



Dental Claim Form

Mail Claims to: PAI, PO Box 6702, Columbia, SC 29260

Please complete entire form.

Employer/Plan Name: _____

Dental Provider: _____ Covered Person: _____

Part 1: To be completed by Employee

Patient's Name: _____
Last First Middle

Patient's SSN: _____ Patient's Birth Date: _____ Sex: Male Female

Full-time Student: Yes No Patient's Relationship to Employee: Self Spouse Child

Employee's Name: _____ Employee's SSN: _____
Last First Middle

Address: _____
Street City State ZIP

I accept the attending dentist's statement and authorize release of information relating hereto. I certify the truth of all personal information contained above. I agree to be responsible for payment of services provided during any ineligible period.

Signed (patient or parent if minor): _____ Date: _____

I hereby authorize payment directly to the dentist named in part 2 or on the attached ADA dental form.

Signed (employee): _____ Date: _____

Authorization

Instructions: The authorization should be completed and signed by the insured. If the insured is unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent.

I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

Employee Signature Date
(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

Legal Guardian Name Address



Part 2: Dentist completes this form or attaches completed ADA dental form.

Name: _____ License Number: _____
Last First Middle

Social Security or TIN Number: _____ Telephone: _____

Mailing Address: _____
Street City State ZIP

- Is treatment result of occupational illness or injury? Yes No (If yes, enter a brief description.)

- Is treatment result of auto accident? Yes No (If yes, enter a brief description.)

- Are any services covered by another plan? Yes No (If yes, enter a brief description.)

- If prostheses, is this initial placement? Yes No (If no, enter a reason for replacement and the date of prior placement.)

- First visit date current series: _____ • Place of treatment: Office ECF Hospital Other
- Radiographs or models enclosed? Yes How many? _____ No
- Pre-treatment estimate required if course of treatment is expected to exceed the limit specified in the benefit package and on the ID card:
(Check one.) Dentist's pre-treatment estimate Dentist's statement of actual services

Examination and Treatment Plan: List in order from Tooth No 1 through No. 32. Use charting system shown.

Identify Missing teeth with "x"

Facial	Tooth # or Letter	Surface	Description of Service <small>(Including X-rays, prophylaxis materials used, etc.)</small>	Date Service Performed <small>Month/Day/Year</small>	ADA Procedure Code	Fee
	1					
	2					
	3					
	4					
	5					
	6					
	7					
	8					
	9					
	10					
	11					
	12					
	13					
	14					
	15					
	16					
	17					
	18					
	19					
	20					
	21					
	22					
	23					
	24					
	25					
	26					
	27					
	28					
	29					
	30					
	31					
	32					

Total: _____

Remarks for unusual services: _____

I hereby certify that services listed above have been performed on the named patient on the dates indicated and that the fees shown are those currently charged to the majority of my patients.

Signed (dentist): _____ Date: _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WARNING:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia, Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** any other person.) Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.