GRANBURY ISD DENTAL PLAN CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

NAME OF EMPLOYEE	SOCIAL SECURITY NUMBER	E-MAIL ADDRESS
HOME ADDRESS	CITY, STATE	ZIP
NAME OF PATIENT/SOCIAL SECURITY NUMBER	RELATIONSHIP TO EMPLOYEE	HOME TELEPHONE

IS THE PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO

IF YES, ATTACH A COPY OF THE PAYMENTS FROM OTHER INSURANCE COMPANY.

IF DEPENDENT CHILD IS 19 OR OLDER, IS HE/SHE A FULL TIME STUDENT? ☐ YES ☐ NO

AN ITEMIZED STATEMENT AND ORIGINAL PAID RECEIPT OR CANCELLED CHECK MUST BE ATTACHED TO CERTIFY THAT CLAIM HAS BEEN PAID. I AUTHORIZE THE DENTAL PROVIDER TO RELEASE INFORMATION RELATING TO THIS CLAIM ON REQUEST FROM FIRST FINANCIAL ADMINISTRATORS, INC.

Signature of Employee **Campus/Department** **Date**

TO BE COMPLETED BY DENTIST

AMOUNT PAID $_____ DATE OF SERVICE: _____

PROCEDURE(S) PERFORMED, IF NOT ON ITEMIZED STATEMENT: _____

DENTAL PROCEDURE(S) FOR THE ABOVE PATIENT ☐ HAVE BEEN COMPLETED, OR ☐ ARE IN PROGRESS.

Signature of Dentist Date

SUBMIT CLAIMS TO: FIRST FINANCIAL ADMINISTRATORS, INC.
ATTN: DENTAL CLAIMS
P.O. BOX 670329
HOUSTON, TX 77267-0329

OR FAX TO: (800) 298-7785

IF YOU HAVE QUESTIONS REGARDING REIMBURSEMENT PROCEDURES, PLEASE CALL FIRST FINANCIAL ADMINISTRATORS, INC. AT (866) 853-3539.

CLAIMS MUST BE RECEIVED WITHIN NINETY (90) DAYS OF THE PROCEDURE/RECEIPT TO BE VALID. CLAIMS NOT RECEIVED WITHIN NINETY (90) DAYS OF PAYMENT WILL BE REJECTED.