Group Dental Claim Form

Administered by:
SIGNIFICA BENEFIT SERVICES, INC.
PO BOX 7777
Lancaster, PA 17604-7777
717-581-1300 or 800-433-3746
www.significabenefits.com

TO BE COMPLETED BY EMPLOYEE

1. Patient Name:	2. Relationship to Employee: Self Spouse Child Other	3. Gender M F	4. Patient Birth date:

5. Employee/Member/Subscriber Name (First, Middle, Last):	6. Employee Member ID:	7. Employee Birth Date:	8. Group #

9. Employee Mailing Address:	10. Company (employer) name and address and/or division and plant location.

11. Is patient covered by another dental plan? Yes No If yes, indicate	Dental Plan Name	Group Number	Name and Address of Carrier

AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment directly to the below named Dentist for the Dental benefits otherwise payable to me.	**Signed (employee)** ______________________	Date: ______________________
CERTIFICATION – I certify that the foregoing information is true and correct.	**Signed (employee)** ______________________	Date: ______________________

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR PLAN, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

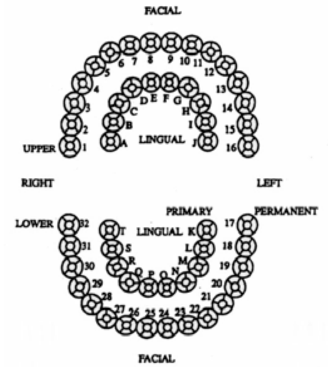
TO BE COMPLETED BY ATTENDING DENTIST

12. Dentist Name	13. Mailing Address	14. Dentist Phone Number	15. Tax ID #: SS #: NPI:

16. Dentist License Number	17. Is treatment result of auto accident? Yes No	If yes, to questions 17, 19 or 20 enter brief description and dates.
18. First visit date current series:	19. Is treatment result of an occupational illness or injury? Yes No	
20. Are any services covered by another plan? Yes No If yes, Name of other plan:	21. If prosthesis, is this initial placement? Yes No	

22. (If no, reason for replacement):	23. Date of prior Placement:	24. Place of Treatment Office Hsp. Other	25. Radiographs or models enclosed? Yes No How many?_____
26. Is treatment for Orthodontics? Yes No	27. If services already commenced, complete questions 28 and 29.	28. Date Appliances:	29.Months of Treatment:

30. Examination and treatment plan-list in order from tooth no. 1 through tooth no. 32-use charting system shown



Tooth # or Letter	Surface (i.e. M,O,D,B,L,LA,I)	Description of Service (including X-Rays, Prophylaxis, Materials Used)	Date Service Completed Mo. Day Year	Procedure Number	Fee	Indicate missing teeth with an "X"

31. Remarks for unusual services:

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE, HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.	Signed (Dentist) ___________________________	Date	Total Fee Charged

Please submit the completed, signed form to:

SIGNIFICA BENEFIT SERVICES, INC.
PO BOX 7777
LANCASTER, PA 17604-7777
PHONE: 717-581-1300 or 800-433-3746
For secure submission of claims with PHI, go to:
www.significabenefits.com\members
select "Submit Secure Email or Attachment"
Fax: 717-581-8379
www.significabenefits.com