ADMINISTERED BY:

☐ **PLEASE CHECK IF NEW ADDRESS**

American Administrative Group

RETURN COMPLETED FORM TO:

AAG
P.O. Box 93670
Lubbock, TX 79493-3670

DENTAL CLAIM NOTICE

PART I - TO BE COMPLETED BY ENROLLEE

1. Patient Name	2. Relationship to enrollee: SELF / SPOUSE / CHILD / OTHER	3. Sex: M / F	4. Patient Birthdate: MO / DAY / YEAR	5. If full time student: SCHOOL / CITY
6. Enrollee Name: First / Middle / Last	7. Enrollee Social Security No.		8. Enrollee Birthdate: Mo / Day / Year	
9. Home Address	10. Group Name and Address			
11. Group Number	12. Are you still enrolled in Plan Yes ☐ No ☐	13. If no, date of Termination	14. Date you became Retired	15. Date COBRA coverage became effective
16. Are other family members employed? ☐ Yes ☐ No	17. If yes, Employee Name / Soc. Sec. No.	18. Name and Address of Employer in item 17		
19. Is Patient Covered by another Dental Plan? ☐ Yes ☐ No	If yes, Dental plan name	Group No.	Name and Address of Carrier	

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Insuring Organization to release information regarding the medical or dental history treatment or benefits payable for this claim to Gallagher Benefit Administrators, Inc. for the purpose of validating and determining benefits payable in connection with this claim. This authorization or photostatic copy of the original shall be valid for one year from the date of signature. I understand that data may be extracted and transmitted to the Plan Administrator for Plan Administration purposes only.

I agree to reimburse the Plan to the extent of any payment which is in excess of the amount payable under this Plan.

Signed (Patient or parent if minor) ____________ Date ________

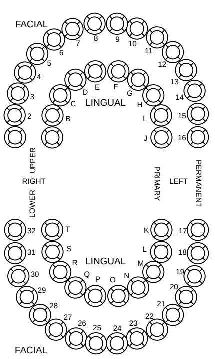
AUTHORIZATION TO PAY BENEFITS TO DENTIST -- I hereby authorize payment directly to the below named Dentist of the Plan Benefits otherwise payable to me.

Signed (Enrollee) ____________ Date ________

PART II - TO BE COMPLETED BY ATTENDING DENTIST CHECK ONE ☐ DENTIST'S PRETREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

				NO	YES	
20. DENTIST NAME			21. Is treatment result of occupational illness or injury			If yes, enter brief description and dates
22. Mailing address			23. Is treatment result of auto accident? Other accident?			
24. City, State, Zip			25. Are any services covered by another plan?			If yes, name of other plan.
26. Dentist Soc. Sec. or TIN.	27. Dentist License No.	28. Dentist Phone No.	29. If prosthesis, is this initial placement?			If no, reason for Replacement / Date of prior placement
30. First visit date current series.	31. Place of treatment Office, Hosp., ECF. Other ☐ ☐ ☐ ☐	32. Radiographs or models enclosed ☐ No ☐ Yes How many?	33. Is treatment for orthodontics?			IF SERVICES ALREADY COMMENCED. ENTER Date Appliances Placed / Mos. Treatment Remaining

Identify missing teeth with "x"



EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USING CHART SHOWN

Tooth # or Letter	Surface (i.e. M.O. D.B.L LA)	Description of Service (including X-rays, prophylaxis, materials used, etc.)	Date Service Performed Mo	Day	Yr	Procedure Number	Fee

Remarks for unusual services

TOTAL FEE CHARGED

PART III - DENTIST CERTIFICATION

"I hereby certify that the procedures as indicated by date have been completed and that the fees submittted are the fees I usually charge and accept for such procedures."

SIGNED (DENTIST) ____________ DATE ________

Amount Paid

Amount Due

PLEASE NOTE: PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT. This estimate of Dental benefits has been calculated based on current available benefits and enrollee eligibility.

FORM A824 REV. 8/05