

Please submit to:
Activa Benefit Services, LLC.
2905 Lucerne Dr., S.E., Suite 555
Grand Rapids, MI 49546
Claims: 866-807-1097
Fax: 616-787-4590
Dental Payor # 38255

DENTAL CLAIM

- Dentist's pre-treatment estimate
- Dentist's statement of actual services

PATIENT INFORMATION					
Patient Name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	Relation to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Other	
If full time Student	School	City			
Employee Information					
Employee Name		Employee, No.	Are other family members, employed? Employee Name		
Employee Mailing Address					
Employer Name & Address					
City		State	Zip Code		
Is Patient covered by another dental plan?		Dental Plan Name		Union Local	Group No.
Name and Address of Carrier					
DENTIST SECTION					
Dentist Name		Mailing Address			
Dentist Soc. Sec. or TIN.		Dentist Licenses No.		Dentist Phone #	
First Visit date current series	Place of treatment	Radiographs or <input type="checkbox"/> Yes How many models enclosed <input type="checkbox"/> No			
Is treatment result of occupation illness or injury		No	Yes	If yes, enter brief description and dates	
Is treatment result of auto accident? Other accident					
Are any services covered by another plan?					
If prosthesis is the initial placement					
Examination and Treatment Received					
Tooth & or Letter	Surfaces	Description of services performed	Date of Service	Procedure Number	Fee
Authorization to release information:					
I hereby authorize any hospital, physician, or other person who has examined or attended _____ To furnish to the Plan administrator, or a representative thereof, any and all information with respect to any illness, medical history, consultation prescriptions or treatment, and copies of all hospital or medical records. I hereby authorize the Plan administrator to release to and receive from other insurance companies, prepayment organizations, employers and unions benefits payment information pertaining to the patient named above. A photocopy of this authorization shall be considered as effective and valid as the original.					
Employee Signature			Spouse's signature if applicable		
X			X		
I hereby certify that the services listed above have been performed and payment is therefore due.					
_____ Signed (Dentist)					
I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown above, I understand that I am financially responsible for any charges not covered by this authorization.					
X			Date		