

CLAIM FORM ~ DENTAL EXPENSE

GROUP INSURANCE

Note: Submit claims to & verify coverage with
C. B. TRACY & ASSOCIATES, INC

506 Pellis Road
 Greensburg, PA 15601
 Phone: 724-834-1090; 800-838-1090
 Fax: 724-834-1070

TO BE COMPLETED BY EMP		TO BE COMPLETED BY EMPLOYEE			
Name of Patient	S.S.#	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Is Patient <input type="checkbox"/> Yourself <input type="checkbox"/> Your Spouse <input type="checkbox"/> Your Child	Is Patient <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated
Name of Employee	S.S.#	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth		
Employer					
First Name of Employee's Spouse	If patient is child, is Child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is Employee's Spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," Complete Name & Mailing Address of Child's Employer				
If "yes," Complete Name and Mailing Address of Spouse's Employer	Is Child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this Claim the result of Accidental Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Occupational Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," Name of School				
Is Patient covered through any other plan which provides benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "yes," what other insurance company or service plan is providing this coverage?					
Name	Identify type of other coverage (Single, Family, etc.)				
Address	Medical				
City	Dental				
State	Vision				
Zip	Drug				
I certify that the foregoing statements and answers are true and complete to the best of my knowledge and belief. I understand that some states require that I be notified that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I hereby authorize any insurance company, pre-payment organization, employer, union, trust fund, hospital, physician or dentist to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization shall be considered as effective and valid as the original. Please note that the signatures required on the other side of this form may not be copied.					
Date	Signature of Employee				
	X				
Home Address	Street	City	State	Zip Code	Phone No.

▶ **Non-completion of any of the above questions could result in a delay in processing of your claims** ◀

BE COMPLETED BY C. B. TRACY and ASSOCIATES, INC.

Name of Company or Plan	Patient's Coverage If coverage terminated, show termination date If coverage reinstated, show date reinstated	Month Day Year
Social Security No.	Group Policy No.	Effective Date
Date Employed		
Is Employee entitled to Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has he made claim for such benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Employer or Plan Administrator	Claims Examiner

Remarks

SEE REVERSE SIDE FOR STATEMENT TO BE COMPLETED BY DENTIST ➡

NOTE: IF PAYMENT IS TO BE SENT TO THE PROVIDER, PLEASE SIGN ON BACK AT BOTTOM OF PAGE.

