Please submit to:

Insight Benefit Administrators LLC
Fax: (616) 588-7915 Email: RA_TPA@insightba.net
Dental Payor #38255

Phone: (877) 827-1414 or (616) 588-5340

Dental Claim Form
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

(**PATIENT INFORMATION**			
Patient Name	Gender ☐ Male ☐ Female	DOB	Relation to Employee ☐ Spouse ☐ Child ☐ Self ☐ Other
If full time Student School		City	

EMPLOYEE INFORMATION		
Employee Name	Empl. Soc. Sec No.	Are other family members employed? Employee Name
Employee Mailing Address		
Employer Name & Address		

City	State	Zip Code	
Is Patient covered by another dental plan?	Dental Plan Name	Union Local	Group No.
Name and Address of Carrier			

DENTIST SECTION			
Dentist Name	Mailing Address		
Dentist Soc. Sec. or TIN.	Dentist Licenses No.		Dentist Phone #
First Visit date current series	Place of treatment	Radiographs or models enclosed ☐ Yes How many ☐ No	

Is treatment result of occupation illness or injury	No	Yes	If yes, enter brief description and dates
Is treatment result of auto accident? Other accident			
Are any services covered by another plan?			
If prosthesis is the initial placement			

Examination and Treatment Record

Tooth & or Letter	Surfaces	Description of services performed	Date of Service	Procedure Number	Fee

Authorization to release information:

I hereby authorize any hospital, physician, or other person who has examined or attended _____
To furnish to the Plan administrator, or a representative thereof, any and all information with respect to any illness, medical history, consultation prescriptions or treatment, and copies of all hospital or medical records. I hereby authorize the Plan administrator to release to and receive from other insurance companies, prepayment organizations, employers and unions benefits payment information pertaining to the patient named above. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature Spouse's signature if applicable

I hereby certify that the services listed above have been performed and payment is therefore due.

_____
Signed (Dentist)

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown above, I understand that I am financially responsible for any charges not covered by this authorization.

Signature: Date: