II, III and V below.
3. Mail completed form to address at left, or have your dentist submit this claim electronically.

**Electronic Filing:
 WebMD 34131**

PART I TO BE COMPLETED BY EMPLOYEE			PATIENT'S DATE OF BIRTH	IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS TREATMENT COVERED UNDER ANY OTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO
PARENT'S NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYEE'S NAME	SPOUSE'S EMPLOYER		NAME AND ADDRESS OF OTHER GROUP PLAN
STREET ADDRESS		ADDRESS OF SPOUSE'S EMPLOYER			
CITY, STATE & ZIP		COMPLETE IF PATIENT IS A DEPENDENT			
SOCIAL SECURITY NUMBER		EMPLOYEE'S DATE OF BIRTH	RELATIONSHIP	AGE	IF A CHILD, IS CHILD A FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S NAME		NAME AND ADDRESS OF CHILD'S SCHOOL			
ACCOUNT #		I hereby certify that the above statements are accurate. I authorize any person or institution rendering care, or any person or organization (including my employer) in possession of information concerning insurance or other benefits covering me or my dependents, to furnish to, or receive from SELF-FUNDED PLANS, INC. or its authorized representative, full information regarding such care or other benefit information. A photocopy of this authorization shall be as valid as the original.			

Employee's Signature _____ Patient's Signature (Parent if a minor) _____

PART II TO BE COMPLETED BY DENTIST			YES	NO
DENTIST'S NAME	FIRST	INIT.	LAST	
STREET ADDRESS			IS ANY TREATMENT FOR ORTHODONTIC PURPOSES?	<input type="checkbox"/>
CITY, STATE			IS TREATMENT THE RESULT OF AN ACCIDENT?	<input type="checkbox"/>
ZIP			IS TREATMENT THE RESULT OF AN OCCUPATIONAL INJURY?	<input type="checkbox"/>
SOC. SEC. <input type="checkbox"/> TAX ID. NO. <input type="checkbox"/> PHONE NO. ()			ARE X-RAYS INCLUDED? HOW MANY?	<input type="checkbox"/>
			IF PROSTHESIS, CROWN, INLAY OR BRIDGE, IS THIS INITIAL PLACEMENT? IF NO, GIVE PROCEDURE NUMBER, DATE OF PRIOR PLACEMENT AND REASON TO REPLACE	<input type="checkbox"/> YES <input type="checkbox"/> NO

PART III	TOOTH	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Procedure Number	Date Service Performed Mo. Day Yr.	FEE	
<p>INDICATE MISSING TEETH WITH AN "X"</p> <p>ORTHODONTICS (give class of malocclusion and describe services in treatment section)</p> <p>DATE FIRST APPLIANCE INSTALLED _____</p> <p>TREATMENT PERIOD (number of mos.) _____</p> <p>TOTAL FEES _____</p>							

PART IV TO BE COMPLETED BY EMPLOYEE - IMPORTANT - READ CAREFULLY **TOTAL FEE**

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment of benefits be made directly to dentist.

EMPLOYEE'S SIGNATURE _____ DATE _____

PART V TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the patient on the date indicated.

DENTIST'S SIGNATURE _____ DATE _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.