DENTAL CLAIM NOTICE

ADMINISTERED BY:

HealthSmart™
SMARTER HEALTHCARE SOLUTIONS

RETURN COMPLETED FORM TO THE MAILING ADDRESS INDICATED ON THE MEMBER I.D. CARD

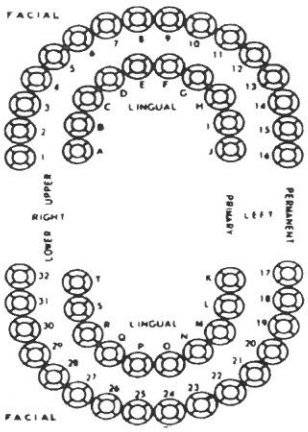
PART I: TO BE COMPLETED BY ENROLLEE/PATIENT

1. PATIENT NAME:	2. RELATIONSHIP TO ENROLLEE: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	3. SEX: ☐M ☐F	4. PATIENT DATE OF BIRTH: / /	5. IF FULL-TIME STUDENT: SCHOOL: CITY:
6. ENROLLEE NAME: FIRST MIDDLE LAST		7. ENROLLEE SOCIAL SECURITY NUMBER:		8. ENROLLEE DATE OF BIRTH: / /
9. HOME ADDRESS: STREET CITY STATE ZIP				
10. PLAN SPONSOR NAME AND ADDRESS: JEFFERSON LOCAL SCHOOLS, 906 WEST MAIN ST., WEST JEFFERSON OH 43162				
11. ARE YOU STILL ENROLLED IN PLAN? ☐ YES ☐ NO	12. IF NO, DATE OF TERMINATION: / /	13. DATE YOU BECAME RETIRED: / /	14. COBRA COVERAGE EFFECTIVE DATE: / /	
15. PLAN NUMBER:	16. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO	17. IF YES, EMPLOYEE NAME AND SOCIAL SECURITY NUMBER:		
18. NAME AND ADDRESS OF EMPLOYER IN BOX #17: STREET CITY STATE ZIP				
19. IS PATIENT COVERED BY ANOTHER PLAN? ☐ YES ☐ NO	20. IF YES, DENTAL PLAN'S NAME: GROUP NO. NAME/ADDRESS OF CARRIER:			

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Employer or Insuring Organization to release any information regarding the medical or dental history treatment or benefits payable for this claim to HealthSmart Benefit Solutions for the purpose of validating and determining benefits payable in connection with this claim. This authorization or photo static copy of the original shall be valid for one year from the date of signature. I understand that data may be extracted and transmitted to the Plan Administrator for Plan Administration purposes only. I agree to reimburse the Plan to the extent of any payment which is in excess of the amount payable under this Plan.		
	PATIENT SIGNATURE ↑ (OR PARENT IF MINOR)	**DATE**
AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment directly to the below named Dentist of the Plan Benefits, otherwise payable to me.	**ENROLLEE SIGNATURE ↑**	**DATE**

PART II: TO BE COMPLETED BY ATTENDING DENTIST

21. DENTIST NAME:			YES	NO	IF YES, PROVIDE BRIEF DESCRIPTION AND DATES:
22. MAILING ADDRESS:		23. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
24. SOCIAL SECURITY OR TIN:		25. IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?			
26. LICENSE NUMBER:	27. PHONE NUMBER:	28. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			IF YES, PLAN NAME:
29. FIRST VISIT DATE CURRENT SERIES:		30. IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT: DATE OF PRIOR PLACEMENT:
31. PLACE OF TREATMENT: ☐ OFFICE ☐ HOSPITAL ☐ OTHER :_____	32. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO HOW MANY?	33. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY INITIATED, DATE APPLIANCES PLACED: MOS. TREATMENT REMAINING:
CHECK ONE:	☐ DENTIST'S PRE-TREATMENT ESTIMATE	☐ DENTIST'S STATEMENT OF ACTUAL SERVICES			



Identify Missing Teeth With "X"

EXAMINATION AND TREATMENT PLAN
USING CHART SHOWN, LIST IN ORDER FROM TOOTH NO.1 THROUGH TOOTH NO.32

TOOTH # or LETTER	SURFACE (i.e., MOD B L LA)	DESCRIPTION OF SERVICE *(Including X-rays, Prophylaxis, Materials Used, etc.)*	DATE SERVICE PERFORMED			PROCEDURE NUMBER	FEE
			Mo	Day	Yr		

ORTHODONTICS: Give class of malocclusion and describe services in treatment section.
DATE FIRST APPLIANCE INSTALLED:
TREATMENT PERIOD (NUMBER OF MONTHS):
REMARKS FOR UNUSUAL SERVICES:

TOTAL FEE CHARGED:

PART III: DENTIST CERTIFICATION

I hereby certify that the procedures as indicated by date performed have been completed and that the fees submitted are the fees I usually charge and accept for such procedures. PLEASE NOTE: PREDETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT. The estimate of Dental benefits has been calculated based on current available benefits and employee eligibility.

AMOUNT PAID:

DENTIST SIGNATURE **DATE**

AMOUNT DUE:

FORM G824
(REV. 2/11)