

# GROUP DENTAL CLAIM

Return this Claim Form and Itemized Medical Bills to:  
**HealthFirst TPA**  
 P.O. Box 130217  
 Tyler, Texas 75713-0217

## INSTRUCTIONS: PLEASE ANSWER ALL QUESTIONS FULLY

- (1) **INSURED:** Complete STATEMENT OF EMPLOYEE below and Authorization on reverse side. Please answer all questions. File separate form for each family member. Give completed form to Physician with Return Claim Office Envelope.
- (2) **PHYSICIAN:** Complete Physician Information section and forward to Group Claims Office for processing.

### STATEMENT OF EMPLOYEE

1. EMPLOYEE'S NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	SOCIAL SECURITY NO.
2. ADDRESS - (NO. & STREET)		(CITY)	(STATE)	(ZIP CODE)
3. EMPLOYER		IS EMPLOYEE <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED		CERTIFICATE NUMBER
4. NAME OF SPOUSE			IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
5. NAME AND ADDRESS OF SPOUSE'S EMPLOYER		SPOUSE DOB	SPOUSE'S SOCIAL SECURITY NO.	
6. DESCRIBE INJURY OR SICKNESS COMPLETELY. (IF INJURY, DESCRIBE HOW, WHEN AND WHERE) WE MUST HAVE COMPLETE ACCIDENT DETAILS IN ORDER TO PROCESS THIS CLAIM.)			DATE OF INJURY OR BEGINNING OF SICKNESS	
7. NAME OF PHYSICIAN WHO FIRST TREATED THIS CONDITION			DATE FIRST TREATED	
ADDRESS - (NO. & STREET)		(CITY)	(STATE)	(ZIP CODE)
8. DATE YOU STOPPED WORKING	DATE YOU RETURNED TO WORK	IS INJURY OR SICKNESS DUE TO EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	WILL YOU OR YOUR DEPENDENT FILE FOR WORKMEN'S COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	
9. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP PLAN, STUDENT ACCIDENT OR GOVERNMENT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE A, B, & C				
A. NAME OF OTHER INSURANCE COMPANY			B. PLAN NUMBER	
C. ADDRESS - (NO. & STREET)		(CITY)	(STATE)	(ZIP CODE)
WHICH FAMILY MEMBER CARRIES THIS COVERAGE: _____		NAME	WHICH FAMILY MEMBERS ARE COVERED? <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN	
<b>IF CLAIM IS FOR DEPENDENT, COMPLETE THIS SECTION IN ADDITION TO QUESTIONS 1-9.</b>				
DEPENDENT'S NAME		RELATIONSHIP	DATE OF BIRTH	
IF CHILD, IS CHILD MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE OF MARRIAGE _____	EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	IF CHILD OVER 19 YEARS OLD, IS CHILD A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF SCHOOL _____ IF YES, CLAIM CANNOT BE PAID WITHOUT CURRENT SEMESTER REGISTRATION	

### AUTHORIZATION TO BE COMPLETED BY EMPLOYEE

PATIENT'S NAME	
<p>I hereby authorize any Physician, Hospital, Insurance Company, Employer, or Organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim. A photostat of this authorization shall be as valid as the original. This authorization shall extend to my spouse and dependents.</p>	
EMPLOYEE'S SIGNATURE	DATE
SPOUSE'S SIGNATURE	DATE
<p>AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PROVIDER OF THE MEDICAL AND/OR HOSPITAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THE SERVICES AS DESCRIBED BELOW BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THOSE SERVICES.</p>	
IF YOU WISH BENEFITS PAID TO THE PROVIDER:	
EMPLOYEE'S SIGNATURE	DATE

