



# HOW TO COMPLETE A DENTAL CLAIM FORM

## Employee . . . Part I . . . Blue Shaded Area

Answer **all** questions in blocks numbered 1 through 11. Sign and date block number 12. Your claim cannot be processed without your signature in this block. If you want the benefit issued to the dentist or provider of service sign block number 13. Have the dentist complete Part II.

## Dentist . . . Part II

**Predetermined Benefits.** If a course of treatment is expected to be costly, a predetermination of benefits must be submitted to School Claims Service, LLC before dental work begins. Complete Part II, excluding dates of service. Attach necessary X-rays and any additional supportive material and mail to the address on the front of this form. School Claims Service, LLC will review the proposed procedures and fees. The covered person and the dentist will be notified of the payable benefit. After the work is completed, indicate the dates and any changes on the form and return to School Claims Service, LLC. Predetermination of benefits is not a guarantee of payment. Actual claim payment will be based on the coverage in effect on the date each service is performed.

“Date of service” for gold restorations, crowns and fixed bridgework is the first date of preparation of the tooth or teeth involved; for dentures, the date the impressions were taken; for root canals, the date the tooth was opened and drained.

If you have any questions please call the toll-free number on the front of this form. Submit claims to School Claims Service, LLC, P.O. Box 812, New Cumberland, PA 17070-0812.

**EMPLOYER:** If employer certification is required, please complete the following:

EMPLOYEE'S NAME <i>(Last, First and Middle Initial)</i>	DATE BENEFITS BECAME EFFECTIVE EMP Mo. Day Year DEP Mo. Day Year	DATE TERMINATED Mo. Day Year	IS EMPLOYEE <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED
EMPLOYER'S NAME	SIGNATURE OF AUTHORIZED PERSON		DATE Mo. Day Year