SCHOOL DISTRICT 27J DENTAL PLAN

Group #0004000

Send Claims To: EBMS, P.O. Box 21367 Billings, MT 59104-1367

Claim Inquiries: (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 ☐ Female ☐
Employee Address Street City State Zip	Phone Number

Patient Name (if other than employee)	Social Security Number	Date of Birth

Patient's Relationship to Employee	Is Patient a Full-Time Student Yes ☐ No ☐	Is Patient Employed? Yes ☐ No ☐

If Patient is Employed, Provide Name and Address of Employer

Are you or your dependent(s) covered under any other dental plan? Yes ☐ No ☐

If yes, please provide complete the following:

Name of Person with Other Insurance: _____ Social Security # _____

Name and Address of Insurance Carrier _____ Policy Number _____

_____

Is any of this treatment the result of an accident? Yes ☐ No ☐

If yes, please give details of the accident: how, when and where did it occur?

AUTHORIZATION AND CERTIFICATION

I hereby certify that the foregoing statements are true and correct. I authorize any dentist or hospital to furnish and disclose all known facts concerning this claim. A photocopy of this authorization shall be as valid as the original.

_____ _____

Patient or Parent Signature Date

SIGN HERE IF PAYMENT IS TO BE MADE TO PROVIDER

I authorize the Plan to make payment directly to my Dentist.

_____ _____

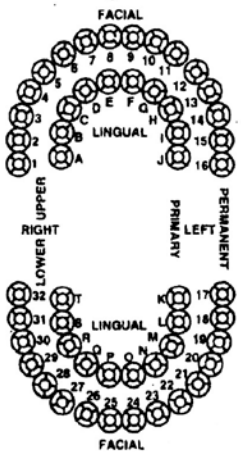
Employee's Signature Date

ATTENDING DENTIST'S REPORT - PLEASE DO NOT SEND X-RAYS UNLESS REQUESTED

PRE-TREATMENT ESTIMATE ☐			STATEMENT OF ACTUAL SERVICES ☐		
Is treatment for orthodontic purposes?	Yes ☐	No ☐	Is treatment for cosmetic purposes	Yes ☐	No ☐
Is treatment the result of an injury?	Yes ☐	No ☐	Is patient covered by another dental plan?	Yes ☐	No ☐

If prosthesis, is this the initial placement? Yes ☐ No ☐ Date of prior placement: _____

Indicate missing teeth with an "X"



EXAMINATION AND TREATMENT PLAN – LIST IN ORDER FROM TOOTH #1 – TOOTH #32 – USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE	DATE OF SERVICE	PROCEDURE CODE	FEE

DENTIST

Name:
Address:

Phone Number:
License Number

Tax ID/SSN

DENTIST'S CERTIFICATION

I certify that

- the procedures as indicated by date have been completed;
- the services are necessary in my professional judgment;
- these are my usual, customary and reasonable fees charged to my private patients.

_____

Dentist's Signature Date