eba&m CORPORATION

P.O. Box 5079
Westlake Village, CA 91359

CLAIM FOR DENTAL EXPENSE BENEFITS

TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER
3. SEX: M | F
4. PATIENT BIRTHDATE: MO. | DAY | YEAR
5. IF FULL TIME STUDENT: SCHOOL | CITY
6. EMPLOYEE NAME: FIRST | MIDDLE | LAST
7. EMPLOYEE SOCIAL SECURITY NO.
9. NAME OF GROUP DENTAL PROGRAM
8. EMPLOYEE MAILING ADDRESS
10. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY, STATE | ZIP
11. GROUP NUMBER
12. BRANCH
13. ARE OTHER FAMILY MEMBERS EMPLOYED? NO ☐ YES ☐ EMPLOYEE NAME | SOC. SEC. NO
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO ☐ YES ☐ IF YES, GIVE: DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER
15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

PATIENT'S SIGNATURE (PARENT IF A MINOR) | DATE

15b. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

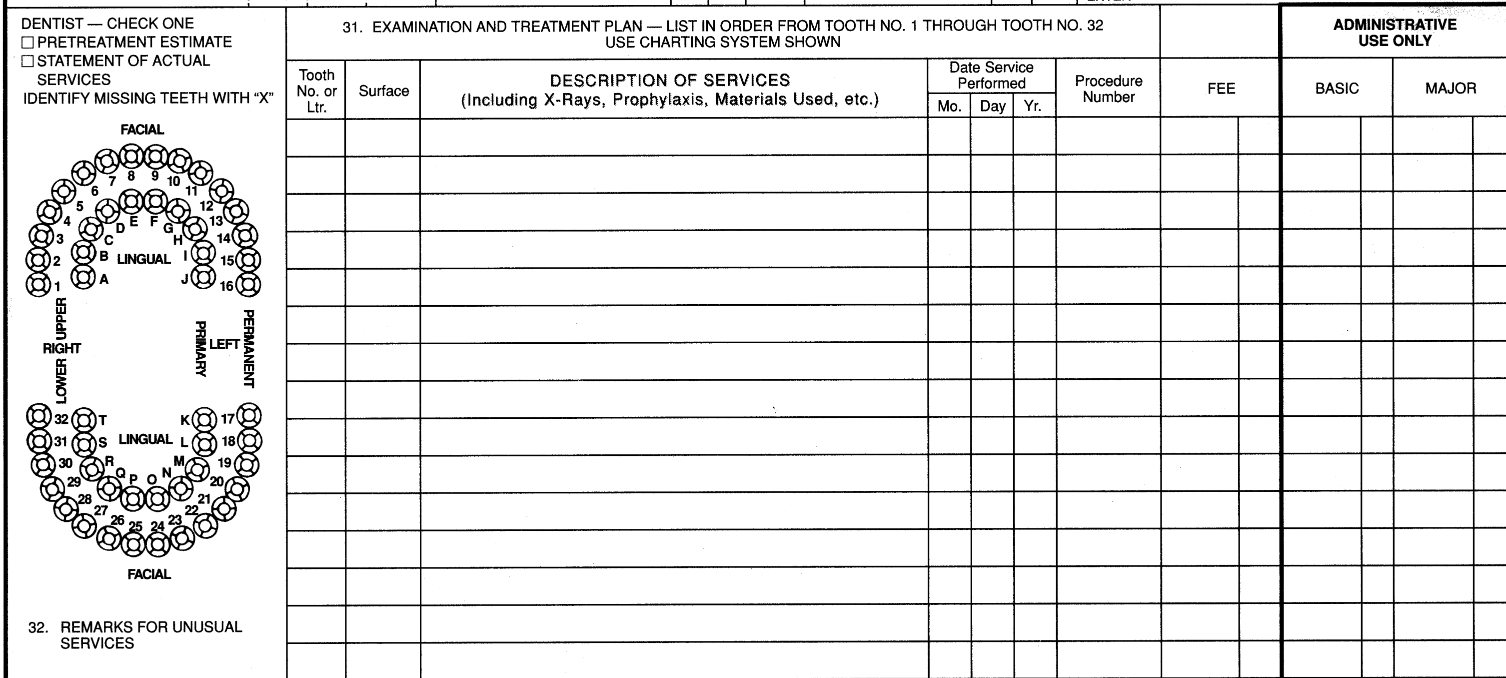
EMPLOYEE'S SIGNATURE | DATE

TO BE COMPLETED BY DENTIST

16. DENTIST NAME: FIRST | MIDDLE | LAST
17. MAILING ADDRESS
CITY, STATE | ZIP
18. DENTIST SOC. SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

DENTIST — CHECK ONE
☐ PRETREATMENT ESTIMATE
☐ STATEMENT OF ACTUAL SERVICES
IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN

Tooth No. or Ltr.	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Performed Mo.	Day	Yr.	Procedure Number	FEE	ADMINISTRATIVE USE ONLY: BASIC	MAJOR
						TOTAL FEE CHARGED			

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN BENEFITS PAYABLE TO THE ATTENDING DENTIST.

EMPLOYEE'S SIGNATURE: ____ DATE: ____

TO BE COMPLETED BY DENTIST

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE ABOVE-NAMED PATIENT ON THE DATES INDICATED:

DENTIST'S SIGNATURE: ____ DATE: ____

EXAMINER ____ TRANSACTION # ____ CHECK DATE ____

DENTAL UNIT USE

Employee Eligible Date ____
Employee Effective Date ____
Termination Date ____
Coverage Code ____
Verified by ____
Date ____

Predetermination is valid for 90 days from the date above.

	BASIC	MAJOR
Deductible		
Balance		
% Payable	%	%
Amt. Payable		

THESE BENEFITS WILL, SUBJECT TO PLAN PROVISIONS, BE PAYABLE IF THE DESCRIBED PROCEDURES, ARE PERFORMED DURING A PERIOD OF THE PATIENT'S ELIGIBILITY.
(THE PATIENT'S PERSONAL ELIGIBILITY HAS NOT BEEN VERIFIED AT THE TIME OF PREDETERMINATION.)

DENTAL EXPENSE COVERAGE — CLAIM INSTRUCTIONS

TO THE EMPLOYEE

1. Complete items one (1) through fifteen (15) in full. Be certain to sign the certification block (15b).

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY PAYMENT OF YOUR CLAIM.

2. If you wish to have your benefits for this claim paid directly to your dentist, sign the "Assignment of Benefits" block located above the dentist's certification.

   If total charges for the planned course of treatment are expected to exceed $300, you must file for Predetermination of Benefits. E.B.A. & M Corp. will notify your dentist of the benefits payable.

NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR A DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COINSURANCE INFORMATION, AND LIMITATIONS AND EXCLUSIONS.

TO THE DENTIST

1. If total changes for this claim are less than $300, check the box noted "STATEMENT OF ACTUAL SERVICES" and complete items 16 through 31. When entering the treatment plan on the form, please indicate a *separate* fee for each individual service rendered. When the work is finished, sign the form and mail to the address shown above.

2. PREDETERMINATION OF BENEFITS — If total charges for this claim are to exceed $300 (and treatment is not emergency in nature), Predetermination of Benefits is required. Check the box marked "PRETREATMENT ESTIMATE," and complete items 16 through 31. Please be sure to answer questions 28 and 29 if the claim includes gold restorations, crowns, bridgework or dentures.

   The completed form should be sent to E.B.A. & M. Corp. at the address shown above.* E.B.A. & M Corp. will notify you of the benefits payable for this course of treatment.

   When treatment has been completed, fill in the date each service was provided, sign the form and return to E.B.A. & M. Corp. for payment.

NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND ADMINISTRATOR CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.

3. Assigned benefits will be sent directly to you with an information copy of the transaction to the employee.

*X-rays taken for gold restorations and crowns should be submitted with treatment plan. They may also be requested for other services.