DENTAL CLAIM FORM

P.O. Box 6392
Grand Rapids, MI 49516-6392
Phone: (616) 464-6635
Fax: (616) 464-4458

Claim Filing Process:
1. The employee and dentist complete the appropriate sections below.
2. The employee or provider mails the completed form to the address shown at left.

NOTE: Failure to answer all questions may delay payment.

Employee Completes

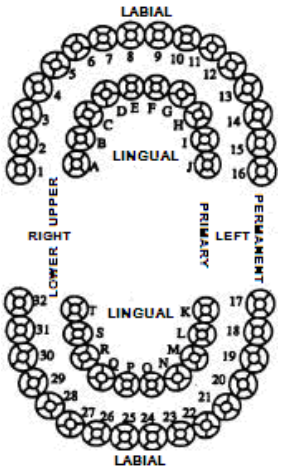
Employer's Name:	Group Number (refer to ASR ID card):
Employee's Name:	Date of Birth:
Address:	
Patient's Name:	Patient's Date of Birth:
Patient's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated	Patient's Sex: ☐ Male ☐ Female
Relationship to Employee: ☐ Employee ☐ Spouse ☐ Child	If patient is dependent child, is child a full-time student? ☐ Yes ☐ No
Is patient eligible for other dental coverage? ☐ Yes ☐ No	If yes, list insurance company's name, address, and policy number:
Is spouse employed? ☐ Yes ☐ No	If yes, list name and address of employer:
Nature of Illness or Injury (Diagnosis):	
Is Claim due to Accident? ☐ Yes ☐ No	Date of Accident:
Is Claim due to an auto accident or occupation? ☐ Yes ☐ No	Explain:
How and Where Did Accident Occur?	

Payments, Reimbursement, and Authorization: I understand that all dental benefits will be issued directly to the service provider unless written evidence/receipt is submitted to ASR showing that I paid the charges. I realize that I am financially responsible for the charges my Plan does not pay. I agree to reimburse the Plan for any overpayments in excess of what the Plan allows. I agree to advise the Plan of any claim against a third party to recover any damages arising out of the event causing the Plan's payment of benefits as soon as I am aware that I may recover damages from another party. If I fail to provide the Plan with written notice of a claim or compromise or settle a claim without prior written consent, the Plan shall deem that I have committed fraud or misrepresentation in a claim for benefits and shall have the right to terminate my participation in the Plan. I further agree to reimburse the Plan for all benefits paid to me or on my behalf if I recover any money for the same accident or illness for which benefits were paid. This agreement applies to all recoveries, including benefits paid or recovered under any state or federal worker's compensation statute, whether by redemption, voluntary payment, compromise, settlement, court order, or any other form.

Employee's Signature: Patient's Signature: Date:

Dentist Completes (Check above for correct name of patient)

Dentist's Name:	Street Address:	
City, State:	ZIP Code:	Phone Number:
Social Security No. or Tax ID No. (Required by law):	If specialist, show specialty:	



Indicate missing teeth with an "X."

Make a schematic drawing of crowns, bridges, and partial dentures.

Examination and Treatment Record (Use Charting System Shown)
Check One: ☐ Pre-Treatment Estimate (Optional) **-or-** ☐ Statement of Actual Services

Plan Use Only

Tooth No. or Ltr.	Surface	Description of Services (including X-rays, Prophylaxis, Materials Used, etc.)	ADA Procedure Number	Date Service Performed Mo.	Day	Yr.	Fee	Basic	Extended

Orthodontics (Give diagnosis, class of malocclusion, and describe any appliance in above treatment section):
Date First Appliance Inserted: _____
Date Last Appliance Removed: _____
Treatment Period (Number of Months): _____
Total Fee: _____

Total Fee ►

Benefits will be subject to plan provisions if the procedures described are performed during a period of the patient's eligibility.

Deductible			
Balance			
% Pay			
% Pay			
Amt. Pay			
Estimated Payment			
Patient Pays			

I hereby certify that services listed above have been performed on the named patient on the dates indicated and that the fees shown are currently charged to the majority of my patients.

Signature: Date: