CLAIM FORM

1 COMPLETE THIS FORM IN FULL AND SIGN BELOW
2 ATTACH ALL BILLS
3 MAIL TO FBMC

780 W. Granda Blvd. STE 250
Ormond Beach, FL 32174
(800)767-2378 or (386) 676-5770
8:00 a.m. to 5:00 p.m. EST.

PART 1 EMPLOYEE STATEMENT — PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME	SOCIAL SECURITY #	NAME OF EMPLOYER		
EMPLOYEE ADDRESS	EMPLOYEE BIRTH DATE	OCCUPATION		GROUP NUMBER
CITY & STATE ZIP	PHONE NO.	IS THE PATIENT A FULL TIME STUDENT? YES ☐ NO ☐ HANDICAPPED? YES ☐ NO ☐	NAME AND ADDRESS OF SCHOOL	
PATIENT (IF OTHER THAN EMPLOYEE) NAME	☐ MALE ☐ FEMALE	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE	IS PATIENT MARRIED ☐ YES ☐ NO
DATE ACCIDENT OR SICKNESS BEGAN	NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL VISIT?		IS CONDITION WORK RELATED? ☐ YES ☐ NO	
IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?				
HAVE YOU BEEN TREATED FOR THIS ILLNESS OR INJURY IN THE LAST 12 MONTHS? ☐ YES ☐ NO		IF YES, NAME AND ADDRESS OF ATTENDING PHYSICIAN		
NAME AND SOC. SEC. # OF SPOUSE	BIRTHDATE	IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME AND ADDRESS OF SPOUSE'S EMPLOYER	

IS THE PATIENT COVERED UNDER ANY OTHER MEDICAL OR DENTAL PLAN? ☐ YES ☐ NO
IF YES, COMPLETE THE FOLLOWING:

NAME AND RELATIONSHIP TO PATIENT: SOCIAL SECURITY #:
PLAN NAME AND ADDRESS: GROUP PLAN #: EFFECTIVE DATE:

PATIENT OR PARENT MUST SIGN AND DATE BELOW — IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X
Patient, or Parent if minor Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):
I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X
Employee Date

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
   - It is important to know how, when and where your accident occurred.
   - Questions regarding other coverage you or your dependents are eligible for must be answered.
   - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
   - If payment is to be made to the provider of services, you should sign that section.

2. Have your doctor or dentist complete the reverse side for each disability, diagnosis or treatment only when not accompanied by an itemized bill.

3. If you have other coverage (including Medicare), make sure you attach all payment statements or declination letters.

4. Attach all bills relating to the claim.
   - Make sure all bills identify the patient.
   - All bills should show the date of treatment, type of service, and amount of charges.
   - Prescription drug bills should be original receipts, showing name and address of pharmacy, name of patient, date of purchase, prescription number, nature of medication and charge.

PART 2 — TO BE COMPLETED BY PHYSICIAN

PATIENT'S NAME	BIRTH DATE OF PATIENT	DOES PATIENT HAVE OTHER COVERAGE? ☐ YES ☐ NO	IF YES, PLEASE IDENTIFY

DIAGNOSIS AND CURRENT CONDITIONS

HAS THE PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? ☐ YES ☐ NO
IF "YES", WHEN AND DESCRIBE.

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED, YOU ONLY NEED DATES AND SERVICES SINCE LAST REPORT) OR ATTACH ITEMIZED BILL.

CLAIMS OFFICE USE ONLY

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE USED	CHARGES
			TOTAL CHARGES	$

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

AMOUNT PAID $

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

LAST DAY WORKED DATE

BALANCE DUE $

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM THROUGH

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

DATE EMPLOYEE RETURNED TO WORK

TYPE OR PRINT
PHYSICIAN'S NAME

ADDRESS

CITY, STATE, ZIP CODE

PHONE

TAX ID NUMBER | SOCIAL SECURITY NUMBER

(DIRECT PAYMENT CANNOT BE MADE IF NOT PROVIDED.)

DEGREE

PHYSICIAN'S SIGNATURE X ____________________

PART 3 — TO BE COMPLETED BY DENTIST

PATIENT'S NAME	BIRTH DATE OF PATIENT	DOES PATIENT HAVE OTHER COVERAGE? ☐ YES ☐ NO	IF YES, PLEASE IDENTIFY

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER ☐	RADIOGRAPHS OR MODELS ENCLOSED ☐ NO ☐ YES	HOW MANY?	IF PROSTHESIS, IS THIS AN INITIAL PLACEMENT? IF NO, ENTER THE REASON FOR REPLACEMENT. ☐ YES ☐ NO	DATE OF PRIOR PLACEMENT

IS TREATMENT FOR ORTHODONTICS? ☐ YES ☐ NO

IF "YES" AND SERVICES ALREADY COMMENCED, GIVE DATE APPLIANCES PLACED. ENTER MONTHS OF TREATMENT REMAINING.

IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY? ☐ YES ☐ NO

IF YES, ENTER A BREIF DESCRIPTION AND DATES

CHECK ONE ☐ **DENTIST'S PRE-TREATMENT EVALUATION** ☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

FACIAL / LINGUAL / RIGHT / LEFT / UPPER / LOWER / PERMANENT / PRIMARY / FACIAL

EXAMINATION TREATMENT PLAN: LIST IN ORDER FROM TOOTH NO. 1 THRU TOOTH NO. 32 USING CHARTING SYSTEM SHOWN

TOOTH	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED	PROCEDURE NUMBER	FEE	ADMINISTRATIVE USE

DENTIST'S NAME
ADDRESS
CITY, STATE, ZIP CODE
DEGREE PHONE

SOCIAL SECURITY #

TAX I.D. #

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

DENTIST'S SIGNATURE X ____________________