Dental Claim Form

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

Please complete entire form.

Employer/Plan Name: _____

Dental Provider: _____ Covered Person: _____

Complete Part 1, sign the authorization, and give it to the dentist.

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

Is patient covered by another dental plan? ☐ Yes ☐ No

Dental Plan Name: _____ Group Name and Number: _____

Name and Address of Claims Administrator: _____

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 below named dentist of the dental plan benefits otherwise payable to me.

Signed (employee): _____ **Date:** _____

Authorization

Instructions: The authorization should be completed and signed by the insured. If the insured in 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 **Relationship to insured if signed by other than insured**

(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**

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

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

Name: _____ License Number: _____
Last First Middle

Social Security or Tax ID 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.)

_____

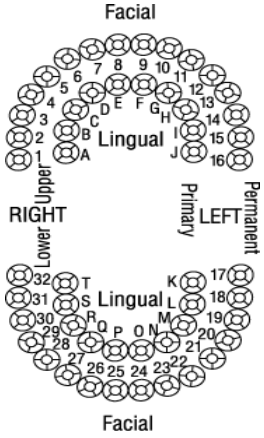
• First visit date current series: _____ • Place of treatment: ☐ Office ☐ ECF ☐ Hospital ☐ Other: _____

• 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 number 1 through number 32. Use charting system shown.

Identify missing teeth with "x"



Tooth # or Letter	Surface	Description of Service (including X-rays, prophylaxis materials used, etc.)	Date Service Performed (Month/Day/Year)	ADA Procedure Code	Fee
				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: _____

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Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection **Arizona** law requires the following statement to appear on this form: Any person who knowingly presents a false or **fraudulent** claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of **insurance** and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: **WARNING**: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

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.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and 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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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