GHI

MAIL COMPLETED DENTAL CLAIM FORM TO:
GHI
P.O. Box 2838
New York NY 10116-2838

## PART A: SUBSCRIBER INFORMATION

1. SUBSCRIBER'S CERTIFICATE NUMBER | CATEGORY | GROUP

2. SUBSCRIBER'S NAME AND ADDRESS
LAST | FIRST

NO. AND STREET | APT. NO.

CITY | STATE | ZIP CODE

AREA CODE | TELEPHONE NUMBER
( )

3a. IS THE SUBSCRIBER'S SPOUSE EMPLOYED? ☐ YES ☐ NO

3b. DOES THE SUBSCRIBER OR SPOUSE HAVE ADDITIONAL DENTAL INSURANCE COVERAGE? ☐ YES ☐ NO

IF YOU ANSWERED YES TO EITHER QUESTION 3a. OR 3b., PART F (OTHER INSURANCE COVERAGE) ON REVERSE SIDE MUST BE COMPLETED.

## PART B: PATIENT INFORMATION

1. PATIENT'S FIRST NAME | 2. PATIENT'S DATE OF BIRTH MONTH | DAY | YEAR

3. PATIENT'S RELATIONSHIP TO SUBSCRIBER
☐ SUBSCRIBER 1 ☐ SPOUSE 2 ☐ SON 3 ☐ DAUGHTER 4 ☐ OTHER: SPECIFY

4. SEX ☐ MALE ☐ FEMALE

IS PATIENT A DISABLED DEPENDENT OVER AGE 19?
☐ YES ☐ NO If Yes, see H on reverse.

| | YES | NO |
|---|---|---|
| 5. IS PATIENT A DEPENDENT STUDENT AGE 19 OR OVER? IF YES, PART G (DEPENDENT STUDENT INFORMATION) ON THE REVERSE SIDE MUST BE COMPLETED. | ☐ | ☐ |
| 6a. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? | ☐ | ☐ |
| 6b. WAS CONDITION RELATED TO AN AUTO ACCIDENT? | ☐ | ☐ |
| 6c. WAS CONDITION RELATED TO OTHER ACCIDENT? | ☐ | ☐ |

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, *and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.***

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE, TO OR BY GHI, OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO CERTIFY THAT BENEFITS ARE NOT AVAILABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.

PATIENT'S OR AUTHORIZED SIGNATURE (Parent or Legal Guardian) | DATE

## PART C: PREDETERMINATION OF BENEFITS

Your contract may require that a predetermination of benefits be made by GHI prior to commencement of orthodontics, prosthetics and surgeries. Please refer to your benefits brochure to determine if predetermination of benefits is required. If so, have your dentist complete Part D of this form. Check the appropriate box in Section 7, submit x-rays if appropriate, and mail to GHI. GHI will notify the dentist and subscriber of the amount of benefits available.

## PART D: DENTIST INFORMATION

1. DENTIST NAME

MAILING ADDRESS

CITY, STATE, ZIP CODE

5. IF PROSTHESIS AND/OR CROWN, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO (IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT

6. IS THIS TREATMENT FOR ORTHODONTICS? ☐ YES ☐ NO IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCE PLACED: MOS. TREATMENT REMAINING

2. DENTIST TAX IDENTIFICATION NO. | DENTIST LICENSE NO.

I AM A SPECIALIST IN:
☐ ORTHODONTICS ☐ ORAL SURGERY
☐ ENDODONTICS ☐ PERIODONTICS
☐ OTHER

3. FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT OFFICE, HOSP. OR OTHER | RADIOGRAPHICS OR MODEL ENCLOSED? NO | YES | HOW MANY?

4. PARTICIPATING DENTIST IN A GHI PLAN
☐ YES ☐ NO

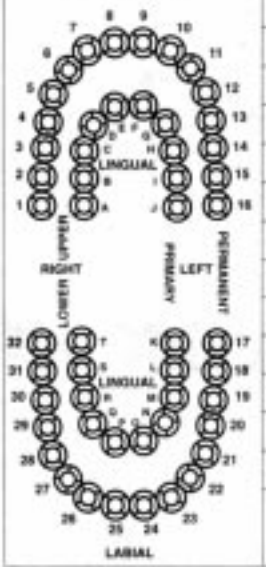
TO BE COMPLETED BY A PARTICIPATING DENTIST ONLY:
I HAVE BEEN PAID ☐ YES (AMOUNT PAID) $ _____ ☐ NO
☐ I WAS NOTIFIED BEFORE SERVICES WERE RENDERED THAT GHI INSURES THE PATIENT.

7. CHECK ONLY ONE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES: I hereby certify that the procedures below were rendered and completed on the dates indicated.
☐ DENTIST'S TREATMENT PLAN (PRE-DETERMINATION OF BENEFITS).

SIGNED (DENTIST) | DATE

8. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO 1 THROUGH TOOTH NO. 32

IDENTIFY MISSING TEETH WITH "X"




| TOOTH # OR LETTER | SURFACE | DATE SERVICE PERFORMED MO | DAY | YEAR | ADA PROCEDURE CODE | FEE | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) | ADMINISTRATIVE USE ONLY |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | TOTAL FEE CHARGED | | | |

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, *and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.***

## E. CLAIMS FILING INSTRUCTIONS

**INSTRUCTIONS:**
**Mail the CLAIM FORM promptly.**
**Follow these instructions to avoid delay.**

1. Complete sections A and B in full to assure positive identification and prompt payment.
2. The Subscriber must sign and date the claim.
3. All Claim forms must be submitted to GHI no later than 180 days after the end of the calendar year in which the service was rendered.
4. If you use a GHI Participating Dentist, payment will be made directly to the dentist.
5. Dental coverage is subject to specific limitations and exclusions. Please refer to your insurance booklet and certificate for a description of covered services, limitations and exclusions.
6. This form will have to be returned if it is incomplete or incorrect.

## F. ADDITIONAL DENTAL INSURANCE COVERAGE

**If your spouse is employed complete this section below.**

EMPLOYER (SPOUSE)

EMPLOYER'S ADDRESS

CITY STATE ZIP CODE

EMPLOYER'S AREA CODE TELEPHONE NUMBER

SPOUSE'S DATE OF BIRTH MONTH DAY YEAR

**If patient is eligible for dental benefits under any other dental insurance policy complete this section below.**

NAME OF POLICYHOLDER

CERTIFICATE OR IDENTIFICATION NO. EFFECTIVE DATE OF COVERAGE

NAME OF PLAN/INSURER

PLAN/INSURER ADDRESS

## G. DEPENDENT STUDENT INFORMATION

**This part must be completed only for those having dependent student coverage if the patient is a dependent student age 19 or over.**

I CERTIFY THAT MY DEPENDENT, _____,
MEETS ALL REQUIREMENTS FOR ELIGIBILITY AS A DEPENDENT STUDENT.

| | YES | NO |
|---|---|---|
| A. 19 YEARS OF AGE OR OLDER | ☐ | ☐ |
| B. UNMARRIED | ☐ | ☐ |
| C. RECEIVES MORE THAN HALF OF SUPPORT FROM THE EMPLOYEE OR RETIRED EMPLOYEE | ☐ | ☐ |
| D. IS A FULL-TIME STUDENT AT AN ACCREDITED SECONDARY OR PREPARATORY SCHOOL OR COLLEGE | ☐ | ☐ |

E. EXPECTED DATE OF GRADUATION _____

NAME OF SCHOOL

CITY

DATE STARTED IF GRADUATED, GIVE DATE

HAS DEPENDENT SERVED IN THE ARMED FORCES? ☐ YES ☐ NO
IF YES, GIVE DATES OF SERVICE.

FROM TO

DATE

SUBSCRIBER'S SIGNATURE

## H. DISABLED DEPENDENT OVER AGE 19.

If dependent over age 19 is disabled and eligibility has not been established, contact your Health Benefits Administrator, personnel department or business office for special form.