MAIL THIS FORM TO
CompuSys/Erisa Group, Inc.
13706 Research BLVD STE 308
Austin, TX 78750
Telephone (512) 250-9397
(800) 933-7472

CITY OF AUSTIN DENTAL CLAIM FORM

CHECK ONE: ☐ Dentist's Statement of Actual Services ☐ Dentist's Request for Predetermination

SECTION A: EMPLOYEE INFORMATION

LAST NAME, FIRST, MIDDLE | SOCIAL SECURITY NO. | DATE OF BIRTH

MAILING ADDRESS | IS THIS A NEW ADDRESS ☐ YES ☐ NO

CITY | STATE | ZIP CODE | PHONE NUMBER AT WORK | AT HOME

SECTION B: PATIENT INFORMATION

PATIENT NAME (LAST NAME, FIRST, MIDDLE) | RELATION TO EMPLOYEE | DATE OF BIRTH

IS CLAIM FOR ORTHODONTIA? ☐ YES ☐ NO | IF YES, GIVE DATE BANDS/APPLIANCES PLACED | DATE _____

IS CLAIM FOR REPLACEMENT OF A PROSTHETIC APPLIANCE? ☐ YES ☐ NO | IF YES, GIVE DATE OF LAST PLACEMENT | DATE _____

REASON FOR PLACEMENT? _____

IS NEED FOR TREATMENT WORK RELATED? ☐ YES ☐ NO | IF YES, HAS CLAIM BEEN FILED WITH WORKER'S COMPENSATION? ☐ YES ☐ NO

IS NEED FOR TREATMENT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO | IF YES, WHEN, WHERE AND HOW DID THE ACCIDENT OCCUR?

WAS A THIRD PARTY RESPONSIBLE FOR THE ACCIDENT? ☐ YES ☐ NO

_____

_____

SECTION C: COORDINATION OF BENEFITS (OTHER COVERAGE)

IS THE PATIENT ALSO COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO | IF YES, COMPLETE THE FOLLOWING:

NAME OF PERSON CARRYING THE OTHER COVERAGE | DATE OF BIRTH | RELATION TO EMPLOYEE | SOC. SECURITY NO.

NAME OF INSURANCE CO./MEDICARE | POLICY NUMBER/GROUP NUMBER

ADDRESS AND PHONE NUMBER OF INSURANCE CO./MEDICARE

SECTION D: AUTHORIZATION

PAYMENT OF BENEFITS

☐ PAY EMPLOYEE

☐ PAY PROVIDER

_____

SIGNATURE OF EMPLOYEE | DATE

FLEXTRA RELEASE

ARE YOU ENROLLED IN THE FLEXTRA HEALTH CARE ACCOUNT

☐ YES ☐ NO

IF YES, DO YOU WANT ERISA TO CONSIDER THIS CLA IM FOR REIMBURSEMENT IN ACCORDANCE WITH YOUR HEALTH CARE ACCOUNT?

☐ YES ☐ NO

I hereby authorize any hospital, dentist, doctor or others persons who have attended to me or examined me to release, when requ ested, any or all information regarding any illness, injury or dental history. A photostatic copy of this authorization is cons idered as valid and effective as the original. I also Certify the information provided above is correct and true to the best of my knowledge.

_____

SIGNATURE OF PATIENT/ GUARDIAN | DATE

NOTE TO DENTIST: PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM IF ITEMIZED BILL OR STANDARD ADA CLAIM FORM IS NOT ATTACHED.

SECTION E: DENTIST INFORMATION

DENTIST NAME | TAX ID NUMBER | DENTAL LICENSE NUMBER

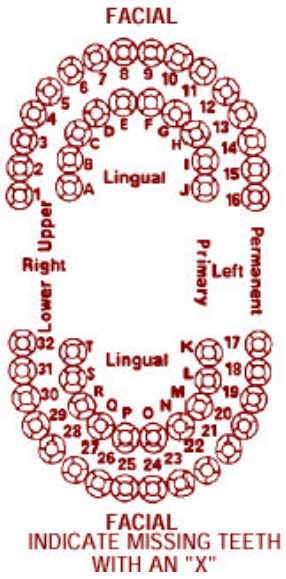
ADDRESS | TELEPHONE NUMBER

CITY | STATE | ZIP CODE | FIRST VISIT DATE (CURRENT SERIES)

TREATMENT LOCATIONS ☐ OFFICE ☐ EMERGENCY ☐ HOSPITAL ☐ OTHER

ARE X-RAYS OR MODELS ENCLOSED? ☐ YES ☐ NO

IF YES, HOW MANY? _____



EXAMINATION AND TREATMENT PLAN LIST IN ORDER FROM TOOTH NO. 1 THROUGH 32 USE CHARTING SYSTEM SHOWN

OFFICE USE ONLY

LINE	TOOTH #OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED	PROCEDURE NUMBER	FEE	PRE AUTH.	ALLOWABLE
1					0			
2					0			
3					0			
4					0			
5					0			
6					0			
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37					0			
38					0			

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED

SIGNED (DENTIST) _____ DATE _____

TOTAL FEE CHARGED