Boston University Dental Health Plan

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 SOCIAL SECURITY OR UID NUMBER

8) MARITAL STATUS — ☐ single ☐ separated ☐ married ☐ divorced

9) EMPLOYEE MAILING ADDRESS ☐ new address — street / city / state / zip

10) IS CLAIM INCURRED DUE TO EMERGENCY TREATMENT ☐ yes ☐ no — if yes, provide more detail:

11) GROUP NUMBER (FOR INTERNAL USE ONLY)

12) ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ yes ☐ 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? ☐ yes ☐ 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)

☐ PRETREATMENT PLAN
☐ STATEMENT OF ACTUAL SERVICES

RADIOGRAPHS OR MODEL ENCLOSED ☐ yes ☐ 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? ☐ yes ☐ no
if yes, give subscriber's name

IS PATIENT A FAMILY MEMBER? ☐ yes ☐ no

IS CLAIM INCURRED DUE TO EMERGENCY TREATMENT? ☐ yes ☐ no *if yes, attach more detail*

IS TREATMENT THE RESULT OF AN ACCIDENT? ☐ yes ☐ no *if yes:* ☐ occupational ☐ auto ☐ other

For crown, bridge, or other prostheses, is this initial placement? ☐ yes ☐ no

INDICATE TEETH INVOLVED IN/REPLACED BY PREVIOUS PROSTHESIS

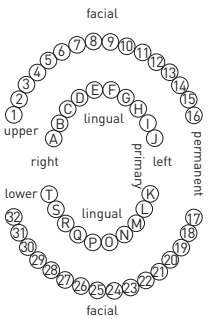
ORTHODONTIC TREATMENT
identify missing teeth with "x"

DATE APPLIANCE INSERTED

EXPECTED TREATMENT DURATION — months

CLASS OF MALOCCLUSION ☐ i ☐ ii ☐ iii

TYPE OF DENTITION ☐ permanent ☐ mixed



EXAMINATION AND TREATMENT PLAN LIST IN ORDER FROM TOOTH NO. 1-32 (USECHART SYSTEM SHOWN)

date service performed	tooth # or letter	surface	description of services	procedure no.	fee	for administrative use only

TOTAL FEE CHARGED

☐ 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.