EBPA Dental Claim Reimbursement Form

GROUP NAME: _____ **GROUP #:** _____

STATEMENT OF CLAIM FOR GROUP DENTAL BENEFITS

MAIL THIS FORM TO:
EBPA P.O. BOX 2000
EXETER, NH 03833-2000
Phone (603) 778-7106 or (800) 578-3272

PART I - TO BE COMPLETED BY EMPLOYEE

Patient Name	Relationship to Employee	Patient Birthdate

Employee Name	Participant ID#	Employee Birthdate

Employee Mailing Address

Is Patient Covered by Another Dental Plan?	☐ Yes ☐ No	If Yes, please Provide Dental Plan Name, Group Number, Name and Address of Carrier
Is Treatment Result of an Occupational Injury?	☐ Yes ☐ No	If Yes, Enter Brief Description
Is Treatment Result of an Accident?	☐ Yes ☐ No	If Yes, Enter Brief Description and Dates

I hereby certify the accuracy of the above statements, and authorize release of any information relative to this claim.	Signed (Patient or Parent if Minor)	Date
I hereby authorize payment of Dental Benefits to be made to the attending Dentist of services related to this claim.	Employee Signature	Date

A PRE-TREATMENT ESTIMATE IS RECOMMENDED FOR CLAIMS EXPECTED TO EXCEED $300.00

PART II - TO BE COMPLETED BY ATTENDING DENTIST

Dentist Name	Dentist Telephone	Dentist SSN or TIN

Mailing Address

Is Treatment for Orthodontics?	☐ Yes ☐ No	If Services Already Commenced, Enter Dates Appliances Placed	Months of Treatment Remaining

CHECK ONE: ☐ **DENTIST'S PRETREATMENT ESTIMATE** ☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

Tooth # or Letter	Surface (i.e. M,O,DB,L,LA,I)	Description of Service (Including X-rays, Prophylaxis, Materials Used, etc.)	Date Service Performed MMDDYY	Procedure Number	Fee	Notes

I hereby certify that the procedures, as indicated by date, have been completed.	Total Fee Charged	

Dentist's Signature

Date