



Send Dental Claims to:  
 Allied Benefit Systems, Inc.  
 P.O. Box 909786-60690  
 Chicago, IL 60690

Phone Numbers  
 Tel: 312-906-8080  
 Fax: 312-906-8359  
 Toll Free: 800-288-2078\*  
 \*Outside IL

## DENTAL CARE CLAIM FORM

INSTRUCTIONS: Complete the applicable items in Part 1. Give the form to your Provider to complete Part 2.  
 Return the completed form to **ALLIED BENEFIT SYSTEMS, INC.**

<b>PART 1: TO BE COMPLETED BY EMPLOYEE</b>			
1. CLAIM IS BEING MADE FOR: <input type="checkbox"/> Employee <input type="checkbox"/> Unmarried Child. If child is between ages of 23 to 25, benefits continued as: <input type="checkbox"/> Full time student, attending _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Other    _____ School			
2. PATIENT'S NAME:		DATE OF BIRTH:    /    /    SEX:	
3. IS THIS CLAIM DUE TO AN ACCIDENT?    IF YES, WHERE DID ACCIDENT OCCUR?    DATE OF ACCIDENT:    /    / <input type="checkbox"/> Yes <input type="checkbox"/> No DESCRIBE ACCIDENT:			
4. IS THIS CLAIM AS A RESULT OF A WORK RELATED ILLNESS OR INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. ARE YOU (EMPLOYEE) MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No    IF CLAIM IS FOR A DEPENDENT CHILD, IS YOUR CHILD IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No    EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", PLEASE PROVIDE:    IF "YES", PLEASE PROVIDE:			
NAME OF SPOUSE		NAME OF DEPENDENT	
EMPLOYER OF SPOUSE		EMPLOYER OF DEPENDENT	
ADDRESS OF EMPLOYER		ADDRESS OF EMPLOYER	
6. IS THE PATIENT COVERED UNDER ANY OTHER PLAN PROVIDING HEALTH BENEFITS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", PROVIDE THE NAME AND ADDRESS OF THE COMPANY OR INSURANCE CARRIER PROVIDING BENEFITS:			
NAME OF COMPANY OF INSURANCE CARRIER			
STREET NUMBER		CITY	STATE
ZIP			
7.			
EMPLOYEE'S NAME (PLEASE PRINT)		SOCIAL SECURITY NUMBER	(Area) TELEPHONE NUMBER
STREET NUMBER		CITY	STATE
ZIP			
8. AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.			
PATIENT'S SIGNATURE		DATE	
(If other than Employee, omit if patient is a minor.)			
EMPLOYEE'S SIGNATURE		DATE	
9. ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.			
EMPLOYEE'S SIGNATURE		DATE	
10. <b>North Suburban Library System</b> <b>A01195</b> (    ) NAME OF EMPLOYER    GROUP NO.    TELEPHONE NUMBER			
STREET NUMBER		CITY	STATE
ZIP			

