SELF-FUNDED PLANS, INC.
1432 Hamilton Avenue
Cleveland, Ohio 44114-1146
(216) 566-1455
1-800-722-7374

DENTAL CLAIM FORM

HOW TO FILE A CLAIM

1. **Complete Part I and IV below. A separate Part I Section is required for each family member. To insure payment, be sure to answer each question completely.**
2. **Have your dentist complete Parts II, III and V below.**
3. **Mail completed form to address at left, or have your dentist submit this claim electronically.**

Please Check Reason For Submission

☐ **Predetermination of Benefits**
☐ **All Listed Services Complete**

Electronic Filing: WebMD 34131

PART I TO BE COMPLETED BY EMPLOYEE

PATIENT'S NAME	SEX	EMPLOYEE'S NAME
	☐ M ☐ F	

STREET ADDRESS

CITY, STATE & ZIP

SOCIAL SECURITY NUMBER | EMPLOYEE'S DATE OF BIRTH

EMPLOYER'S NAME

ACCOUNT # 506-448

PATIENT'S DATE OF BIRTH | IS SPOUSE EMPLOYED? ☐ YES ☐ NO

SPOUSE'S EMPLOYER

ADDRESS OF SPOUSE'S EMPLOYER

COMPLETE IF PATIENT IS A DEPENDENT

RELATIONSHIP | AGE | IF A CHILD, IS CHILD A FULL TIME STUDENT? ☐ YES ☐ NO

NAME AND ADDRESS OF CHILD'S SCHOOL

IS TREATMENT COVERED UNDER ANY OTHER INSURANCE PLAN? ☐ YES ☐ NO

NAME AND ADDRESS OF OTHER GROUP PLAN

I hereby certify that the above statements are accurate. I authorize any person or institution rendering care, or any person or organization (including my employer) in possession of information concerning insurance or other benefits covering me or my dependents, to furnish to, or receive from SELF-FUNDED PLANS, INC. or its authorized representative, full information regarding such care or other benefit information. A photocopy of this authorization shall be as valid as the original.

Employee's Signature ____________ Patient's Signature (Parent if a minor) ____________

PART II TO BE COMPLETED BY DENTIST

DENTIST'S NAME

FIRST	INIT.	LAST

STREET ADDRESS

CITY, STATE | ZIP

SOC. SEC. ☐ TAX I.D. NO. ☐ | PHONE NO. ( )

	YES	NO
IS ANY TREATMENT FOR ORTHODONTIC PURPOSES?	☐	☐
IS TREATMENT THE RESULT OF AN ACCIDENT?	☐	☐
IS TREATMENT THE RESULT OF AN OCCUPATIONAL INJURY?	☐	☐
ARE X-RAYS INCLUDED? HOW MANY?	☐	☐

IF PROSTHESIS, CROWN, INLAY OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO
IF NO, GIVE PROCEDURE NUMBER, DATE OF PRIOR PLACEMENT AND REASON TO REPLACE

PART III

UPPER / LOWER / RIGHT / LEFT / PRIMARY / PERMANENT / LINGUAL

INDICATE MISSING TEETH WITH AN "X"

ORTHODONTICS (give class of malocclusion and describe services in treatment section)

DATE FIRST APPLIANCE INSTALLED ____________

TREATMENT PERIOD (number of mos.) ____________

TOTAL FEES ____________

TOOTH #	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc.)	Procedure Number	Date Service Performed Mo. Day Yr.	FEE
				TOTAL FEE	

PART IV TO BE COMPLETED BY EMPLOYEE – IMPORTANT – READ CAREFULLY

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment of benefits be made directly to dentist.

EMPLOYEE'S SIGNATURE ____________ **DATE** ____________

PART V TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the patient on the date indicated.

DENTIST'S SIGNATURE ____________ **DATE** ____________

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.