CLAIM FOR DENTAL EXPENSE BENEFITS

Affordable Benefit Administrators, Inc. ABA Est. 1987

Mail to:
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(818) 842-0147

TO BE COMPLETED BY EMPLOYEE

PATIENT NAME | RELATIONSHIP TO EMPLOYEE: SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ❑ | SEX: M ❑ F ❑ | PATIENT BIRTHDATE: MO DAY YEAR | IF FULL TIME STUDENT | SCHOOL | CITY

EMPLOYEE FIRST NAME | MIDDLE | LAST | EMPLOYEE SOCIAL SECURITY NO. | GROUP NUMBER

EMPLOYEE MAILING ADDRESS | PHONE NUMBER | WORK LOCATION | DATE EMPLOYED

CITY, STATE | ZIP CODE | NAME AND ADDRESS OF EMPLOYER

ARE OTHER FAMILY MEMBERS EMPLOYED? ❑ YES ❑ NO | EMPLOYEE NAME | SOCIAL SECURITY NO.

IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO | DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

PATIENT'S SIGNATURE (PARENT IF MINOR) ______ DATE ______

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

EMPLOYEE'S SIGNATURE ______ DATE ______

PROVIDER OF SERVICES

DENTIST FIRST NAME | MIDDLE | LAST

MAILING ADDRESS

CITY, STATE | ZIP CODE

DENTIST SOC. SEC. OR T.I.N. | DENTIST LICENSE NO. | DENTIST PHONE NO.

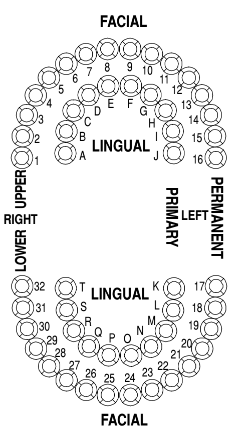
FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT: OFFICE ❑ HOSP ❑ ECF ❑ OTHER ❑ | RADIOGRAPHS OR MODELS ENCLOSED ❑ YES ❑ NO | HOW MANY?

	YES	NO	
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
IS TREATMENT RESULT OF AUTO ACCIDENT ? OTHER ACCIDENT?			
DATE TEETH WERE EXTRACTED			
IF PROTHESIS IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR PLACEMENT / DATE OF PRIOR PLACEMENT.
IS TREAMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED / MOS TREATMENT REMAINING

TO BE COMPLETED BY DENTIST

DENTIST - CHECK ONE
❑ PRE-TREATMENT ESTIMATE
❑ STATEMENT OF ACTUAL SERVICES

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN

ADMINISTRATIVE USE ONLY

Tooth No. or Letter	Surface	DESCRIPTION OF SERVICES (Including X-Rays, Prophylaxis, Materials Used, etc)	Date Service Performed Mo	Day	Yr	Procedure Number	FEE	BASIC	MAJOR

I AUTHORIZE PAYMENT OF DENTAL BENEFITS TO THE ABOVE NAMED PROVIDER OF SERVICES

EMPLOYEE"S SIGNATURE: ______ DATE ______

TO BE COMPLETED BY DENTIST

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE ABOVE NAMED PATIENT ON THE DATES INDICATED.

DENTIST'S SIGNATURE: ______ DATE ______

CALENDAR YEAR MAXIMUM BENEFITS: ______

EXAMINER'S INITIALS: ______ DATE ______

TOTAL FEE CHARGED

DENTAL UNIT USE

Employee Eligible Date ______
Employee Effective Date ______
Termination Date ______
Coverage Code ______
Verified By ______
Date ______

	BASIC	MAJOR
DEDUCTIBLE		
BALANCE		
% PAYABLE	%	%
AMOUNT PAYABLE		

COPY TO DENTIST

ORIGINAL TO ABA

***All Dental Treatment in Excess of $150 Must Be Pre-Authorized**

ORIGINAL TO ABA