HMA HEALTHCARE MANAGEMENT ADMINISTRATORS

Send claims to: Healthcare Management Administrators, Inc.
P.O. Box 85008, Bellevue, WA 98015
Toll Free (800) 869-7093 Local (425) 462-1000

Schwartz Brothers Restaurants

DENTAL CLAIM FORM

PART 1: Employee Information

EMPLOYEE NAME (Last and First)	EMPLOYEE DATE OF BIRTH MONTH DAY YEAR	EMPLOYEE MEMBER ID #	GROUP #
		— —	020203

EMPLOYEE ADDRESS CITY STATE ZIP	IS THIS AN ADDRESS CHANGE? ❑ YES ❑ NO	EMPLOYEE'S TELEPHONE NUMBER

MARITAL STATUS ❑ SINGLE ❑ MARRIED_____ ❑ WIDOWED ❑ LEGALLY SEPARATED ❑ DIVORCED
NAME OF SPOUSE

IF DIVORCED & CLAIM IS FOR DEPENDENT CHILD, ANSWER THE FOLLOWING QUESTIONS: A) IS THIS CHILD IN YOUR PERMANENT CUSTODY? ❑ YES ❑ NO

B) IS THERE A COURT ORDER FOR PROVISION OF MEDICAL CARE FOR THIS CHILD? ❑ YES ❑ NO

PART 2: Patient Information

PATIENT NAME	IS PATIENT ❑ EMPLOYEE ❑ SPOUSE ❑ CHILD ❑ OTHER IF OTHER, SPECIFY_____
PATIENT'S DATE OF BIRTH MONTH DATE YEAR	IF CLAIM IS FOR DEPENDENT OVER AGE 19, IS THE DEPENDENT A FULL TIME STUDENT? IF SO, PLEASE PROVIDE PROOF OF STUDENT STATUS.

PART 3: Description of Claim

DESCRIBE ILLNESS OR INJURY:	WORK RELATED ILLNESS OR INJURY? ❑ YES ❑ NO IF YES, DID YOU OR WILL YOU BE FILING A CLAIM WITH L&I? ❑ YES ❑ NO	IF CLAIM IS DUE TO ACCIDENT STATE WHEN, WHERE AND HOW THE ACCIDENT OCCURRED:

HAS PATIENT BEEN TREATED FOR THIS ILLNESS OR INJURY WITHIN THE PAST 12 MONTHS? ❑ YES ❑ NO IF YES, DATE OF SERVICE: _____	IF YES, NAME AND ADDRESS OF ATTENDING PHYSICIAN REFERRING PHYSICIAN IF APPLICABLE _____

PART 4: Other Group Health Insurance

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED BY OTHER INSURANCE FOR MEDICAL, DENTAL, OR VISION BENEFITS? ❑ YES ❑ NO CHECK ONLY THOSE COVERED BY OTHER GROUP INSURANCE.: ❑ SELF ❑ SPOUSE DATE OF BIRTH _____ ❑ DEPENDENT(S) LIST THE DEPS. _____ _____ _____	NAME AND ADDRESS OF OTHER INSURANCE CARRIER: POLICY NUMBER: _____ EFFECTIVE DATE: _____

IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS?
❑ YES ❑ NO IF YES, ENTER DATE OF ELIGIBILITY _____ SOCIAL SECURITY NO._____

PART 5: Complete for all claims

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE _____ DATE _____

PART 6: Claims Benefit Assignment and Authorization

SIGN HERE IF YOU WISH PAYMENT TO BE MADE TO YOU, OTHERWISE IT WILL GO TO THE PROVIDER OF CARE., _____ DATE _____
SIGNED (BY EMPLOYEE)

AUTHORIZATION TO RELEASE INFORMATION: I expressly authorize any provider of care to furnish, any records concerning me or any Member of my family for whom benefits or services has been claimed.

_____ DATE _____
SIGNED (BY PATIENT, OR PARENT, IF MINOR)