

Great-WestSM HEALTHCARE

DENTAL CLAIM FORM

PART A - MEMBER STATEMENT - Failure to Answer All Questions May Delay Payment					
1. Member's Name		Street Address		City or Town	
2. Plan Number		Social Security #		Are you still employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Date of Birth		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		Name of Your Employer	
4. Spouse's Date of Birth		Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter the name and address of spouse's employer	
5. Are you or your dependents covered under another group insurance or government plan such as Medicare, an HMO or automobile no fault coverage, which will also cover any of the medical expenses on the claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, enter name and address: Policy # / ID #: Family Member Holding Policy:	
6. Is claim for a dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter dependent name (first, last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
6a. If child, is he/she married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is child over 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Is claim for an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date: Time:		Where did it occur? While working? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. SIGN HERE IF YOU WANT BENEFITS PAID TO DOCTOR/HOSPITAL				DATE:	
9. SIGN HERE FOR ALL CLAIMS				DATE:	
I hereby authorize any insurance company, hospital, or physician to release all information which may have a bearing on benefits payable under this plan of benefits.					
PART B - DENTIST'S STATEMENT Check One <input type="checkbox"/> Dentist's Pretreatment Estimate <input type="checkbox"/> Dentist's Statement of Actual Services					
Patient's Name		Date of Birth		Has any other group insurance carrier been billed for these services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is treatment result of occupational illness or injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, advise date and details	
Is treatment result of automobile or other accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, advise date and details	
If prosthesis, is this initial placement?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If no, reason for replacement	
Is treatment for orthodontics?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Date appliances placed	
Examination and treatment plan - List in order from tooth No. 1 to tooth No. 32 - Use charting system shown					
Tooth # or Letter	Surface	Description of Service (Including x-rays, prophylaxis, materials used, etc.) Line No.	Date Service Performed	Procedure Number	Fee
		1			
		2			
		3			
		4			
		5			
		6			
		7			
		8			
		9			
Signature of Dentist			Total Charges	Amount Paid	Balance Due
Signed _____			Date: _____		
X-rays Enclosed <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider's Social Security # / Tax ID #	Dentist's Name, Address, ZIP Code			Telephone (Include Area Code)

Group Dental Claim - HOW TO FILE A CLAIM

Member

1. Complete Part A - One for each family member
2. If claim is for a dependent, also complete lines 6 & 6a
3. If claim is for an accident, complete line 7
4. For all claims, sign line 9
5. If you want benefits paid to doctor/hospital, sign form on line 8
6. Enclose a copy of other carriers' payment worksheet when you have other insurance.
7. Ask your doctor to provide itemized bills with diagnosis for care

Dentist

1. Complete Part B
2. Or, attach Itemized Bill which includes Diagnosis for care
3. Sign form - return to patient

Forward Completed Claim Forms to:
1000 Great-West Drive
Kennett, MO 63857-3749

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against a claims administrator of payer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. Such action is considered to be a felony in some states.

Authorization is valid for the duration of the claim. Claimant or Claimant's authorized representative is entitled to receive a copy of this form.

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