compbenefits

Dental Claim Notice

LGHP Local Government Dental Group #960

HOW TO SUMBIT A CLAIM

A. Fill out every section of the claim form completely.
B. Include Your Social Security Number.
C. Attach only original itemized bills (not copies) or ask your dentist to complete the reverse side of this form.
D. If bills are attached, label them. Make sure the bills include the name, address and telephone number of the doctor.
E. The doctor must show the cost of each service and the date the service was performed.
F. If the patient is covered by another group insurance plan which is primary, the claim must be filed unther that plan first.
Then you can file a claim under State of Illinois' plan by attaching a copy of the other plan's Explanation of Benefits payments(s) and a copy of the itemized bill(s).
G. Then send to: Administered By CompBenefits
P.O. Box 4721, Chicago, IL 60608-4721
Telephone: 1-800-999-1669

claims can be submitted electronically to Payer ID CX021

TO BE COMPLETED BY THE EMPLOYEE

1. Complete for All Claims

Employee's Name _____ o Male o Female

Employee's Home Address (No. Street) _____

City, State Zip Code _____ Social Security Number _____

Date of Birth (Mo, Day, Yr) _____ Marital Status: o Single o Married o Widowed o Divorced o Separated

2. Complete for Dependent Claims Only

Dependent's Name (Spouse/Child) _____ o Male o Female

Relationship to Employee _____ Date of Birth (Mo, Day, Yr) _____

Marital Status: o Single o Married

Give dependent's address if other than above _____

o Claim is for Dependent Child over age 19, indicate o Full-time Student o Handicapped

if student, give name of school _____

3. Complete for All Claims

Are you, your spouse of child entitled to benefits from any kind of group dental insurance? o Yes o No

Name of Person with Other Insurance _____ Social Security Number _____

Name of other Employer _____

Name and Address of the insurance carrier providing these benefits _____ Policy number _____

4. Complete for Accidents Only

Work Related o Yes o No

Date Accident Occured _____

Give a brief description of the accident (include the place where it happened) _____

5. Complete for All Claims

I hereby agree to reimburse State of Illinois for any overpayment made by the Plan.
To all providers of dental care, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators. Your are authorized to provide CompBenefits and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on CompBenefits' behalf with information concerning dental care, advice, treatment or supplies provided the Patient, and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for dental benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Signed (Employee) _____ (Date) _____ Signed (Dependent Patient - Not Minor) _____ (Date) _____

6. Complete only if you want payment to go directly to Provider

Authorization to Pay Benefits, I hereby authorize payment directly to the provider of service for the claimed expenses as provided under the State of Illinois Dental Plan. I understand I am financially responsible for charges not covered by this authorization.

Employee's Signature) _____ Date _____

DENTAL CLAIM FORM

Check One:
o Dentist's pre-treatment estimate
o Dentist's statement of actual services

TO BE COMPLETED BY THE PROVIDER OF DENTAL SERVICES

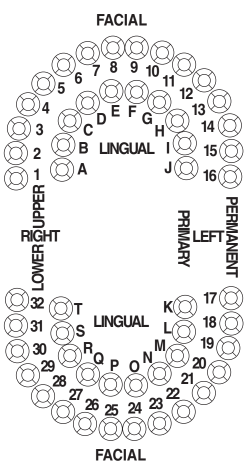
- A PRETREATMENT ESTIMATE IS REQUIRED FOR ANY CHARGES OVER $600 TO AVOID ANY MISUNDERSTANDING BETWEEN THE PATIENT AND DENTIST
- FOR PERIODONTAL TREATMENT FMX AND PERIODONTAL CHARTING ARE REQUIRED
- FOR MAJOR RESTORATIVE TREATMENT FMX, COMPLETE MOUTH CHARTING AND DATE OF EXTRACTIONS ARE REQUIRED
- FOR ENDODONTIC THERAPY
    - PREOP XR FOR PRETREATMENT ESTIMATE
    - POSTOP RX FOR PAYMENT IS REQUIRED
- AFTER SERVICES ARE COMPLETED, SIGN THE DENTIST'S STATEMENT PORTION BELOW

PATIENT NAME FIRST INITIAL LAST	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE	SEX o MALE o FEMALE	DATE OF BIRTH

BILLING DENTIST

Name of Billing Dentist or Dental Entity	Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.
Address where payment should be remitted	Is treatment result of auto accident?			
City, State, Zip	Other accident?			
Dentist Soc. Sec. or T.I.N. / Dentist License No. / Dentist Phone No.	If Prosthesis, is this initial placement?			(If no, reason for replacement) / Date of prior placement
First visit date current series / Place of treatment: Office, Hosp., ECF, Other / Radiographs or models enclosed? NO / YES / HOW MANY?	Is treatment for orthodontics?			If services already commenced enter: / Date appliances placed / Mos. treatment remaining

Identify missing teeth with "x"



Examination and treatment plan _ List in order from tooth no. 1 through tooth no. 32 _ Use charting system shown.

Tooth # or Letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo.	Day	Year	Procedure number	Fee	FOR ADMINISTRATIVE USE ONLY

Remarks for unusual services

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist) License Number Date