EBA&M

DENTAL CARE EXPENSE CLAIM FORM

PO BOX 17179
Irvine, CA 92614

TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE (SELF / SPOUSE / CHILD / OTHER)	3. SEX (M / F)	4. PATIENT BIRTHDAY (MO / DAY / YEAR)	5. IF FULL TIME STUDENT (SCHOOL / CITY)

6. EMPLOYEE NAME (FIRST / MIDDLE / LAST)	7. EMPLOYEE SOC. SEC. 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? DENTAL PLAN NAME / UNION LOCAL / GROUP NO. / NAME AND ADDRESS OF CARRIER

NO ☐ YES ☐ IF YES, GIVE

15a. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.	15b. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.
PATIENT'S SIGNATURE (PARENT IF A MINOR) _____ DATE _____	EMPLOYEE'S SIGNATURE _____ DATE _____

TO BE COMPLETED BY DENTIST

16. DENTIST NAME (FIRST / MIDDLE / LAST)	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER DESCRIPTION/DATES
17. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
	26. OTHER ACCIDENT?			
CITY, STATE / ZIP	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			

18. DENTIST SOC. SEC. OR T.I.N.	19. DENTIST LICENSE NO.	20. PHONE NUMBER	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON) 29. DATE OF PRIOR PLACEMENT

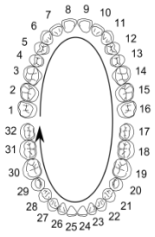
21. FIRST VISIT DATE / CURRENT SERIES	22. PLACE OF TREATMENT (OFFICE / HOSP / ECF / OTHER)	23. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY	30. IS TREATMENT FOR ORTHODONTICS? ☐ NO ☐ YES (IF SERVICES ALREADY COMMENCED, ENTER / DATE PLACED / MOS REMAINING)

DENTIST - CHECK ONE

☐ PRETREATMENT ESTIMATE

☐ STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINIATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU TOOTH NO. 32

ADMINISTRATIVE USE ONLY

Tooth No. or Ltr	Surface	DESCRIPTION OF SERVICCES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Date Service Perfomed Mo.	Day	Yr.	Procedure Number	FEE		BASIC		MAJOR	
32. REMARKS FOR UNUSAL SERVICES												

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 _____

		BASIC		MAJOR	
Total Fee Charged					
Deductible					
Balance					
% Payable		%		%	
Amt Payable					

Predetermination is valid for 90 days from the date above.

These benefits will, subject to Plan provsiions, 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)