

Dental Claim Form

Claims Administrator:
 **BOON-CHAPMAN**

Employer Name _____

P.O. Box 9201
 Austin, Texas 78766-9201
 (512) 454-2681
 (800) 252-9653

Instructions for filing your claim

1. COMPLETE "EMPLOYEE'S STATEMENT" BELOW. Please be sure to answer every question.
2. Complete "Authorization to Release Information."
3. If you want payment to be made directly to the dentist, complete "Authorization to Pay Benefits to Dentist." Otherwise, payment will be made to the employee.
4. Have your dentist complete the other side of this form.
5. Attach itemized bills. All bills must show the patient's name, date of treatment, nature of treatment (diagnosis), fee, and the dentist's tax identification number.
6. **PLEASE NOTE:** The employee's social security number is required on all claims. Your claim cannot be processed without it.
7. If you are covered by other insurance, attach their payment sheets with copies of your bills.
8. Mail completed form to: **Boon-Chapman**
 P.O. Box 9201
 Austin, TX 78766-9201

If you have any questions about this claim or payment of benefits, contact Boon-Chapman at the address above.

Employee's statement of claim for group dental benefits

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|---|--|--|---------------------------------|
| 1. CLAIM IS FOR <input type="checkbox"/> Unmarried child. If child is age 19 or older, coverage continued as full-time student, attending _____ School Name <input type="checkbox"/> Self <input type="checkbox"/> Spouse | | | |
| 2. PATIENT'S NAME | | DATE OF BIRTH | SEX |
| 3. IS CLAIM DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | IF "YES," WHERE DID ACCIDENT OCCUR? | |
| DATE OF ACCIDENT | | | |
| DESCRIBE ACCIDENT: | | | |
| 4. IS THIS CLAIM THE RESULT OF A WORK-RELATED ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 5. IS EMPLOYEE MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | IF YES, IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| NAME OF SPOUSE _____ DATE OF BIRTH _____ | | 5a. IF CLAIM IS FOR A DEPENDENT CHILD, IS THIS CHILD EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| EMPLOYER _____ ADDRESS _____ | | EMPLOYER _____ ADDRESS _____ | |
| 6. IS PATIENT COVERED FOR ANY OTHER HEALTH BENEFITS AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," check box below that applies and complete Part 6a <input type="checkbox"/> Group dental benefits of any kind. <input type="checkbox"/> Coverage of medical care expenses provided by an employer, any welfare plan, or any federal, state, or other governmental program. <input type="checkbox"/> Other arrangement of benefits for individuals of a group <input type="checkbox"/> Any automobile insurance policy | | 6a. GIVE NAME AND ADDRESS OF OTHER COMPANY OR ORGANIZATION PROVIDING INSURANCE NAME _____ ADDRESS _____ OTHER BENEFIT GROUP PLAN NUMBER(S) _____ | |
| 7. EMPLOYEE'S NAME | | EMPLOYEE'S SIGNATURE | EMPLOYEE'S SOC. SEC. NO. |
| ADDRESS _____ CITY _____ | | STATE _____ | ZIP _____ DATE _____ |
| 8. HAVE YOU MOVED SINCE YOUR LAST CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, IS THE ABOVE ADDRESS YOUR NEW ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | HOME TELEPHONE NO. | BUSINESS TELEPHONE NO. |
| Authorization to Release Information I hereby authorize the dentist to release any information acquired in the course of my examination or treatment. I understand that such information will be used by Boon-Chapman for the purpose of verifying that the services charged for were provided and that I or my authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim, unless revoked in writing by me or my legal representative. I agree that a photographic copy of this authorization shall be as valid as the original. | | Authorization to Pay Benefits to Dentist SIGN ONLY IF YOU WANT PAYMENT MADE TO DENTIST If you have paid the dentist, write "Pay Employee" below instead of signing. I hereby authorize payment directly to the dentist of the dental benefits, if any, otherwise payable to me but not to exceed the usual, customary, and reasonable charges for those services. Authorizations signed with the dentist will be honored. | |
| Signature of patient (or parent, if patient is a minor) _____ | | Employee's signature _____ | |
| Date _____ | | Date _____ | |

