GROUP INSURANCE SERVICE CENTER, INC.
P.O. Box 9120 • Marshfield, MA 02050-9120
(800) 242-3834 MA Only / (800) 242-4472 Nationwide

DENTAL CLAIM FORM

HOW TO FILE YOUR CLAIM

A. Please complete items 1 through 8 below. Incomplete answers may cause a delay in processing your claim.

B. The reverse side of this form (Section II) should be completed by the attending dentist or the dentist's own claim information statement should be attached.

C. This completed form, along with *itemized* bills (if applicable) should be sent to Group Insurance Service Center, Inc. at the above noted address.

D. If you anticipate extensive dental work, you may request a pre-treatment estimate of benefits by using this claim form.

EMPLOYEE'S STATEMENT - SECTION I

1. **EMPLOYER'S NAME:** _____

2. Employee's Name _____

3. Employee's Address _____

   _____

4. Employee's Social Security Number _____

5. Patient Information: Name _____

   Relationship to Employee: ☐Self ☐Spouse ☐Child ☐Other_____ Sex ☐ Male ☐ Female

   Date of Birth_____ Full-time Student ☐ Yes ☐ No

   Is Patient Employed? ☐Yes ☐No Employer's Name_____

6. Is Claim Due to an Accident? ☐Yes ☐No

   If Yes, Provide: Date _____

   Where _____

   How _____

   Related to Employment? ☐Yes ☐No

7. Is Other Group Dental Coverage Available? ☐Yes ☐No

   If Yes, Provide: Name of Insurance Company _____

   Address of Insurance Co. _____

   Group Name and Policy # _____

8.	**I herby certify that the foregoing answers are true and correct to the best of my knowledge and authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, Insurance company, or other organization, Institution or person, that has any records or knowledge of me or my eligible dependents or our health, to give any such information to Group Insurance Service Center, Inc. or their designee. A copy of this authorization shall be as valid as the original.**
Date:	**Signature of Employee** **Signature of Patient**
9.	**ASSIGNMENT: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST HEREIN NAMED OF THE GROUP DENTAL BENEFITS PAYABLE TO ME FOR THE TREATMENT OR SERVICE DESCRIBED. I UNDERSTAND AND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.**
Date:	**Signature of Employee**

ATTENDING DENTIST'S STATEMENT - SECTION II

1. Patient Name	2. Birth Date Mo Da Yr	3. Relationship to Employee	4. Employee Name (If not Patient)

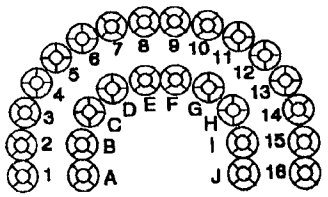
5. DIAGNOSIS AND CONCURRENT CONDITIONS	CHECK ONE ☐ Dentist's Pre-Treatment Estimate ☐ Dentist's Statement of Actual Services
6. Place of Treatment ☐ Office ☐ Hospital ☐ Other:	7. Date First Visit (Current Series)

8. Is any of the Treatment for:	A. Orthodontic Purposes: ☐ Yes ☐ No	B. Accidental Injury ☐ Yes ☐ No	C. Occupational Injury ☐ Yes ☐ No

9. If prosthesis, is this initial placement? ☐ Yes ☐ No	If No, Reason for Replacement	10. Date of Prior Placement

11. REPORT OF SERVICES (or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report.)

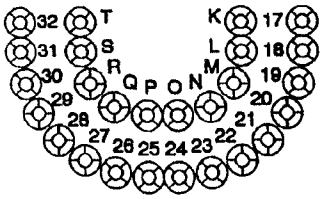
FACIAL



UPPER

RIGHT LINGUAL LEFT

LOWER



FACIAL

PLEASE PLOT WORK AND INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis Materials Used, Etc.)	DATE SERVICE PERFORMED MO	DA	YR	ADA PROCEDURE NUMBER	FEE

TOTAL CHARGES $_____

AMOUNT PAID $_____

BALANCE DUE $_____

12. Does Patient Have Other Health / Dental Coverage? ☐ Yes ☐ No

If "Yes" Please Identify:

DATE DENTIST'S SIGNATURE TIN #

DENTIST'S NAME (Print) DEGREE TELEPHONE NUMBER

STREET ADDRESS CITY OR TOWN STATE ZIP CODE