Dental Claim Form

This claim form is to be used only if your provider did not file Claims directly to International Claims Services (ICS) on your behalf. Return this form along with itemized bills, diagnosis, and receipts to the address below. ICS must receive claims within 180 days after first day of treatment.

Please send completed claim form and supporting documents to Global Benefits Group:

- **Online claims submission:** www.gbg.com
- **Submit:** eclaims@gbg.com / **Inquiries:** customerservice@gbg.com
- **Mail:** 27422 Portola Parkway, Suite 110, Foothill Ranch, CA 92610 USA
- **Fax**: +1.949.271.2330

A. PRIMARY INSURED INFORMATION	
Name (Last, First, MI):	
Policy #:	GBG ID #:
Employer (if applicable):	
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	
B. PATIENT INFORMATION (If different from Primary Insured)	
Name (Last, First, MI):	
Date of Birth (DD/MMM/YYYY):	Patient: ☐ Dependent Spouse ☐ Dependent Child
Address:	
Postal Code:	Country:
C. CLAIM INFORMATION	
Date illness/injury occurred (DD/MMM/YYYY):	
Describe problem, symptom or complaint:	
Physician's Diagnosis/Results of your visit:	
Has diagnosis/treatment for same condition or related condition been given previously? If so, provide dates, results, kind of treatment, prescribed drugs, name of physician/facility:	
Treatment resulting from: a. The patient's occupation? ☐ Yes ☐ No If yes to any of the above, please provide date and details of accident:	b. An automobile accident? ☐ Yes ☐ No c. Any type of accident? ☐ Yes ☐ No

Is this patient also covered by:	b. Medicare / other Government Agency? ☐ Yes ☐ No
a. Other Group Medical /Dental plan(s)? ☐ Yes ☐ No	c. No-fault auto carrier? ☐ Yes ☐ No
If yes to any of the above, please provide:	
Name of Carrier:	Policy number of other source:
Carrier Address:	

ORTHODONTIA	
Are orthodontic services included? ☐ Yes ☐ No	If yes, is this the initial treatment? ☐ Yes ☐ No
Date appliance placed (DD/MMM/YYYY):	Months of treatment remaining:
Expected completion date (DD/MMM/YYYY):	Total charge for active treatment:

CROWNS, BRIDGES AND DENTURES	
Replacement of prosthesis (crown, bridge, dentures)? ☐ Yes ☐ No	If yes, date of original prosthesis? (DD/MMM/YYYY)
Date of original placement or restoration, if applicable (DD/MMM/YYYY):	
Original teeth involved (numbers):	
Reason for replacement:	
Original was: ☐ Damaged ☐ Lost or Stolen ☐ Other: _____.	

PHYSICIAN/FACILITY INFORMATION	
Physician/Facility/Provider Name:	
Address:	
Postal Code:	Country:
Phone:	Email:

RECEIPTS: In order to receive payment, please attach receipts and list treatments and/or prescribed drugs and the charges for each below.

Date of Service (DD/MMM/YYYY)	Tooth #	Procedure Code	Description of each Service/Prescription Drug	Cost	Currency
			Total amount paid by Patient:		
			Total unpaid balance still due to Provider:		

D. PAYMENT INFORMATION	
Please make payment to: ☐ Primary Insured ☐ Provider (Payment by check)	
PAYMENT TYPE (Please make payment as marked below)	
☐ Primary Insured's Address, as listed in PRIMARY INSURED INFORMATION section.	
☐ Other Mailing Address:	
☐ Send by Electronic Direct Deposit (U.S. banks only) or Wire Transfer (non-U.S. banks)	
Bank Name:	
Name on Account:	
Account #/IBAN:	
Routing #/ABA # (for Electronic Direct Deposit):	
SWIFT code (for Wire Transfer):	
Bank Address (for Wire Transfer):	

E. AUTHORIZATION

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

The above answers are true and correct to the best of my knowledge. I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to Global Benefits Group as required to properly pay all benefits, if any due to me, my spouse, or any other dependents. A photocopy of this authorization shall be considered effective and valid as the original.

Insured Person	
Name:	Date:

Signature:
By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.

Fair Processing Notice

The GBG Group includes insurance companies, brokering and management companies, as well as assistance and operations companies. We respect your privacy and we are all committed to protecting your personal information.

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at https://www.gbg.com/#/AboutGBG/PrivacyPolicy and we would advise you to read the policy so you understand your rights and your personal data use by the GBG Group.