GHI

MAIL COMPLETED DENTAL CLAIM FORM TO:
GHI
P.O. Box 2838
New York NY 10116-2838

PART A: SUBSCRIBER INFORMATION

1. SUBSCRIBER'S CERTIFICATE NUMBER | CATEGORY | GROUP

2. SUBSCRIBER'S NAME AND ADDRESS
LAST | FIRST

NO. AND STREET | APT. NO.

CITY | STATE | ZIP CODE

AREA CODE | TELEPHONE NUMBER
( )

3a. IS THE SUBSCRIBER'S SPOUSE EMPLOYED? ☐ YES ☐ NO

3b. DOES THE SUBSCRIBER OR SPOUSE HAVE ADDITIONAL DENTAL INSURANCE COVERAGE? ☐ YES ☐ NO

IF YOU ANSWERED YES TO EITHER QUESTION 3a. OR 3b., PART F (OTHER INSURANCE COVERAGE) ON REVERSE SIDE MUST BE COMPLETED.

PART B: PATIENT INFORMATION

1. PATIENT'S FIRST NAME | 2. PATIENT'S DATE OF BIRTH MONTH | DAY | YEAR

3. PATIENT'S RELATIONSHIP TO SUBSCRIBER
☐ SUBSCRIBER 1 ☐ SPOUSE 2 ☐ SON 3 ☐ DAUGHTER 4 ☐ OTHER: SPECIFY

4. SEX ☐ MALE ☐ FEMALE

IS PATIENT A DISABLED DEPENDENT OVER AGE 19?
☐ YES ☐ NO If Yes, see H on reverse.

	YES	NO
5. IS PATIENT A DEPENDENT STUDENT AGE 19 OR OVER? IF YES, PART G (DEPENDENT STUDENT INFORMATION) ON THE REVERSE SIDE MUST BE COMPLETED.	☐	☐
6a. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT?	☐	☐
6b. WAS CONDITION RELATED TO AN AUTO ACCIDENT?	☐	☐
6c. WAS CONDITION RELATED TO OTHER ACCIDENT?	☐	☐

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, *and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE, TO OR BY GHI, OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO CERTIFY THAT BENEFITS ARE NOT AVAILABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.

PATIENT'S OR AUTHORIZED SIGNATURE (Parent or Legal Guardian) | DATE

PART C: PREDETERMINATION OF BENEFITS

Your contract may require that a predetermination of benefits be made by GHI prior to commencement of orthodontics, prosthetics and surgeries. Please refer to your benefits brochure to determine if predetermination of benefits is required. If so, have your dentist complete Part D of this form. Check the appropriate box in Section 7, submit x-rays if appropriate, and mail to GHI. GHI will notify the dentist and subscriber of the amount of benefits available.

PART D: DENTIST INFORMATION

1. DENTIST NAME

MAILING ADDRESS

CITY, STATE, ZIP CODE

5. IF PROSTHESIS AND/OR CROWN, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO (IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT

6. IS THIS TREATMENT FOR ORTHODONTICS? ☐ YES ☐ NO IF SERVICES ALREADY COMMENCED ENTER: DATE APPLIANCE PLACED: MOS. TREATMENT REMAINING

2. DENTIST TAX IDENTIFICATION NO. | DENTIST LICENSE NO.

I AM A SPECIALIST IN: ☐ ORAL SURGERY ☐ ORTHODONTICS ☐ PERIODONTICS ☐ ENDODONTICS ☐ OTHER

3. FIRST VISIT DATE CURRENT SERIES | PLACE OF TREATMENT OFFICE, HOSP. OR OTHER | RADIOGRAPHICS OR MODEL ENCLOSED? NO | YES | HOW MANY?

7. CHECK ONLY ONE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES: I hereby certify that the procedures below were rendered and completed on the dates indicated.
☐ DENTIST'S TREATMENT PLAN (PRE-DETERMINATION OF BENEFITS).

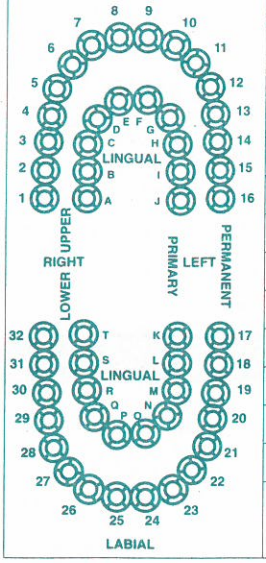
SIGNED (DENTIST) | DATE

4. PARTICIPATING DENTIST IN A GHI PLAN ☐ YES ☐ NO

TO BE COMPLETED BY A PARTICIPATING DENTIST ONLY:
I HAVE BEEN PAID ☐ YES (AMOUNT PAID) $ _____ ☐ NO
☐ I WAS NOTIFIED BEFORE SERVICES WERE RENDERED THAT GHI INSURES THE PATIENT.

8. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO 1 THROUGH TOOTH NO. 32

IDENTIFY MISSING TEETH WITH "X"



TOOTH # OR LETTER	SURFACE	DATE SERVICE PERFORMED MO	DAY	YEAR	ADA PROCEDURE CODE	FEE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	ADMINISTRATIVE USE ONLY
					TOTAL FEE CHARGED			