INSTRUCTIONS FOR FILING A CLAIM

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF TREATMENT.

THE FORM **MUST** BE FULLY COMPLETED IN ORDER TO RECEIVE PROMPT PROCESSING.

IF PATIENT IS A FULL TIME COLLEGE STUDENT, PROVIDE NAME OF SCHOOL AND GRADUATION DATE.

OTHER COVERAGE INFORMATION MUST BE COMPLETED TO EXPEDITE PROCESSING.

PRE-ESTIMATE: TREATMENT WHICH WILL EXCEED $250 SHOULD BE APPROVED BY BOLLINGER PRIOR TO SERVICES BEING PERFORMED IN ORDER THAT YOU KNOW BEFOREHAND HOW MUCH WILL BE PAID BY INSURANCE AND THE BALANCE YOU WILL HAVE TO PAY. PRE-TREATMENT X-RAYS SHOULD BE SENT WITH THE CLAIM FORM.

BENEFITS ARE PAYABLE ONLY UPON COMPLETION OF SERVICES.

CALL (973) 467-0444 IF YOU HAVE ANY QUESTIONS.

PLAN ADMINISTRATION AND CLAIM SERVICE

Bollinger Specialty Group

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

P.O. BOX 1322
MORRISTOWN, N.J. 07962
TEL: (973) 467-0444

PREFERRED PROVIDER NETWORK:

DENTEMAX

www.DENTEMAX.com
1-800-752-1547

GROUP DENTAL INSURANCE CLAIM FORM

-PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING-

PLEASE PRINT ALL INFORMATION

PREFERRED PROVIDER NETWORK:

DENTEMAX

PLEASE SEND ALL FORMS TO
CLAIMS ADMINISTRATOR:
BOLLINGER, INC.
P.O. BOX 1322
MORRISTOWN, NJ 07962

CHECK ONE ☐ DENTIST PRE-TREATMENT ESTIMATE ☐ DENTIST STATEMENT OF ACTUAL SERVICES

PATIENT

EMPLOYEE NAME	SOC. SEC.#	EMPLOYEE BIRTHDATE	SPOUSES BIRTHDATE	SPOUSE'S SOC. SEC.#	PATIENT NAME

STREET	IF PATIENT IS A FULL TIME STUDENT, DATE OF GRADUATION AND NAME OF SCHOOL

CITY	STATE	ZIP	PHONE#	RELATIONSHIP TO EMPLOYEE	PATIENT'S BIRTHDATE

EMPLOYER NAME	POLICY NUMBER	DOES PATIENT HAVE ANY OTHER DENTAL COVERAGE? IF "YES" PLEASE IDENTIFY YES ☐ NO ☐

DENTIST

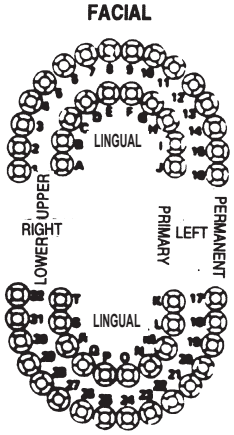
NAME	PHONE #	LICENSE NO.	INDIVIDUAL PRACTITIONER'S SS# ALL OTHERS EMPLOYER I.D.#

ADDRESS	CITY	STATE	ZIP

IS ANY OF THE TREATMENT FOR (A) ORTHODONTIC PURPOSES? YES ☐ NO ☐	(B) ACCIDENTAL INJURY? YES ☐ NO ☐	(C) OCCUPATIONAL INJURY? YES ☐ NO ☐	(D) AUTO ACCIDENT? YES ☐ NO ☐

IF CROWNS OR DENTURES IS THIS THE INITIAL PLACEMENT? YES ☐ NO ☐ IF NOT, REASON FOR PLACEMENT?	DATE OF PRIOR PLACEMENTS OF CROWNS OR DENTURES?	ARE X-RAYS ENCLOSED? YES ☐ NO ☐ IF YES, HOW MANY?____

Identify missing teeth with "x"



32. Remarks for unusual services

EXAMINATION AND TREATMENT RECORD • USE CHARTING SYSTEM SHOWN

TOOT # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHY-LAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO	DA	YR	ADA PROCEDURE NUMBER	FEE	FOR CARRIER USE ONLY	EXPLANATION SEE REVERSE SIDE

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

_____ DATE_____
(SIGNED PATIENT OR PARENT IF MINOR)

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE ☐ HAVE BEEN ☐ PERFORMED

_____ DATE_____
(SIGNED PATIENT OR PARENT IF MINOR)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTISTS OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. BUT NOT TO EXCEED THE CHARGES SHOWN, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

_____ DATE_____
(SIGNED PATIENT OR PARENT IF MINOR)

*The estimate is based on the information we have at present. Estimates will be subject to eligibility , deductibles and plan maximums and may be reduced by payments made before these services are rendered. Actual payments will be made in order of claims received.

TOTAL FEE CHARGED

ORTHODONTICS (Give diagnosis, class of maloclusion and describe appliance(s) in above treatment section.)

DATE FIRST APPLIANCE INSERTED _____

DATE LAST APPLIANCE REMOVED _____

TREATMENT PERIOD (NO MONTHS)_____

PLEASE INDICATE NUMBER OF MILLIMETERS

OF OVER-BITE OR OVER-JET_____

TOTAL FEE $ _____