CBA Blue

GROUP NAME:_____

GROUP # _____

STATEMENT OF CLAIM FOR GROUP DENTAL BENEFITS	MAIL THIS FORM TO: CBA BLUE P.O. BOX 9350 SO BURLINGTON, VT 05407-9350 Phone (888) 222-9206

PART I - TO BE COMPLETED BY EMPLOYEE

Patient Name	Relationship to Employee	Patient Birthdate
Employee Name	**Participant ID#**	**Employee Birthdate**
Employee Mailing Address		

Is Patient Covered by Another Dental Plan?	— Yes — No	If Yes, please Provide Dental Plan Name, Group Number, Name and Address of Carrier
Is Treatment Result of an Occupational Injury?	— Yes — No	If Yes, Enter Brief Description
Is Treatment Result of an Accident?	— Yes — No	If Yes, Enter Brief Description and Dates

I hereby certify the accuracy of the above statements, and authorize release of any information relative to this claim.	Signed (Patient or Parent if Minor)	Date
I hereby authorize payment of Dental Benefits to be made to the attending Dentist of services related to this claim.	Employee Signature	Date

A PRE-TREATMENT ESTIMATE IS RECOMMENDED FOR CLAIMS EXPECTED TO EXCEED $300.00

PART II - TO BE COMPLETED BY ATTENDING DENTIST

Dentist Name	Dentist Telephone	Dentist SSN or TIN
Mailing Address		

Is Treatment for Orthodontics?	— Yes — No	If Services Already Commenced, Enter Dates Appliances Placed	Months of Treatment Remaining

CHECK ONE: _____ **DENTIST'S PRETREATMENT ESTIMATE** _____ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

Tooth # or Letter	Surface (i.e. M,O,DB,L,LA,I)	Description of Service (Including X-rays, Prophylaxis, Materials Used, etc.)	Date Service Performed MMDDYY	Procedure Number	Fee	Notes

I hereby certify that the procedures, as indicated by date, have been completed.	Total Fee Charged	
Dentist's Signature: Date:		

Rev 1/1/2008

CBA Blue

PLEASE READ BEFORE FILING YOUR DENTAL CLAIM

FOR THE EMPLOYEE

Authorization To Pay Dentist

1. PLEASE ANSWER ALL QUESTIONS IN THE SECTION ENTITLED "TO BE COMPLETED BY EMPLOYEE.
2. SIGN AND DATE THE "AUTHORIZATIONTO RELEASE INFORMATION".
3. IF YOU WISH TO HAVE BENEFITS PAID DIRECTLY YO THE DENTIST, SIGN AND DATE THE "AUTHORIZATION TO PAY BENEFITS TO DENTIST". IF AUTHORIZED, PAYMENT WILL BE MADE DIRECTLY TO YOUR DENTIST. A COPY OF THE PAYMENT WILL BE SENT TO YOU FOR YOUR RECORDS. OTHERWISE PAYMENT WILL BE MADE DIRECTLY TO YOU.
4. IF THE PATIENT HAS COVERAGE UNDER ANY OTHER GROUP POLICY OR GOVERNMENT PLAN, SUBMIT THE SAME BILLS TO THE OTTHER INSURANCE COMPANY AT THE SAME. THIS IS VERY IMPORTANT BOTH IN RECEIVING FULL BENEFITS FROM YOUR DENTAL PLAN AND IN THE LENGTH OF TIME REQUIRED TO PROCESS YOUR CLAIM.

FOR THE DENTIST

Predetermination Of Benefits

WHEN PROPOSED DENTAL WORK INVOLVES MORE EXTENSIVE AND COSTLY DENTAL PROCEDURES, PREDETERMINATION OF BENEFITS IS REQUESTED.
THIS PROCESS ENABLES YOU AND YOUR PATIENT TO FIND OUT, IN ADVANCE, HOW MUCH OF THE TOTAL CHARGE IS PAYABLE BY THE DENTAL PLAN. PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT; HOWEVER, IT WILL HELP AVOID MISUNDERSTANDINGS BETWEEN THE PATIENT, THE DENTIST, AND THE PLAN ADMINISTRATOR ABOUT BENEFITS PAYABLE. IT IS SUBJECT TO MODIFICATION BASED UPON THE REMAINING BENEFITS AVAILABLE AND ELIGIBILITY WHICH APPLIES AT THE TIME SERVICES ARE COMPLETED.

1. USING THE APPROPRIATE ADA CODES, COMPLETE THE SECTION ENTITLED "TO BE COMPLETED BY ATTENDING DENTIST". BE SURE TO ITEMIZE CHARGES FOR EACH PROPOSED PROCEDURE.
2. SEND A COPY OF THIS FORM AND THE PRETREATMENT X-RAYS TO THE ADDRESS SHOWN ON THE FRONT OF THIS FORM.
3. CBA WILL REVIEW THE TREATMENT PLAN AND PROVIDE YOU WITH A DETAILED ESTIMATE OF AMOUNTS PAYABLE
FOR COVERED SERVICES. WE WILL PROMPTLY RETURN THE PREDETERMINATION OF BENEFITS FORM AND THE X-RAYS TO YOU.
4. REVIEW THE FORM AND BENEFIT ESTIMATES WITH YOUR PATIENT BEFORE THE WORK IS DONE. YOU AND PATIENT ARE FREE TO PURSUE ANY TREATMENT PLAN YOU RECOMMEND.
5. WHEN YOU COMPLETE THE TREATMENT, RETURN THE FORM TO US WITH TREATMENT DATES COMPLETED AND YOUR SIGNATURE.

PREDETERMINATION OF BENEFITS IS NOT NECESSARY:

1. WHEN SERVICES TO BE PERFORMED ARE FOR EMERGENCY TREATMENT
2. FOR DIAGNOSED CONDITIONS WHICH REQUIRE IMMEDIATE TREATMENT
3. WHEN THE TREATMENT PLAN INVOLVES ONLY THE USE OF AMALGAM, PLASTIC OR SILICATE RESTORATION.

Claims For Actual Services

FOR CLAIMS NOT INVOLVING PREDETERMINATION OF BENEFITS:

PLEASE COMPLETE THE SECTION ENTITLED "TO BE COMPLETED BY ATTENDING DENTIST" USING THE APPROPRIATE ADA CODES. BE SURE TO DATE AND ITEMIZE CHARGES FOR EACH SERVICE.

Important

WE ARE SORRY, BUT IF THE CLAIM FORM IS NOT COMPLETED IN FULL AND SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED.