HUMANA
CompBenefits

College Insurance Program Dental Group #970

Dental Claim Notice

HOW TO SUMBIT A CLAIM

A. Fill out every section of the claim form completely.
B. Include Your Social Security Number.
C. Attach only original itemized bills (not copies) or ask your dentist to complete the reverse side of this form.
D. If bills are attached, label them. Make sure the bills include the name, address and telephone number of the doctor.
E. The doctor must show the cost of each service and the date the service was performed.
F. If the patient is covered by another group insurance plan which is primary, the claim must be filed unther that plan first.
Then you can file a claim under State of Illinois' plan by attaching a copy of the other plan's Explanation of Benefits payments(s) and a copy of the itemized bill(s).
G. Then send to: Administered By Humana / CompBenefits
P.O. Box 14285, Lexington, KY 40512-4285
Telephone: 1-800-999-1669

claims can be submitted electronically to Payer ID CX021

TO BE COMPLETED BY THE EMPLOYEE

1. Complete for All Claims

Employee's Name ____ o Male o Female

Employee's Home Address (No. Street) ____

City, State Zip Code ____ Social Security Number ____

Date of Birth (Mo, Day, Yr) ____ Marital Status: o Single o Married o Widowed o Divorced o Separated

2. Complete for Dependent Claims Only

Dependent's Name (Spouse/Child) ____ o Male o Female

Relationship to Employee ____ Date of Birth (Mo, Day, Yr) ____

Marital Status: o Single o Married

Give dependent's address if other than above ____

o Claim is for Dependent Child over age 19, indicate o Full-time Student

o Handicapped

if student, give name of school ____

3. Complete for All Claims

Are you, your spouse of child entitled to benefits from any kind of group dental insurance? o Yes o No

Name of Person with Other Insurance ____ Social Security Number ____

Name of other Employer ____

Name and Address of the insurance carrier providing these benefits ____ Policy number ____

4. Complete for Accidents Only

Date Accident Occured ____ Work Related o Yes o No

Give a brief description of the accident (include the place where it happened) ____

5. Complete for All Claims

I hereby agree to reimburse State of Illinois for any overpayment made by the Plan.
To all providers of dental care, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators. Your are authorized to provide CompBenefits and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on CompBenefits' behalf with information concerning dental care, advice, treatment or supplies provided the Patient, and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for dental benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Signed (Employee) ____ (Date) ____ Signed (Dependent Patient - Not Minor) ____ (Date) ____

6. Complete only if you want payment to go directly to Provider

Authorization to Pay Benefits, I hereby authorize payment directly to the provider of service for the claimed expenses as provided under the State of Illinois Dental Plan. I understand I am financially responsible for charges not covered by this authorization.

Employee's Signature) ____ Date ____

DENTAL CLAIM FORM

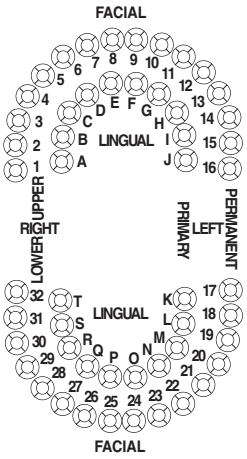
Check One:
o Dentist's pre-treatment estimate
o Dentist's statement of actual services

TO BE COMPLETED BY THE PROVIDER OF DENTAL SERVICES

- A PRETREATMENT ESTIMATE IS REQUIRED FOR ANY CHARGES OVER $600 TO AVOID ANY MISUNDERSTANDING BETWEEN THE PATIENT AND DENTIST
- FOR PERIODONTAL TREATMENT FMX AND PERIODONTAL CHARTING ARE REQUIRED
- FOR MAJOR RESTORATIVE TREATMENT FMX, COMPLETE MOUTH CHARTING AND DATE OF EXTRACTIONS ARE REQUIRED
- FOR ENDODONTIC THERAPY
  - PREOP XR FOR PRETREATMENT ESTIMATE
  - POSTOP RX FOR PAYMENT IS REQUIRED
- AFTER SERVICES ARE COMPLETED, SIGN THE DENTIST'S STATEMENT PORTION BELOW

	PATIENT NAME FIRST INITIAL LAST	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE	SEX o MALE o FEMALE	DATE OF BIRTH
BILLING DENTIST	Name of Billing Dentist or Dental Entity	Is treatment result of occupational illness or injury?	No / Yes	If yes, enter brief description and dates.	
	Address where payment should be remitted	Is treatment result of auto accident?			
	City, State, Zip	Other accident?			
	Dentist Soc. Sec. or T.I.N. / Dentist License No. / Dentist Phone No.	If Prosthesis, is this initial placement?		(If no, reason for replacement)	Date of prior placement
	First visit date current series / Place of treatment: Office Hosp. ECF Other / Radiographs or models enclosed? NO YES HOW MANY?	Is treatment for orthodontics?		If services already commenced enter:	Date appliances placed / Mos. treatment remaining

Identify missing teeth with "x"



Examination and treatment plan _ List in order from tooth no. 1 through tooth no. 32 _ Use charting system shown.

Tooth # or Letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

FOR ADMINISTRATIVE USE ONLY

Remarks for unusual services

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier Pays	
Patient Pays	

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist) License Number Date