



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 APT. NO. NO. AND STREET CITY STATE ZIP CODE AREA CODE TELEPHONE NUMBER
3a. IS THE SUBSCRIBER'S SPOUSE EMPLOYED? 3b. DOES THE SUBSCRIBER OR SPOUSE HAVE ADDITIONAL DENTAL INSURANCE COVERAGE?

PART B: PATIENT INFORMATION

1. PATIENT'S FIRST NAME 2. PATIENT'S DATE OF BIRTH MONTH | DAY | YEAR
3. PATIENT'S RELATIONSHIP TO SUBSCRIBER 4. SEX
5. IS PATIENT A DISABLED DEPENDENT OVER AGE 19?
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.

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?
6. IS THIS TREATMENT FOR ORTHODONTICS?
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).

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

Table with columns: IDENTIFY MISSING TEETH WITH 'X', TOOTH # OR LETTER, SURFACE, DATE SERVICE PERFORMED, ADA PROCEDURE CODE, FEE, DESCRIPTION OF SERVICE, ADMINISTRATIVE USE ONLY. Includes a dental chart diagram.

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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 | <input type="checkbox"/> | <input type="checkbox"/> |
| B. UNMARRIED | <input type="checkbox"/> | <input type="checkbox"/> |
| C. RECEIVES MORE THAN HALF OF SUPPORT FROM THE EMPLOYEE OR RETIRED EMPLOYEE | <input type="checkbox"/> | <input type="checkbox"/> |
| D. IS A FULL-TIME STUDENT AT AN ACCREDITED SECONDARY OR PREPARATORY SCHOOL OR COLLEGE | <input type="checkbox"/> | <input type="checkbox"/> |
| E. EXPECTED DATE OF GRADUATION _____ | | |

NAME OF SCHOOL	
CITY	_____
DATE STARTED	IF GRADUATED, GIVE DATE
HAS DEPENDENT SERVED IN THE ARMED FORCES? IF YES, GIVE DATES OF SERVICE. <input type="checkbox"/> YES <input type="checkbox"/> NO	
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.