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

[ ] Self [ ] Spouse [ ] Child [ ] 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: [ ] **Dentist's Pre-Treatment Estimate** [ ] **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? [ ] Yes [ ] 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?** [ ] Yes [ ] No
Date of Service	**Place of Treatment** [ ] Doctor's Office [ ] Hospital [ ] Other: _____
Radiographs of Models Enclosed? [ ] Yes [ ] 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 Siganture

Date