SCHOOL DISTRICT 27J DENTAL PLAN

Group #0004000

Send Claims To: Claim Inquiries: EBMS, P.O. Box 21367 Billings, MT 59104-1367 (866) 247-1447

DENTAL CLAIM FORM

EMPLOYEE INFORMATION – COMPLETE IN FULL

Employee Name				Social Security Number		Date of Birth	
Marital Status Single □	Married		Divorced	□ Widowed □		Sex Male □ Fen	nale 🗆
Employee Address						Phone Number	
Street Patient Name (if other than employee	Citv			State Social Security Number	Zip	Date of Birth	
Fallent Name (ii other than employee)			Social Security Number		Date of Billi	
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Patient's Relationship to Employee				Is Patient a Full-Time Stude	ent	Is Patient Emplo	yea?
				Yes □ No □		Yes □	No □
If Patient is Employed, Provide Name	and Addres	s of Emplo	oyer				
Are you or your dependent(s) covered If yes, please provide complete the fo		other dent	al plan?	Yes □	No 🗆		
Name of Person with Other Insurance				Social Se			
Name and Address of Insurance Carrier				Policy Number			
lo only of this trootment the requite of				Yes □	No 🗆		
Is any of this treatment the result of a If yes, please give details of the accid		hen and w	here did it o		NO LI		
AUTHORIZATION AN	D CERTIFIC	ATION		SIGN HERE IF PAY	MENT IS TO B	E MADE TO PR	OVIDER
I hereby certify that the foregoing statemen	ts are true an	d correct. I		I authorize the Plan to ma			_
dentist or hospital to furnish and disclose a photocopy of this authorization shall be as			this claim. A				
Patient or Parent Signature Date				Employee's Signature Date			
ATTENDING DEN	Z'T2IT	REPO	RT - DIF	ASE DO NOT SEND X	-PAVS IINI	ESS REOUE	STED
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