G.U.T. GROUP MEDICAL PLAN

P.O Box 452, Marine Villa, St. George
PHONE: 440-5988/3248 FAX: 444-5988
Email: medplan95@yahoo.com /medical.p2013@gmail.com

DENTAL CLAIM FORM

Section 1: (To be completed by Member/Employee)

Name in full of Member/Employee	Sex M __ F __	Date of birth
Name of Patient	Sex M__ F__	Date of Birth
Is spouse employed? __ Yes __ No If yes employer' name & address:	Relationship of patient to Member/Employee __ Self __ Child ___ Spouse __ Other _____	
Have you submitted a previous claim for this complaint? ___ Yes ____ No If yes show date submitted.		
Is patient covered through any other plans (including auto insurance) which provide medical or dental benefits or services? ___ Yes ___ No		
If yes list all other insurance companies or service plans providing this coverage. Name: Address:	Through what employers or organization are plans provided if other than previously stated. Name: Address:	
Identify other type of coverage __ Group Policy# _____Cert. #_____ Cert# _____		__ Individual __ Other _____
Was treatment required because of injury? __Yes ___No	When did accident happen? AM___ Date _____ Hour _____ PM___	
Describe injury received.	If treatment was for injury, was accident caused by patient's employment? __Yes __No Name of attending Dentist:	
We certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief. We hereby agree to reimburse G.U.T GROUP MEDICAL PLAN to the extent of the amount paid on this claim under any non-occupational policy provision in the event benefits are provided under any workman's compensation law or similar legislation.	**We hereby authorized any insurance company, pre-payment organization, employer, union, trust fund, hospital or physician to release all information with respect to us or any of our dependants whish may have a bearing on the benefits payable under this or any other plan providing benefits or service. A photocopy of this authorization shall be considered as effective and valid as the original.**	

Date	***Signature of Member/Employee***	***Signature of Patient:***

Section 11: ***To be completed by Employer or Plan Administrator***

Group Policy #	**Name of Company or Plan Certificate #**	**Insurance Classification**

Plan Administrator's Section **Effective date of Insured's coverage _____** **Effective date of Dependent's Coverage_____**

_____ **_____**

Signature of Administrator **Date**

This form is to be completed by the Employee or Member, his Employer or the Plan Administrator, and his Dentist. Be certain all questions are answered and all information requested is furnished. The attending Dentist's statement on the reverse side must be completed and furnished. Attach detailed bills from hospital, attending dentist etc. if claim is filed for these benefits. Employee should mail completed form and bills to Grenada Union of Teachers Group Medical Plan.

SCHOOL:_____

CONTACT #: **EMAIL ADDRESS:**

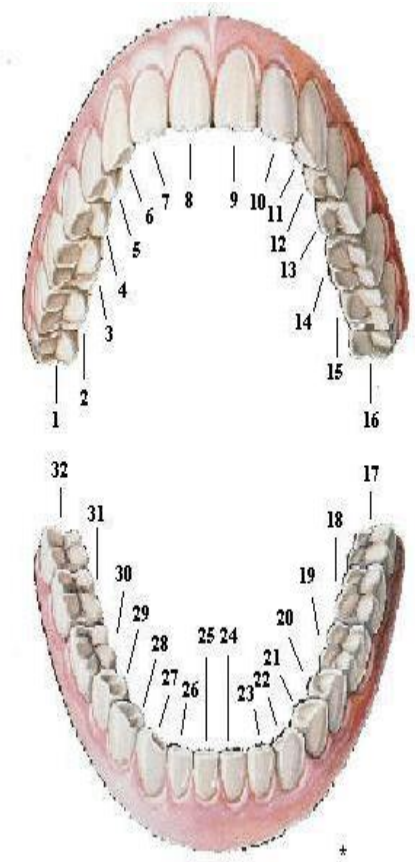
ATTENDING DENTIST'S STATEMENT OF ACTUAL SERVICES

Section 2: (To be completed by Dentist)

Patient Name	**Relationship to Member/Employee**	**Birth Date**	**Date First Visit**
Does patient have any other health coverage? ___Yes ___No **If "Yes" Please identify.**			
Group Dental Plan Name			
Dentist Name (Print)			
Address			

Is any of the treatment for Orthodontic Purposes? ___Yes ___No	**Accidental injury ___Yes ___No**	**Occupational Injury ___Yes ___No**

Is prosthesis? Is this Initial Placement? **If no, reasons for replacement:** **If yes, date of extraction(s) of teeth being replaced.**	**Date of prior placement**	**Are X-rays enclosed? ___Yes ___ No** **If Yes, how many?**



EXAMINATION AND TREATMENT RECORD – USE CHARTING SYSTEM SHOWN

Tooth\Letter	**Surfaces**	**Description of service (Including x-rays, prophylaxis\ specific material used for Crowns, Dentures & other restorations).**	**Date service performed**	**Fee $**	

Name of Drug/s Prescribed	**Cost if Supplied**	**Duration**

Orthodontics: (give diagnosis, class of malocclusion & describe appliance(s) in above treatment section) Date first appliance inserted _____ Date last appliance removed _____ Treatment period (number months) _____ Total Fee $ _____	Total fee actually charged		
	Patients Pays		
	Balance		
	Carrier's		
	Carrier pays		

I authorize release of any information related to this claim.

_____ _____

Signed (patient or parent of minor) **Date**

I hereby certify that the services listed above have been performed.

_____ _____

Signed (Dentist) **Date**

I hereby authorize payment directly to the above-named Dentist of the Group Insurance benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

_____ _____

Signed (Insured person) **Date**