



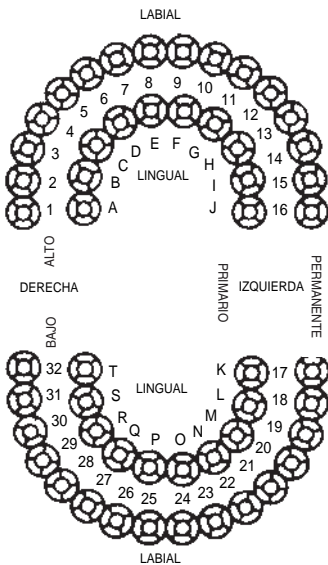
**Benefit Administrators, Inc.**  
**Claims Division**  
 P.O. Box 211757  
 Eagan, MN 55121  
 1-800-298-7269

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Plan No./No. Plan

Claim No./No. Reclamo

1. Employee Name/Nombre del Empleado		2. Soc. Sec. No./No. Seguro Social	3. Name of Group Dental Plan/Nombre del Plan del Grupo Dental	
4. Employee Mailing Address/Dirección Postal del Empleado			5. Patient Birthdate Mo. Day Year Fecha de Nacimiento del Paciente Mes Día Año	
7. City Ciudad	State Estado	Zip Código	8. Employer Name/Nombre del Empleado	
9. Patient Name/Nombre del Paciente		10. Patient Relationship to Employee Relación entre el Empleado y el Paciente		12. Date Patient's First Visit (Current Series) Fecha de la Primera Visita del Paciente (Serie Actual)
13. Dentist Name Nombre del Dentista		14. License No. No. Licencia		15. Is Patient Covered By Other Plan? Yes___ No___ (Name Other Plan) Está el Paciente Cubierto por Otro Plan? Sí ___ No ___ (Nombre del Otro Plan)
16. Dentist Mailing Address/Dirección Postal del Empleado			18. Is Any Of Treatment For Orthodontic Purposes? Yes___ No___ Tiene el Tratamiento Fines de Ortodoncia? Sí ___ No ___	
17. Phone No./No. Teléfono				
19. City Ciudad	State Estado	Zip Código Postal	20. Treatment Result of Accident? Tratamiento Resultante del Accidente? Yes___ No___ Sí ___ No ___	
21. If Prosthesis Yes___ En Caso de Prótesis Sí ___ Is This Initial No___ se trata de una No ___ Placement? primera ubicación Si No, Razón de la Reposición			22. Result of Occupational Injury? Resultado de Lesión Ocupacional? Yes___ No___ Sí ___ No ___	
23. Dentist Soc. Sec. No. or T.I.N. No. Seguro Social del Dentista o No. T.I.N.		24. Date Of Prior Placement Fecha de la Ubicación Previa		25. Are X-Rays Enclosed? Yes___ No___ If Yes, How Many___ Se Adjuntan Rayos-X? Sí ___ No ___ Si es Así, Cuantos___



INDICATE MISSING  
TEETH WITH AN 'X'  
INDIQUE LOS DIENTES QUE  
FALTAN CON UNA 'X'

26. Examination and Treatment Record—List in Order From Tooth No. 1 through Tooth No. 32. Informe del Examen y Tratamiento—Liste Por Orden Desde el Diente No. 1 Hasta el Diente No. 32.						Do Not Use This Column No Utilize Esta Columna
Tooth Number Or Letter No. ó Letra del Diente	Surfaces Superficies	Description Of Service (Including X-Rays, Prophylaxis, Materials, Etc.) Descripción del Servicio (Incluyendo Rayos-X, Materiales de Profilaxis, Etc.)	Date Of Service Fecha del Servicio Mo Day Yr Mes Día Año	Procedure No. Número del Procedimiento	Fee Costo	

ORTHODONTICS (give diagnosis, class of malocclusion and describe appliances in above treatment section) ORTODONCIAS (proporcione el diagnóstico, clase de maloclusión y describa los aparatos en la sección anterior de tratamiento)				Total Fee Actually Charged Costo Total Realmente Cobrado	Amount Paid Cantidad Pagada
Date First Appliance Inserted/Fecha de Inserción del Primer Aparato _____ Date First Appliance Removed/Fecha de Eliminación del Último Aparato _____ Treatment Period (Number Months)/Periodo de Tratamiento (Número de Meses) _____ Total Fee/Coste Total \$ _____					
27. Remarks For Unusual Services Comentarios por Servicios Excepcionales					

I hereby accept the foregoing treatment plan and authorize release of any information relating to this claim.  
 Por la presente acepto el plan de tratamiento anterior y autorizo la difusión de cualquier información relacionada con este reclamo.

PATIENT'S SIGNATURE  
FIRMA DEL PACIENTE \_\_\_\_\_ Date/Fecha \_\_\_\_\_  
 (Or employee if patient is a minor/o empleado si el paciente es un menor.)

DENTIST'S SIGNATURE  
FIRMA DEL DENTISTA \_\_\_\_\_ Date/Fecha \_\_\_\_\_

I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by this authorization. Por la presente autorizo el pago directo al dentista nombrado anteriormente perteneciente a los beneficios de seguro del grupo o en caso alternativo pagadero a mí, pero a no exceder los costes señalados arriba. Tengo constancia de que soy el responsable financiero de cualquier coste no cubierto por esta autorización.

PATIENT'S SIGNATURE  
FIRMA DEL PACIENTE \_\_\_\_\_ Date/Fecha \_\_\_\_\_  
 (Or employee if patient is a minor/o empleado si el paciente es un menor.)



**NOTICE: 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.**

Any person who **knowingly presents a false or fraudulent claim** for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## Important Notice

- ❖ ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ❖ ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ❖ ***For residents of the District of Columbia:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ❖ ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ❖ ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ❖ ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ❖ ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ❖ ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ❖ ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ❖ ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ❖ ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ❖ ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- ❖ ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ❖ ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.