DENTAL CLAIM FORM

BOON-CHAPMAN

CHECK ONE:
☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

If the cost of treatment is expected to exceed $300, a pre-treatment estimate should be completed
The physician or dentist must indicate: A list of every recommended dental procedure; and the charge for each procedure and provide supporting pre-treatment radiographs.

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD	3. SEX M / F	4. PATIENT BIRTHDATE (MM/DD/YY) / /	5. IS DEPENDENT A FULL TIME STUDENT? ___YES ___NO
6. EMPLOYEE'S NAME (Last, First, Middle Initial)	7. EMPLOYEE'S SSN	8. GROUP NUMBER / NAME		
9. EMPLOYEE'S MAILING ADDRESS	10. CITY, STATE, ZIP			
11. OTHER FAMILY MEMBERS EMPLOYED? IF YES, MEMBER'S NAME	SSN#	12. NAME AND ADDRESS OF EMPLOYER		
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	GROUP NUMBER	14. NAME AND ADDRESS OF EMPLOYER	

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

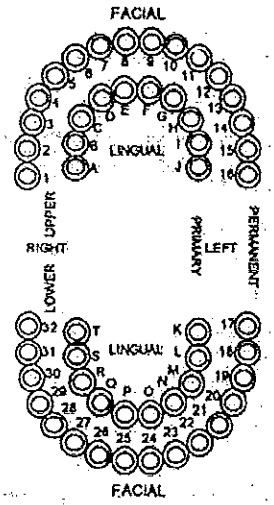
SIGNED (PATIENT OR PARENT IF MINOR) DATE

I AUTHORIZE DIRECT PAYMENT OF BENEFITS TO THE DENTIST OR SUPPLIER.

SIGNED (EMPLOYEE) DATE

14. DENTIST'S NAME	22. Is treatment result of Occupational Illness or Injury? ☐ YES ☐ NO If yes, give brief description and dates
15. DENTIST'S ADDRESS	23. Is treatment result of Auto Accident? ☐ YES ☐ NO Other Accident? ☐ YES ☐ NO 24. If yes, give brief description and dates
16. DENTIST'S SSN OR TIN 17. LICENSE # 18. PHONE #	25. If Prothesis, is this initial placement? ☐ YES ☐ NO If no, reason for placement 26. Date of placement
19. FIRST VISIT DATE CURRENT SERIES 20. PLACE OF TREATMENT ☐Office ☐ Hospital ☐ ECF ☐ Other_____ 21. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO HOW MANY?	27. Is Treatment for Orthodontics? ☐ YES ☐ NO 28. If services already commenced; Date appliances placed; Months treatment remaining

29. Identify missing teeth with "X"



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

TOOTH No. or Letter	SURFACE	DESCRIPTION OF SERVICE (Including Xrays, Prophylaxis, Materials Used, Etc.)	Date Service Performed Mo.	Day	Year	Procedure Code		FEE	

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE ☐ WILL BE ☐ HAVE BEEN COMPLETED.

SIGNED DATE

TOTAL FEE CHARGED	
MAXIMUM ALLOWABLE	
DEDUCTIBLE	
PLAN %	
PLAN PAYS	
PATIENT PAYS	

REMARKS:

MAIL CLAIMS TO: Boon-Chapman, P O Box 9201 Austin, TX 78766

BOON-CHAPMAN

VISION CLAIM FORM

PATIENT INFORMATION

1. EMPLOYEE'S SSN	GROUP NUMBER 597	GROUP NAME San Antonio Police Officers and Firefighters Benefit Plan & Trust
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTHDATE SEX (mm/dd/yr) M ☐ F ☐	4. EMPLOYEE'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO EMPLOYEE Self ☐ Spouse ☐ Child ☐ Other ☐	7. EMPLOYEE'S ADDRESS (No. Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	Employed ☐ Full-time Student ☐ Part-time Student ☐	ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) c. OTHER ACCIDENT? ☐ YES ☐ NO d. PLEASE PROVIDE ACCIDENT DETAILS:	11. EMPLOYEE'S POLICY GROUP
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYEE'S DATE OF BIRTH SEX (mm/dd/yr) M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH SEX (mm/dd/yr) M ☐ F ☐		b. CLAIMS ADMINISTRATOR Boon-Chapman P. O. Box 9201 Austin, TX 78766 EDI PAYER ID #74238 1(800)936-7689
c. EMPLOYER'S NAME OR SCHOOL NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		13. AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (mm/dd/yr)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (mm/dd/yr)	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (mm/dd/yr) TO (mm/dd/yr)
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	18. I.D. NUMBER OF REFERRING PHYSICIAN	19. HOSPITAL DATES RELATED TO CURRENT SERVICES FROM (mm/dd/yr) TO (mm/dd/yr)
20. OUTSIDE LAB? ☐ YES ☐ NO	$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From (mm/dd/yr)	To(mm/dd/yr)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstance) CPT HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSOT Family Plan	I EMG	J COB
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO	28. TOTAL CHARGE / 29. AMOUNT PAID / 30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	33. PHYSICIAN/SUPPLIER BILLING ADDRESS: PIN# GRP#