



Fax Cover Sheet

Allied Benefit Systems
PO Box 909786-60690
Chicago, IL 60690-9786

P 800.288.2078
F 312-906-8359
E webinfo@alliedbenefit.com

| Sender's Name | Sender's Phone Number | Today's Date |
|---------------|-----------------------|--------------|
| | | |

| Employer Name | Group Number |
|---------------|-----------------|
| Employee Name | Employee UID |
| Patient Name | Date of Service |
| Claim # | Provider Name |
| | |
| | |
| | |
| | |

Documents Included:

- Medical Record
 - New Claim(s) / Corrected Claim(s)
 - Repricing / Repricing Sheet
 - Coordination of Benefits Letter
 - Itemized Bill
 - Explanation of Benefits (EOB)
 - Other. Please provide description
-

| Special Notes and/or Instructions |
|-----------------------------------|
| |

FAX CLAM FORM TO: 312-261-9363

Include:

- Claim Form
- Itemized Bill with Provider Name, Type of Service, and Procedure Codes
- Proof of Payment



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Dental Claim Form

Part 1: To be completed by Employee/Patient

| | |
|--|------------------------|
| Employer Information | |
| Employer Name Matanuska-Susitna Borough | Group Number A22206 |

| | | | |
|-----------------------------|-----------------------------------|-----------|-----|
| Employee Information | | | |
| Employee Name | Social Security Number/UID Number | Birthdate | |
| Employee Address | City | State | Zip |

Do you or any of your dependents have other group dental coverage?
 Yes (please provide information below) No

| | | | |
|--|--------------------------------|-------|-----|
| Name of Individual with other coverage | Other Insurance Carrier or TPA | | |
| Address of Carrier or TPA | City | State | Zip |

| | | | |
|--|--------|-----------|--|
| Patient Information | | | |
| Patient Name | Gender | Birthdate | |
| Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____ | | | |

| | |
|--|---------------|
| Employee Authorization | |
| I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. | |
| _____ Employee Signature | _____ Date |
| ASSIGNMENT OF BENEFITS: I hereby authorize payment to the provider of dental services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan. | |
| _____ Employee Signature | _____ Date |

Part 2: To be completed by Dentist

| | | | |
|--|------|---------------------------------|-----|
| Please select one: <input type="checkbox"/> Dentist's Pre-Treatment Estimate <input type="checkbox"/> Dentist's Statement of Actual Services | | | |
| Provider Name | | Provider TIN and License Number | |
| Provider Address | City | State | Zip |

| | |
|--|--|
| Claim Information | |
| Was this claim due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what was the date of the accident? |
| Where did the accident occur? | Is this claim the result of a work related illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of Service | Place of Treatment <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____ |
| Radiographs of Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many? |
| If treatment is for Orthodontia, date the appliances were placed | If treatment is for Orthodontia, how many months of treatment remain? |

| Provider Name | Patient Name | Date of Service | Provider TIN | ADA Dental Code | Total Charge |
|---------------|--------------|-----------------|--------------|-----------------|--------------|
| | | | | | |
| | | | | | |

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

Provider Signature

Date