

Please submit to:

Insight Benefit Administrators LLC
 Fax: (616) 588-5341 Email: RA_TPA@insightba.net
 Dental Payor #38255

Dental Claim Form

- Dentist's pre-treatment estimate
- Dentist's statement of actual services

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

(PATIENT INFORMATION)					
Patient Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	Relation to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		How many	
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
<p>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.</p>					
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: