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Dental Claim Statement* Required Field Check one: Carrier name and address: Dentists pre-treatment estimate Dentists statement of actual services Fortis Benefits Insurance Company 1 Patient name * 2 Relationship to employee 3 Sex 4 Patient birthdate 5 If full-time studentPATIENT COVERAGE INFORMATION First M.I. Last Self Child School M F MO DAY YR Spouse Other City 6 Employee subscriber name 7 Empl...

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HEADER INFORMATION 1. Type of Transaction (Mark all applicable boxes) EMI Health Dental Claims Statement of Actual Services Request for Predetermination Preauthorization 852 East Arrowhead Lane P.O. Box 14283 Murray, Utah 84107-5298 Lexington, KY 40512-4283 EPSDT Title XIX 2. Predetermination Preauthorization Number POLICYHOLDER SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 12. Polic...

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ADMINISTERED BY: HealthSmart Benefit Solutions P.O. Box 2525 Elizabethtown, KY 42702 1-866-812-9671 (phone) 270-769-2521 (fax)PART I: TO BE COMPLETED BY ENROLLEE PATIENT 1. PATIENTNAME: 2. RELATIONSHIPTOENROLLEE: 3. SEX: 4. PATIENTDATEOFBIRTH: 5. IFFULL?TIMESTUDENT: SCHOOL: SELF SPOUSE CHILD OTHER M F CITY: 6. ENROLLEENAME:FIRST MIDDLE LAST 7.ENROLLEE SOCIALSECURITYNUMBER: 8. ENROLLEE DATEOFBIRTH:...

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