PROCEDURES FOR FILING A CLAIM

1. Complete the "Employee, Part 1" section of the form. Make sure you include your SSN and your employer or group name. If the patient is your dependent be sure to complete all questions, including, if married and if a full time student. It is important to know when, how and where your accident, illness or disability began, especially if it is job related. Questions regarding other coverage you or your dependent are eligible for must be answered.
2. If you have other coverage, including Medicare or CHAMPUS, make sure you attach all payment statements or declination letters, this will speed up the payment process.
3. Have your dentist complete "Part2". Attach all dental bills relating to claim, make sure all bills identify patient, and all bills should show date of treatment, type of service, and amount of charges. Make a final check to see that all parts of the claim form are complete.
4. Mail all claims to Secure Health Plans of GA, PO Box 13447, Macon, GA 31208.

PART 2 TO BE COMPLETED BY THE DENTIST

PATIENT'S NAME	PATIENT'S DATE OF BIRTH	DOES PATIENT HAVE OTHER COVERAGE? (If yes, please identify)

IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES_____NO_____
GIVE DETAILS

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATEMENT *(Circle One)* OFFICE HOSPITAL ECF OTHER	RADIOGRAPHS OR MODELS ENCLOSED? YES_____ NO_____	HOW MANY?

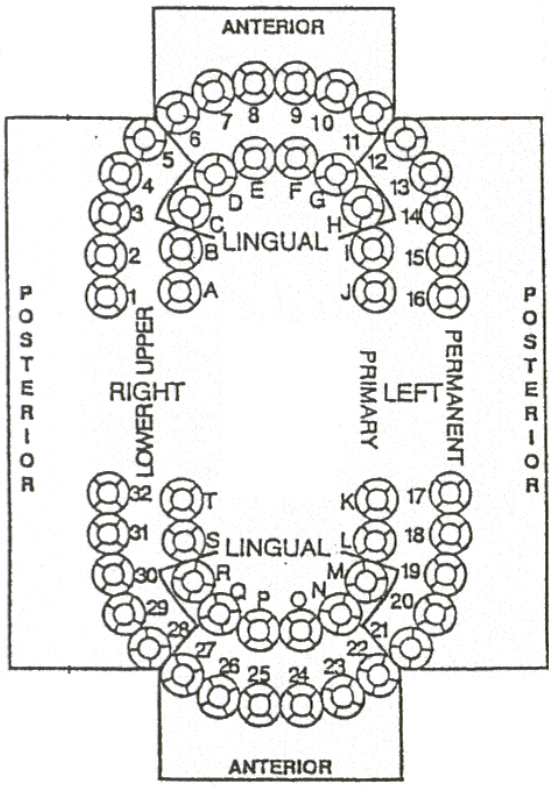
IS TREATMENT FOR ORTHODONICS? YES_____ NO_____

If services already commenced, please provide, Date Appliance Placed:_____

# of treatments remaining:_____

IF PROSTHESIS, IS THIS INITIAL PLACEMENT?
(If "NO" enter reason for placement).

Date of prior placement:_____



REPORT OF SERVICES OR ATTACH ITEMIZED BILL

CHECK ONE: ☐ **PRE-ESTIMATE** ☐ **ACTUAL CHARGES**

Description of Service ***(Including x-rays, phophylaxis, ect.)***	**Date of Service**	**Procedure Or ADA Code**	**Fee Charged**
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$

PHYSICIAN'S NAME _____
GROUP PRACTICE NAME _____
CITY, STATE, ZIPCODE _____
PHONE (_____)_____FAX _____

TOTAL CHARGES	$
AMOUNT PAID	$
BALANCE DUE	$

_____ _____
SIGNATURE OF THE DENTIST DATE

Direct Payment Cannot Be Made If Not Provided

TAX ID#:_____
SSN#: _____

DENTAL CLAIM FORM
Complete this form & attach all bills

MAIL TO

Secure Health Plans of Georgia
Dental Claims Dept.
PO Box 13447
Macon, Georgia 31208-3447

SECUREHEALTH

PART 1 MUST BE COMPLETED BY EMPLOYEE, PLEASE REFER TO INSTRUCTIONS ON REVERSE SIDE

EMPLOYEE NAME	MEMBER NUMBER	NAME OF EMPLOYER
HOME ADDRESS	EMPLOYEE DATE OF BIRTH	GROUP NUMBER
CITY, STATE, & ZIP	HOME PHONE NUMBER	WORK PHONE NUMBER *(OPTIONAL)*

PATIENT NAME (____Female ____Male) (IF OTHER THAN EMPLOYEE)	IF OVER AGE 19, IS PATIENT FULL TIME STUDENT? ____YES ____NO	RELATIONSHIP TO EMPLOYEE	PATIENT DATE OF BIRTH	IS PATIENT MARRIED? ____YES ____NO

IF FULL TIME STUDENT, NAME OF SCHOOL: _____ # OF HOURS ENROLLED? _____

DATE ACCIDENT OR ILLNESS BEGAN	IF INJURED, HOW & WHERE DID ACCIDENT HAPPEN?	DID ACCIDENT OCCUR AT WORK?

NATURE OF ILLNESS, INJURY, DIAGNOSIS OR MEDICAL CAUSE?	DENTIST NAME
	DENTIST PHONE NUMBER

NAME OF SPOUSE	SPOUSE DATE OF BIRTH	IS SPOUSE EMPLOYED? IF YES, NAME & ADDRESS OF EMPLOYER.

ARE YOU, THE PATIENT OR SPOUSE COVERED UNDER ANY OTHER GROUP PLAN, HEATH MAINTENACE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY? YES _____ NO _____
IF YES, GIVE NAME, ADDRESS, AND POLICY NUMBER OF PLAN PROVIDING BENEFITS.

NAME & ADDRESS, INCLUDING CITY, STATE, & ZIP: _____

SOCIAL SECURITY NUMBER: _____ POLICY NUMBER: _____

ASSIGNMENTS OF BENEFITS
A SIGNATURE IS REQUIRED AS AUTHORIZATION TO PAY BENEFITS DIRECTLY 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.

_____ _____
Signature of Covered Person Date

AUTHORIZATION TO RELEASE INFORMATION (A patient or parent must sign below)

I hereby authorize any insurance company, prepayment organization, 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 or services. I hereby certify the information provided is correct and true to the best of my knowledge.

_____ _____
Signature of Patient or Parent (if minor) Date