DENTAL CLAIM NOTICE

ADMINISTERED BY:

HealthSmart™ HEALTHCARE SOLUTIONS

RETURN COMPLETED FORM TO THE MAILING ADDRESS INDICATED ON THE MEMBER I.D. CARD

PART I: TO BE COMPLETED BY ENROLLEE/PATIENT

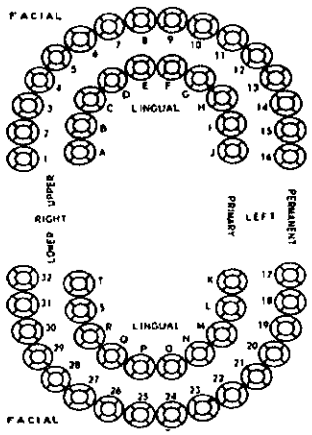
1. PATIENT NAME:	2. RELATIONSHIP TO ENROLLEE: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	3. SEX: ☐M ☐F	4. PATIENT DATE OF BIRTH: / /	5. IF FULL-TIME STUDENT: SCHOOL: CITY:
6. ENROLLEE NAME: FIRST MIDDLE LAST		7. ENROLLEE SOCIAL SECURITY NUMBER:		8. ENROLLEE DATE OF BIRTH: / /
9. HOME ADDRESS: STREET CITY STATE ZIP				
10. PLAN SPONSOR NAME AND ADDRESS:				
11. ARE YOU STILL ENROLLED IN PLAN? ☐ YES ☐ NO	12. IF NO, DATE OF TERMINATION: / /	13. DATE YOU BECAME RETIRED: / /	14. COBRA COVERAGE EFFECTIVE DATE: / /	
15. PLAN NUMBER:	16. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO	17. IF YES, EMPLOYEE NAME AND SOCIAL SECURITY NUMBER:		
18. NAME AND ADDRESS OF EMPLOYER IN BOX #17: STREET CITY STATE ZIP				
19. IS PATIENT COVERED BY ANOTHER PLAN? ☐ YES ☐ NO	20. IF YES, DENTAL PLAN'S NAME: GROUP NO. NAME/ADDRESS OF CARRIER:			

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Employer or Insuring Organization to release any information regarding the medical or dental history treatment or benefits payable for this claim to HealthSmart Benefit Solutions 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. I understand that data may be extracted and transmitted to the Plan Administrator for Plan Administration purposes only. I agree to reimburse the Plan to the extent of any payment which is in excess of the amount payable under this Plan.	PATIENT SIGNATURE ↑ (OR PARENT IF MINOR)	DATE
AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment directly to the below named Dentist of the Plan Benefits, otherwise payable to me.	ENROLLEE SIGNATURE ↑	DATE

PART II: TO BE COMPLETED BY ATTENDING DENTIST

21. DENTIST NAME:			YES	NO	IF YES, PROVIDE BRIEF DESCRIPTION AND DATES:
22. MAILING ADDRESS:		23. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
24. SOCIAL SECURITY OR TIN:		25. IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
26. LICENSE NUMBER:	27. PHONE NUMBER:	28. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF YES, PLAN NAME:
29. FIRST VISIT DATE CURRENT SERIES:		30. IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT: DATE OF PRIOR PLACEMENT:
31. PLACE OF TREATMENT: ☐ OFFICE ☐ HOSPITAL ☐ OTHER :_____	32. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO HOW MANY?	33. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY INITIATED, DATE APPLIANCES PLACED: MOS. TREATMENT REMAINING:

CHECK ONE:	☐ DENTIST'S PRE-TREATMENT ESTIMATE	☐ DENTIST'S STATEMENT OF ACTUAL SERVICES



Identify Missing Teeth With "X"

EXAMINATION AND TREATMENT PLAN
USING CHART SHOWN, LIST IN ORDER FROM TOOTH NO.1 THROUGH TOOTH NO.32

TOOTH # or LETTER	SURFACE (i.e., MOD B L LA)	DESCRIPTION OF SERVICE *(Including X-rays, Prophylaxis, Materials Used, etc.)*	DATE SERVICE PERFORMED			PROCEDURE NUMBER	FEE
			Mo	Day	Yr		

ORTHODONTICS: Give class of malocclusion and describe services in treatment section.
DATE FIRST APPLIANCE INSTALLED:
TREATMENT PERIOD (NUMBER OF MONTHS):
REMARKS FOR UNUSUAL SERVICES:

TOTAL FEE CHARGED:

PART III: DENTIST CERTIFICATION

I hereby certify that the procedures as indicated by date performed have been completed and that the fees submitted are the fees I usually charge and accept for such procedures. PLEASE NOTE: PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT. The estimate of Dental benefits has been calculated based on current available benefits and employee eligibility.

AMOUNT PAID:

DENTIST SIGNATURE **DATE**

AMOUNT DUE:

FORM G824
(REV. 2/11)

Dental Direct Reimbursement Orthodontic Treatment Plan Form

This Orthodontic Treatment Plan form is required for reimbursement. The orthodontist needs to complete and sign this form and submit it to our office along with an itemized bill.

Commencement of orthodontic treatment begins the date the braces are placed on your teeth. Orthodontists typically require a down payment and collect the balance of their fees over the duration of the treatment. For claims ¼ (25%) of the entire treatment plan charge will be reimbursed under the benefit formula. The balance of the charges ¾ (75%) will be reimbursed monthly by the plan over the period of treatment. Benefit checks will be sent monthly until the treatment plan is finished or coverage terminates.

For orthodontic claims that began before the effective date of an employee's coverage, the remaining monthly charges will be reimbursed as treatment is received. If the patient paid the entire bill before the effective date of the employee's coverage, no benefits are payable. This is because there are no expenses to be reimbursed after the individual became eligible for benefits.

Patient Information – To Be Completed by the Employee

Employee Name:	Employer:
Patient Name:	
Address:	
Telephone #	Employee SS/Member#:
Records Date & Charge:	Date braces placed on teeth:
Down Payment Charge:	Date of Down Payment:
Date treatment is expected to terminate:	
Total charge for treatment plan:	
Monthly maintenance fee:	Total # of monthly payments:
Are benefits to be paid to the doctor? ☐ Yes ☐ No If yes, provider's W-9 form is required to meet I.R.S. regulations.	
Employee Signature:	

Information on the Orthodontist

Name:	
Address:	
Fax #:	E Mail Address:
Telephone #	Tax ID #:
Orthodontist Signature:	Date:____/____/____