

# CLAIM FORM

1. COMPLETE THIS FORM IN FULL AND SIGN BELOW.
2. ATTACH ALL BILLS.
3. MAIL TO:

Fringe Benefit Coordinators  
 P O BOX 5249  
 Gainesville, FL 32627-5249

**NORTH EAST FLORIDA  
 EDUCATIONAL CONSORTIUM**  
 FRINGE BENEFIT COORDINATORS  
 1239 NW 10<sup>TH</sup> Ave  
 Gainesville, FL 32601  
 (352) 377-1239 Fax (352) 372-9805  
**WWW.FBC-INC.COM**



## PART 1 EMPLOYEE STATEMENT

PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME			SOCIAL SECURITY #		NAME OF DISTRICT			
EMPLOYEE MAILING ADDRESS				EMPLOYEE BIRTH DATE		OCCUPATION		GROUP NUMBER NEF _____
CITY		STATE	ZIP	PHONE NO.		EMAIL ADDRESS (OPT)		NAME OF SCHOOL
DEPENDENT NAME		RELATIONSHIP		DATE OF BIRTH		IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION?		<input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT NAME		RELATIONSHIP		DATE OF BIRTH		IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION?		<input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT NAME		RELATIONSHIP		DATE OF BIRTH		IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION?		<input type="checkbox"/> YES <input type="checkbox"/> NO
IS THE PATIENT A FULL TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				IS THE PATIENT HANDICAPPED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
NAME OF SPOUSE			SOC. SEC. # OF SPOUSE		BIRTHDATE		SPOUSE EMPLOYER	
IS THE PATIENT COVERED BY ANY OTHER DENTAL / VISION / DISABILITY PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO								IF YES, COMPLETE THE FOLLOWING:
MEMBER NAME:					PLAN NAME AND ADDRESS:			
RELATIONSHIP TO PATIENT: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/> _____					GROUP PLAN #:			
SOCIAL SECURITY # OF MEMBER:					EFFECTIVE DATE:			

### PATIENT OR PARENT MUST SIGN AND DATE BELOW

### IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW

**AUTHORIZATION TO RELEASE INFORMATION**  
 I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Patient, or Parent if minor

**AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):**  
 I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Employee

### PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
  - Questions regarding other coverage you or your dependents are eligible for must be answered.
  - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
  - If payment is to be made to the provider of services, you should sign that section.
2. **When not accompanied by an itemized bill** have your doctor or dentist complete PART 2 for each dental or vision claim
3. Attach all itemized bills relating to the claim to PART 1 of the Claim Form.
  - Make sure all bills identify the patient.
  - All bills should show the date of treatment, type of service, and amount of charges.
4. If you have other coverage (including Medicare), make sure you attach all Payment Statements, Explanations of Benefits or declination letters.

**PART 2 TO BE COMPLETED BY DENTIST**

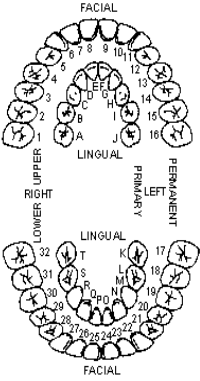
PATIENT'S NAME	BIRTH DATE OF PATIENT	RELATIONSHIP TO MEMBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>
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FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE <input type="checkbox"/> OTHER <input type="checkbox"/> _____	RADIOGRAPHS OR MODELS ENCLOSED <input type="checkbox"/> NO <input type="checkbox"/> YES	HOW MANY?	IF PROSTHESIS, IS THIS AN INITIAL PLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PROVIDE THE REASON FOR REPLACEMENT:  DATE OF PRIOR PLACEMENT:
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IS TREATMENT FOR ORTHODONTICS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES" AND SERVICES ALREADY COMMENCED, GIVE DATE APPLIANCES PLACED: _____ ENTER MONTHS OF TREATMENT REMAINING: _____
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IS TREATMENT THE RESULT OF ILLNESS OR ACCIDENTAL INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES TO EITHER, ENTER A BRIEF EXPLANATION INCLUDING DATES WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO
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CHECK ONE  DENTIST'S PRE-TREATMENT EVALUATION  DENTIST'S STATEMENT OF ACTUAL SERVICES

	EXAMINATION TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THRU TOOTH NO. 32 USING CHARTING SYSTEM SHOWN						ADMINISTRATIVE USE
	TOOTH #	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED	PROCEDURE CODE	FEE	
							
<b>TOTAL CHARGE</b>							

REMARKS FOR UNUSUAL SERVICES

DENTIST'S NAME	DEGREE	TAX I.D. # or SSN	ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
ADDRESS		PHONE NUMBER	
CITY	STATE		

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE <input type="checkbox"/> WILL BE PERFORMED <input type="checkbox"/> HAVE BEEN PERFORMED	PATIENT ACCOUNT #
DENTIST'S SIGNATURE X _____	