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

TYPE OR PRINT

IDA Insurance Design Administrators

SEE REVERSE SIDE FOR CLAIM FILING INFORMATION

DENTAL CLAIM FORM 875

PATIENT INFORMATION (TO BE COMPLETED BY INSURED)

1. INSURED'S Employer

2. INSURED'S Soc. Sec. No.

3. INSURED'S Name, Address and Phone No.
☐ 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 ☐ M ☐ F

7. PATIENT'S relation to INSURED ☐ self ☐ spouse ☐ child ☐ other

8. PATIENT'S Status: a ☐ Single ☐ Married ☐ Other
b. Employed full-time Yes ☐ No ☐ c. Student full-time Yes ☐ No ☐

9. Is PATIENT'S condition related to:
a. ☐ Employment? (Current or Previous)
b. ☐ Auto Accident? Place _____ (State)
c. ☐ Other Accident?
d. If injured:
→ Describe how and where ▶
→ Date _____
→ Will you sue?
YES ☐ NO ☐

10. PATIENT'S Address (If different from INSURED'S) and Phone No.
☐ If this is a new address, you must notify your employer

11. INSURED'S Date of Birth

12. INSURED'S Sex ☐ M ☐ F

13. Is INSURED Now actively at work? ☐ YES ☐ NO or under ☐ 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

	YES	NO
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		
IS TREATMENT RESULT OF AUTO ACCIDENT?		
OTHER ACCIDENT?		
ARE ANY SERVICES COVERED BY ANOTHER PLAN?		
IF PROSTHESIS, IS THIS INITIAL PLACEMENT? (IF NO REASON FOR REPLACEMENT		
IS TREATMENT FOR ORTHODONTICS?		

DATE OF PRIOR PLACEMENT

FIRST VISIT DATE OF CURRENT SERIES

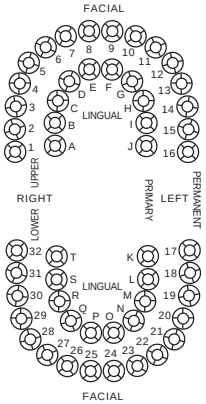
PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER LIST

RADIOGRAPHS OR MODELS ENCLOSED NO ☐ YES ☐ ▶ HOW MANY?

IF SERVICE ALREADY COMMENCED } DATE PLACED

MOS TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



REMARKS FOR UNUSUAL SERVICES

▶ EXAMINATION AND TREATMENT - LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 USING CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) IF SERVICES LISTED EXCEED LINES BELOW, PLEASE COMPLETE A SEPARATE FORM AND ATTACH	DATE SERVICE COMPLETED	A.D.A. PROCEDURE CODE	FEE	IDA USE ONLY

DENTIST'S SSN OR T.I.N.

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

TOTAL FEE

DENTIST'S LICENSE NO.

DENTIST'S SIGNATURE

DATE

IDADENT 5 / 93

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAM 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 875
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.