DENTAL CLAIM FORM

INSTRUCTIONS **For Customer Service, call 1-866-317-0167 (toll-free)**

1. You must fully complete PART A – EMPLOYEE'S STATEMENT and sign it.
2. Attach bills for dental benefits you are claiming. These bills must be itemized and show the patient's name, condition being treated (diagnosis), type of treatment given, date expense was incurred and individual charges made.
3. A DENTIST STATEMEMT is provided on the back of this form.
4. When completed return this form and required documents to: **America's Choice Healthplans, LLC**
   13111 NW Freeway, Suite 510
   Houston, TX 77040
   Fax: 713-895-5049

PART A - EMPLOYEE'S STATEMENT				**Employer's Name:** Conroe Independent School District
FULLY COMPLETE FOR ALL CLAIMS	Employee's Name (Please Print)	Group Number **71200**	Date of Birth	Social Security Number
	Address (Street and No.)	City	State	Zip Code
	Phone Number	This claim is on: ☑ Myself	Are you covered under another plan? ☐ Yes ☐ No	
	What was the sickness or injury?		On what date did it begin?	Date of first expense for this condition
	Are Benefits payable from any other source (including Military, Automobile, Liability Insurance, School Accident Insurance) for the expense submitted? ☐ Yes ☐ No	If "Yes", (a) Other Source:________ (b) Address:________ (c) Policy No. or I.D. No.________		
COMPLETE FOR ALL INJURIES	Date of Injury?	Where did the injury occur?	How did the injury occur? Is the injury due to automobile accident? ☐ Yes ☐ No	
	Has or will claim be filed under any Worker's Compensation Act or similar law? ☐ Yes ☐ No			

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical or dental history, treatment or benefit payable for this claim to America's Choice Healthplans, LLC for the purpose of validating and determining benefits payable in connection with this claim. This authorization or photo static copy of the original shall be valid for one year from the date of signature. Data may be extracted for statistical, audit, and verification purposes. I understand that I may request to receive a copy of this authorization.

Employee/Patient Signature ________________________________ Date ____________________

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

PART B - DENTIST STATEMENT

Type or Print

PATIENT & COVERED PERSON (SUBSCRIBER INFORMATION)

1. PATIENT'S NAME *(First name, middle initial, last name)*

➢ ______________________________

2. PATIENT'S SEX
☐ MALE ☐ FEMALE

MAIL THIS FORM TO:

America's Choice Healthplans, LLC
13111 NW Freeway, Suite 510
Houston, TX 77040

Fax: 713-895-5049

AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Group Dental Benefits payable to me.

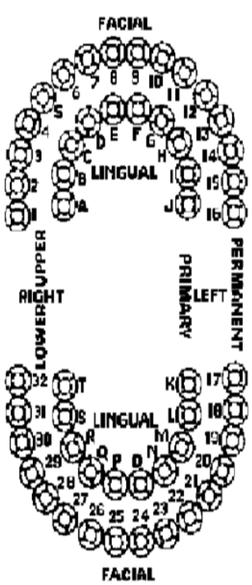
➢ ______________________________

EMPLOYEE'S SIGNATURE DATE

		NO	YES	
3. DENTIST NAME	4. Is treatment result of occupational illness or injury?			If "Yes" enter brief description and dates.
10. MAILING ADDRESS	5. Is treatment result of auto accident? 6. Other accident?			
CITY, STATE, ZIP	7. Are any services covered by another plan?			If "Yes", name of other plan
11. DENTIST SOC. SEC. OR TIN | 12. DENTIST LICENSE. NO. | 13. DENTIST PHONE NO.	8. If prostheses, is the initial placement?			If "No", reason for replacement | 29. Date of Prior placement?
14. FIRST VISIT DATE CURRENT SERIES | 15. PLACE OF TREATMENT Office |Hosp |ECF |Other | 16. RADIOGRAPHS OR MODELS ENCLOSED | NO | YES | HOW MANY?	9. Is treatment for orthodontics?			IF SERVICES ALREADY COMMENCED, ENTER: Date appliances placed | Mos. Treatment remaining

CHECK ONE: ☐ **DENTIST'S PRETREATMENT ESTIMATE** ☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

Identify missing teeth with "X"



17. 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, etc)	DATE SERVICE PERFORMED			PROCEDURE NUMBER	FEE	
			MO	DAY	YEAR			

18. REMARKS FOR UNUSUAL SERVICE

I hereby certify that the procedures as indicated by date have been completed.

____

SIGNED (Dentist) DATE

TOTAL FEE CHARGED		
MAXIMUM ALLOWABLE		
DEDUCTIBLE		
CARRIER PERCENTAGE		
CARRIER PAYS		
PATIENT PAYS		