

PLEASE SUBMIT ORIGINAL ITEMIZED BILLS WITH A COMPLETED AND SIGNED CLAIM FORM!

IMPORTANT: These forms are electronically scanned, please do not use HIGHLIGHTER or anything else that might distort the information on this form.

- Payment
- Predetermination



SEE REVERSE SIDE FOR CLAIM FILING INFORMATION

DENTAL CLAIM FORM 895

TYPE OR PRINT

PATIENT INFORMATION (TO BE COMPLETED BY INSURED)

1. INSURED'S Employer		2. INSURED'S ID No.		3. INSURED'S Name, Address and Phone No. <input type="checkbox"/> If this is a new address, you must notify your employer	
4. PATIENT'S Name (First name, middle initial, last name)			5. PATIENT'S Date of Birth		
6. PATIENT'S Sex <input type="checkbox"/> M <input type="checkbox"/> F		7. PATIENT'S relation to INSURED <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		8. PATIENT'S Status: a <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other b. Employed full-time Yes <input type="checkbox"/> No <input type="checkbox"/> c. Student full-time Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Is PATIENT'S condition related to: a. <input type="checkbox"/> Employment? (Current or Previous) b. <input type="checkbox"/> Auto Accident? Place _____ (State) c. <input type="checkbox"/> Other Accident? YES <input type="checkbox"/> NO <input type="checkbox"/> d. If injured: → Describe how and where ► → Date _____ → Will you sue? YES <input type="checkbox"/> NO <input type="checkbox"/>				10. PATIENT'S Address (If different from INSURED'S) and Phone No. <input type="checkbox"/> If this is a new address, you must notify your employer	
11. INSURED'S Date of Birth		12. INSURED'S Sex <input type="checkbox"/> M <input type="checkbox"/> F		13. Is INSURED Now actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO or under <input type="checkbox"/> COBRA	
14. Date INSURED'S hired					

15. OTHER HEALTH INSURANCE COVERAGE - SECTIONS BELOW MUST BE ANSWERED FOR CLAIM TO BE APPROVED. ◀

A. INSURED'S SPOUSE'S employer (If unmarried or spouse is unemployed check none)

None Employer Name _____ Phone _____

Street _____ City _____ State _____ Zip _____

B. Name and address of other insurance company. If none, check None

None

C. Name of person covered - last & first _____ Date of Birth _____ Sex M F Policy No. Identification _____

D. Person covered & named in item "C" above is insured's: Self wife Husband Daughter Son Other (Describe)

16. I authorize the release of any medical information necessary to process this request
Signed (PATIENT or Authorized person) _____ Date _____

17. I authorize payment of benefits directly to the Dentist or Supplier named below.
Signed (INSURED or Authorized person) _____

ATTENDING DENTIST INFORMATION - CHECK "PAYMENT" OR "PREDETERMINATION" IN THE UPPER LEFT CORNER OF THIS FORM.

DENTIST NAME, ADDRESS AND PHONE NUMBER _____

IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
IS TREATMENT RESULT OF AUTO ACCIDENT?	<input type="checkbox"/>	<input type="checkbox"/>
OTHER ACCIDENT?	<input type="checkbox"/>	<input type="checkbox"/>
ARE ANY SERVICES COVERED BY ANOTHER PLAN?	<input type="checkbox"/>	<input type="checkbox"/>
IF PROSTHESIS, IS THIS INITIAL PLACEMENT? (IF NO REASON FOR REPLACEMENT)	<input type="checkbox"/>	<input type="checkbox"/>
		DATE OF PRIOR PLACEMENT _____

FIRST VISIT DATE OF CURRENT SERIES	PLACE OF TREATMENT OFFICE HOSP ECF OTHER LIST	RADIOGRAPHS OR MODELS ENCLOSED NO <input type="checkbox"/> YES <input type="checkbox"/>	HOW MANY?	IS TREATMENT FOR ORTHODONTICS?	IF SERVICE ALREADY COMMENCED	DATE PLACED	MOS TREATMENT REMAINING
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IDENTIFY MISSING TEETH WITH "X" FACIAL	EXAMINATION AND TREATMENT - LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 USING CHARTING SYSTEM SHOWN		DATE SERVICE COMPLETED	A.D.A. PROCEDURE CODE	FEE	IDA USE ONLY
	TOOTH # OR LETTER	SURFACES				
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REMARKS FOR UNUSUAL SERVICES _____

DENTIST'S SSN OR T.I.N. _____

DENTIST'S LICENSE NO. _____

I CERTIFY THAT THE PROCEDURES AS INDICATED: WERE COMPLETED ARE/WERE NECESSARY

DENTIST'S SIGNATURE _____

TOTAL FEE _____

DATE _____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION WITH THE INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR PERSON IS GUILTY OF A FELONY.

1. COMPLETE THE “**PATIENT INFORMATION**” SECTION (ITEMS 1 THROUGH 14) ON THE REVERSE SIDE OF THIS FORM.

If you wish your dental benefits paid directly to your doctor, sign ITEM 17.
A separate form must be submitted for each family member.

2. HAVE YOUR DOCTOR COMPLETE THE “**ATTENDING DENTIST INFORMATION**” SECTION OR SUBMIT COMPLETELY ITEMIZED BILLS.

An itemized bill is one that shows the PATIENT’S name, relationship to INSURED, date of service, type of service rendered, and the nature of the condition being treated

3. THE COMPLETED FORM AND ITEMIZED BILLS MUST BE SENT TO THE ADDRESS BELOW:

**INSURANCE DESIGN ADMINISTRATORS
P.O. BOX 895
OAKLAND, NJ 07436**

ELIGIBILITY / CLAIM INQUIRIES CALL: 1-800-225-1345

IMPORTANT REMINDER

Please be sure you have provided the INSURED’S Social Security Number.

NOTE TO CLAIMANT

Please attach all itemized bills and supporting documents to this completed and signed claim form. Do not use highlighter or anything else that might distort the information on this form; **otherwise, your claim will be delayed.**

NOTE TO ATTENDING DENTIST

If the PATIENT named will be under continuous treatment for the stated condition, there will be no need to fill out an ATTENDING DENTIST’S statement each time a bill is submitted. An itemized bill will be acceptable for processing. However, if the patient consults you for any other condition, a new ATTENDING PHYSICIAN’S statement will be necessary.

INCOMPLETE CLAIM FORMS WILL BE RETURNED FOR COMPLETION. ALSO, IF YOU OR YOUR IMMEDIATE FAMILY ARE COVERED BY ANY OTHER INSURANCE PROGRAMS, INCLUDING MEDICARE, THE “**OTHER HEALTH INSURANCE COVERAGE**” SECTION MUST BE COMPLETED EACH TIME YOU SUBMIT A CLAIM FORM OR YOUR FORM WILL BE RETURNED.