

MAIL ALL CLAIMS TO:



Group Resources, Inc.
 2121 San Jacinto, Suite 830
 Dallas, TX 75201

DENTAL INSURANCE CLAIM FORM

Please complete this form and attach all itemized bills.

**Ector County, Texas
 #4808**

EMPLOYEE INFORMATION

Employee's Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth MM DD YY	Employee Social Security #
Address (Street, City, State, Zip)			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

PATIENT INFORMATION AND AUTHORIZATION

Claim Is For <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Patient's Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth MM DD YY
<i>Answer <u>Only</u> For Claims On Child</i>		Name & Address of School	
Is Child age 19 or older and a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have custody of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are natural parents divorced or separated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does natural parent without custody have financial responsibility for health expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are your dependents covered by any other group insurance, Medicare or other governmental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason For Claim <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Wellness	
Was Illness or accident work related? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Accident", please provide date, place, and how injury occurred below:	
Was patient totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's Name	Name, Address, and Phone # of Spouse's Employer	
Dates Patient Was Disabled	Date of Birth MM DD YY	Social Security #	
Is your Spouse covered by any other group insurance, Medicare or other governmental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you covered by any other group insurance, Medicare or other governmental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insured's Name		Group Insurance Company or Plan's Name	
Certificate #	Policy #	Group Insurance Company or Plan's Address (Street, City, State, Zip)	

Notice: Any person who knowingly and with intent to injury, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or other information necessary to process this claim.	
Signature _____	Date _____