

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

PART A: SUBSCRIE	BER IN	IFORMA	10IT	1			PART B:	PATIEN	NT INFORMA	TION		Y.	
1: SUBSCRIBER'S CERTIFIC	CATE NU	MBER CA	TEGOF	RY GRO	DUP		1. PATIENT:				2 PATIENT'S MONTH 1	DATE OF BIRTH DAY YEAR	
2. SUBSCRIBER'S NAME AN	JD ADDR	 F99	sagaige	900 1000	eg al-ga		a DATICALLY	S DEL ATIO	NSHIP TO SUBSO	ODEO			
LAST	1.0			FIRST			o. FAHENI.	MECANO	Manir 10 ausac	,miden		4. SEX	
							SUBSCRIBER	SPOUSE	SON DAUG	HTER OTHER:	SPECIFY	MALE	
NO AND STREET APT NO								1 2 3 4 IS PATIENT A DISABLED DEPENDENT OVER AGE 19?					
							YES NO 11 Yes, see H on reverse.						
CITY	STATE ZIP CODE							5. IS PATIENT A DEPENDENT STUDENT AGE 19 OR OVER? IF YES, YES NO					
STATE ZII SODE								PART G (DEPENDENT STUDENT INFORMATION) ON THE REVERSE SIDE MUST BE COMPLETED.					
AREA CODE TELEPHONE NUMBER								6a. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT?					
// /				6b. WAS CONDITION RELATED TO AN AUTO ACCIDENT?									
3a. IS THE SUBSCRIBER'S TYES 3b. DOES THE SUBSCRIBER OR SPOUSE HAVE TYES								6c. WAS CONDITION RELATED TO OTHER ACCIDENT?					
SPOUSE EMPLOYED? NO ADDITIONAL DENTAL INSURANCE COVERAGE? NO								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					
IF YOU ANSWERED YES TO EITHER QUESTION 3a. OR 3b								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.					
PART F (OTHER INSURANCE				IUST E	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.								
PART C: PREDETERMINATION OF BENEFITS								AT THE INFO	HMATION GIVEN IS C ECESSARY TO PROC	CORRECT AND AUTH CESS THIS CLAIM. I	ORIZE RELEAS ALSO CERTIF	SE, TO OR BY GHI, THAT BENEFITS	
Your contract may require the	at a pred	etermination	of be	nefits be	ARE NOT AVA	ILABLE UND	ER ANY OTHER GR	OUP PLAN EXCEPT	AS INDICATED	ABOVE.			
commencement of orthodonti brochure to determine if pred complete Part D of this form	eterminat Check t	ion of benef	its is re	quired.	If so, I	nave your dentist							
complete Part D of this form appropriate, and mail to GHI. benefits available.	GHI will	notify the d	entist a	nd subs	criber	of the amount of	PATIENT'S OF	AUTHORIZ	ED SIGNATURE (Par	ent or Legal Guardia	n) DAT	E	
PART D: DENTIST I	NFOR	MATION				"我将在"人"。						Physical Property	
1. DENTIST NAME			and the			5. IF PROS		(IF NO, REASON F	OR REPLACEME	NT) DAT	E OF PRIOR	
						AND/OF	R CROWN, INITIAL	YES			PLA	CEMENT	
MAILING ADDRESS					a ,	PLACEN		∐NO					
CITY, STATE, ZIP CODE				.	;	— FOR OR	TREATMENTHODONTICS	? Tyes A	ALREADY	ATE APPLIANCES		OS. TREATMENT EMAINING	
								NO E	COMMENCED ENTER:		•		
2. DENTIST TAX IDENTIFICA	ATION NO).	j5. 7		DE	NTIST LICENSE NO).		1 AM A	SPECIALIST IN:	☐ ORA	L SURGERY	
								☐ ORTHODONTICS ☐ PERIODONTICS					
3. FIRST VISIT DATE	PLACE OF	TREATMENT	er a beat.	RADIOG	<u>ା</u> Raphic	S OR NO YES	1 HOW	7 CHEC		DODONTICS	□ ОТН	ER	
3. FIRST VISIT DATE CURRENT SERIES OF TREATMENT RADIOGRAPHICS OR NO YES HOW MANY? OFFICE, HOSP, OR OTHER MODEL ENCLOSED? OFF											certify that the		
4. PARTICIPATING	TO 05	OOMBI ETE	D DV /	. DA DTI	215.471		<u> </u>	1					
DENTIST IN A GHI PLAN		BEEN PAID		YES (AM		NG DENTIST ONLY: PAID)\$	9.1		DENTIST'S TREATME	NI-PLAN (PRE-DETI	ERMINATION O	F BENEFITS).	
☐ YES				NO .		,,							
□ NO				7.		DERED THAT GHI INSURE		SIGNED (DATI		
8. EXAMINATION AND TREA	ATMENT	PLAN. LIST	IN OF	RDER FF	T MOF	OOTH NO 1 THROL	IGH TOOTH	NO. 32	Determination				
IDENTIFY MISSING TEETH WITH "X" 8 9	TOOTH # OR Letter	SURFACE		DATE SERVICE PERFORMED MO DAY YEAR		ADA PROCEDURE CODE	F	EE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)		LAXIS,	ADMINISTRATIVE USE ONLY	
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GHI DENTAL INSURANCE CLAIM FORM SIDE 2

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.

INSTRUCTIONS: Mail the CLAIM FORM promptly. Follow-these instructions to avoid-delay:								
Complete sections A and B in full to assure positive identification and prompt payment.	If you use a GHI Participating Dentist, payment will be made directly to the dentist.							
 The Subscriber must sign and date the claim. All Claim forms must be submitted to GHI no later than 180 days after the end of the calendar year in which the service was rendered. 	 5. Dental coverage is subject to specific limitations and exclusions. Please refer to your insurance booklet and certificate for a description of covered services, limitations and exclusions. 6. This form will have to be returned if it is incomplete 							
	or incorrect.							
F. ADDITIONAL DENTAL INSURANCE COVERAGE								
If your spouse is employed complete this section below.	If patient is eligibile for dental benefits under any other dental insurance policy complete this section below.							
EMPLOYER (SPOUSE)	NAME OF POLICYHOLDER							
EMPLOYER'S ADDRESS	CERTIFICATE OR IDENTIFICATION NO. EFFECTIVE DATE OF COVERAGE							
CITY STATE ZIP CODE	NAME OF PLAN/INSURER							
EMPLOYER'S AREA CODE TELEPHONE NUMBER	PLAN/INSURER ADDRESS							
SPOUSE'S DATE OF BIRTH MONTH DAY YEAR								
G. DEPENDENT STUDENT INFORMATION								
This part must be completed only for those having dependent student coverage if the patient is a dependent student age 19 or over.								
	NAME OF SCHOOL							
I CERTIFY THAT MY DEPENDENT, MEETS ALL REQUIREMENTS FOR ELIGIBILITY AS A DEPENDENT STUDENT.								
A. 19 YEARS OR AGE OR OLDER	СІТУ							
B. UNMARRIED	DATE STAFTED IF GRADUATED, GIVE DATE							
C. RECEIVES MORE THAN HALF OF SUPPORT FROM THE EMPLOYEE OR RETIRED EMPLOYEE	HAS DEPENDENT SERVED IN THE ARMED FORCES? YES NO IF YES, GIVE DATES OF SERVICE.							
D. IS A FULL-TIME STUDENT AT AN ACCREDITED SECONDARY OR PREPARATORY SCHOOL OR COLLEGE	FROM TO							
E. EXPECTED DATE OF GRADUATION	DATE SUBSCRIBER'S SIGNATURE							
H. DISABLED DEPENDENT OVER AGE 19.								
If dependent over age 19 is disabled and eligibility has not been establed or business office for special form.	ished, contact your Health Benefits Administrator, personnel department							

E. CLAIMS FILING INSTRUCTIONS