



## DENTAL CARE CLAIM FORM

INSTRUCTIONS: Complete the applicable items in Part 1. Give the form to your Provider to complete Part 2.  
 Return the completed form to ALLIED BENEFIT SYSTEMS, INC.

PART 1: TO BE COMPLETED BY EMPLOYEE			
1. CLAIM IS BEING MADE FOR: <input type="checkbox"/> Employee <input type="checkbox"/> Unmarried Child. If child is 19 or over, benefits continued as: <input type="checkbox"/> Full time student, attending _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Other    _____ School			
2. PATIENT'S NAME: _____ DATE OF BIRTH:    /    /    SEX: _____			
3. IS THIS CLAIM DUE TO AN ACCIDENT?    IF YES, WHERE DID ACCIDENT OCCUR?    DATE OF ACCIDENT:    /    / <input type="checkbox"/> Yes <input type="checkbox"/> No DESCRIBE ACCIDENT: _____			
4. IS THIS CLAIM AS A RESULT OF A WORK RELATED ILLNESS OR INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. ARE YOU (EMPLOYEE) MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No    IF CLAIM IS FOR A DEPENDENT CHILD, IS YOUR CHILD IF "YES", IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No    EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", PLEASE PROVIDE: _____ IF "YES", PLEASE PROVIDE: _____  _____ NAME OF SPOUSE    _____ NAME OF DEPENDENT _____ EMPLOYER OF SPOUSE    _____ EMPLOYER OF DEPENDENT _____ ADDRESS OF EMPLOYER    _____ ADDRESS OF EMPLOYER			
6. IS THE PATIENT COVERED UNDER ANY OTHER PLAN PROVIDING HEALTH BENEFITS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", PROVIDE THE NAME AND ADDRESS OF THE COMPANY OR INSURANCE CARRIER PROVIDING BENEFITS:  _____ NAME OF COMPANY OF INSURANCE CARRIER _____ STREET NUMBER    _____ CITY    _____ STATE    _____ ZIP			
7. _____ EMPLOYEE'S NAME (PLEASE PRINT)    SOCIAL SECURITY NUMBER    (Area) TELEPHONE NUMBER _____ STREET NUMBER    CITY    STATE    ZIP			
8. AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.  _____ PATIENT'S SIGNATURE    _____ DATE (If other than Employee, omit if patient is a minor.)  _____ EMPLOYEE'S SIGNATURE    _____ DATE			
9. ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.  _____ EMPLOYEE'S SIGNATURE    _____ DATE			
10. <b>Butler Health Plan</b> _____ <b>A08103</b> _____ NAME OF EMPLOYER    GROUP NO.    TELEPHONE NUMBER  _____ STREET NUMBER    _____ CITY    _____ STATE    _____ ZIP			

