gpm group benefits

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DENTAL CLAIM AND TREATMENT PREDETERMINATION FORM

FOR DENTIST USE ONLY

Dentist's Information

Practice No.: Phone No.:

Unique No. Spec.

Provider No.

Patient's Information

For dentist use only - for additional information, diagnosis, procedures, or special considerations.

☐ I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

PARTICIPANT'S SIGNATURE

Treatment Date (d/m/yyyy)	Procedure Code	Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	TOTAL CHARGES

☐ Duplicate Form

☐ Treatment Plan

This estimate is valid for 60 days only.

Fees do not cover complications that may occur during and after treatment. Laboratory costs are approximate.

No date of treatment should appear on this form.

This is an accurate statement of services performed and fees charged, or of services to be performed and fees to be charged in the case of a treatment plan, except errors and omissions.

DENTIST'S SIGNATURE Date (d/m/yyyy)

TOTAL FEES SUBMITTED

Patient's Information

Relationship to insured participant: Date of Birth (d/m/yyyy)

Are any dental benefits or services covered under another group insurance or dental plan? ☐ No ☐ Yes

Is the treatment required as the result of an accident? ☐ No ☐ Yes

DATE OF ACCIDENT (d/m/yyyy) NATURE OF ACCIDENT Please indicate details on a separate sheet.

Is any treatment required for orthodontic purposes? ☐ No ☐ Yes

If denture, crown or bridge, is this the initial placement? ☐ No ☐ Yes

DATE OF PRIOR PROSTHESIS REASON FOR REPLACEMENT

Participant's Information

Group Name

Group No. GPM User ID Date of Birth (d/m/y)

Participant's Family Name(s)

Participant's Given Name(s)

Participant's Email Address

PATIENT'S DECLARATION AND AUTHORIZATION

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of $_____ is accurate and has been charged to me for services rendered. I authorize release of the information contained in this claim form to my insuring company/plan administrator. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

PATIENT'S, PARENT'S OR GUARDIAN'S SIGNATURE

PARTICIPANT'S DECLARATION AND AUTHORIZATION

By submitting your claim, you confirm that the information provided is accurate, precise and true. Any false information may result in the rejection of your claim. You authorize GPM and its representatives to: (i) Investigate all providers of goods or services and obtain all information relating to the goods sold and services provided; (ii) Collect information regarding the reimbursement request or the claim; (iii) Obtain, use and disclose personal information concerning you or the persons referred to in your claim, necessary for its due diligence to determine its veracity. Note that we will share information relating to a false declaration or fraudulent claim to the competent authorities as well as to the Policyholder. You also agree that the person to whom the request for information is addressed to, answers the questions submitted for the verification of your claim and our inquiry.

PARTICIPANT'S SIGNATURE Date (d/m/yyyy)