Please submit to:

Activa Benefit Services, LLC.

P.O. Box 37

Farmington, MI 48332-0037

Claims Ph.: (877) 827-1414 or (616) 588-5340

Fax: (616) 588-7915 Email: RA-TPA@activabenefits.com

Dental Payor # 38255

DENTAL CLAIM FORM

- Dentist's pre-treatment estimate
- Dentist's statement of actual services

PATIENT INFORMATION

Patient Name	Gender · Male ☐ · Female ☐	DOB	Relation to Employee · Spouse ☐ · Child ☐ · Self ☐ · Other ☐
If full time Student	School		City

EMPLOYEE INFORMATION

Employee Name	Empl. Soc. Sec No.	Are other family members employed? Employee Name
Employee Mailing Address		
Employer Name & Address		

City	State	Zip Code	
Is Patient covered by another dental plan?	Dental Plan Name	Union Local	Group No.
Name and Address of Carrier			

DENTIST SECTION

Dentist Name	Mailing Address	
Dentist Soc. Sec. or TIN.	Dentist Licenses No.	Dentist Phone #

First Visit date current series	Place of treatment	Radiographs or models enclosed ☐ Yes ☐ No	How many	
Is treatment result of occupation illness or injury		No ☐	Yes ☐	If yes, enter brief description and dates
Is treatment result of auto accident? Other accident		☐	☐	
Are any services covered by another plan?		☐	☐	
If prosthesis is the initial placement		☐	☐	

Examination and Treatment Record

Tooth & or Letter	Surfaces	Description of services performed	Date of Service	Procedure Number	Fee

Authorization to release information:

I hereby authorize any hospital, physician, or other person who has examined or attended _____

To furnish to the Plan administrator, or a representative thereof, any and all information with respect to any illness, medical history, consultation prescriptions or treatment, and copies of all hospital or medical records. I hereby authorize the Plan administrator to release to and receive from other insurance companies, prepayment organizations, employers and unions benefits payment information pertaining to the patient named above. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature_____Spouse's signature if applicable_____

I hereby certify that the services listed above have been performed and payment is therefore due.

_____

Signed (Dentist)

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown above, I understand that I am financially responsible for any charges not covered by this authorization.

X_____ **Date** _____