



Dental Claim Statement

ALL CLAIMS MUST BE SUBMITTED
WITHIN SIX MONTHS OF DATE INCURRED

HOW TO FILE YOUR CLAIM

1. Complete Part I: Employee's Statement
2. Have your dentist complete Part II: Attending Dentist's Statement
3. Be sure form is completed. Mail completed form to address shown at right.

MAIL COMPLETED CLAIM FORM TO:

Boston University Dental Health Plan
80 East Concord Street
Box 1000
Boston, MA 02118
t 617 638 5223
f 617 638 6381

NOTICE: FRAUDULENT CLAIMS

Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in the Dental Health Plan will be grounds for disciplinary action against the employee or for termination of participation by the employee and/or covered dependent(s) under the Dental Health Plan

PART 1 EMPLOYEE'S STATEMENT (please print)

1) PATIENT NAME (ONE PATIENT PER FORM) first middle last			2) RELATIONSHIP TO EMPLOYEE self spouse child other		
3) SEX m f	4) PATIENT BIRTH DATE mo day year	5) IF FULL-TIME STUDENT (19 YRS OR OVER) school city			
6) EMPLOYEE NAME first middle last			7) EMPLOYEE UID NUMBER	8) MARITAL STATUS <input type="checkbox"/> single <input type="checkbox"/> separated <input type="checkbox"/> married <input type="checkbox"/> divorced	
9) EMPLOYEE MAILING ADDRESS <input type="checkbox"/> new address street city state zip			10) IS CLAIM INCURRED DUE TO EMERGENCY TREATMENT <input type="checkbox"/> yes <input type="checkbox"/> no if yes, provide more detail:		
11) GROUP NUMBER (FOR INTERNAL USE ONLY)	12) ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> yes <input type="checkbox"/> no name social security no.				
13) NAME AND ADDRESS OF EMPLOYER IN ITEM 12 name address					
14) IS PATIENT COVERED BY ANY OTHER DENTAL PLAN? <input type="checkbox"/> yes <input type="checkbox"/> no if yes, give: dental plan name policy/group no. name and address of carrier					

RELEASE AUTHORIZATION: I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to Boston University Dental Health Plan and its legal representatives: any dentist, physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution, or person, any employer, group policy holder, or certificate holder.

signature of employee (and spouse, if patient) date

PART 2 ATTENDING DENTIST'S STATEMENT (please print)

NAME OF DENTIST (first, middle, last)		<input type="checkbox"/> PRETREATMENT PLAN <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES		RADIOGRAPHS OR MODEL ENCLOSED <input type="checkbox"/> yes <input type="checkbox"/> no	QTY	DENTIST'S LICENSE NO.	
DENTIST'S COMPLETE MAILING ADDRESS (street city, state zip)		DENTIST'S TAX ID NUMBER		DENTIST'S SOCIAL SECURITY NUMBER		DENTIST'S TELEPHONE NO.	
		NAME OF PATIENT (first, middle, last)		ARE ANY SERVICES COVERED BY OTHER DENTAL PLANS? <input type="checkbox"/> yes <input type="checkbox"/> no if yes, give subscriber's name			
IS PATIENT A FAMILY MEMBER? <input type="checkbox"/> yes <input type="checkbox"/> no	IS CLAIM INCURRED DUE TO EMERGENCY TREATMENT? <input type="checkbox"/> yes <input type="checkbox"/> no if yes, attach more detail	IS TREATMENT THE RESULT OF AN ACCIDENT? <input type="checkbox"/> yes <input type="checkbox"/> no if yes: <input type="checkbox"/> occupational <input type="checkbox"/> auto <input type="checkbox"/> other					
For crown, bridge, or other prostheses, is this initial placement? <input type="checkbox"/> yes <input type="checkbox"/> no	INDICATE TEETH INVOLVED IN/REPLACED BY PREVIOUS PROSTHESIS						
ORTHODONTIC TREATMENT identify missing teeth with "x"	DATE APPLIANCE INSERTED	EXPECTED TREATMENT DURATION months	CLASS OF MALOCCLUSION <input type="checkbox"/> i <input type="checkbox"/> ii <input type="checkbox"/> iii	TYPE OF DENTITION <input type="checkbox"/> permanent <input type="checkbox"/> mixed			
	EXAMINATION AND TREATMENT PLAN LIST IN ORDER FROM TOOTH NO. 1-32 (USE CHART SYSTEM SHOWN)						
	date service performed	tooth # or letter	surface	description of services	procedure no.	fee	for administrative use only
					TOTAL FEE CHARGED		
<input type="checkbox"/> X-RAYS RETURNED TO DENTIST	I hereby certify that the procedures as indicated by date have been completed.			dentist's signature	date		

Pretreatment Plan does not guarantee payment. Required of charges of \$300 or more. Pretreatment of your claim advises you in advance of the amount of benefits payable if described procedures are performed during a period of patient's eligibility. Benefits payable are subject to COB and other policy provisions. PAYMENT. You must pay your dentist for services. You will be reimbursed for covered services.