

## **DENTAL CLAIM FORM**

28-48 Barbados Avenue, Kingston 5, Jamaica Tel: (876)	929-8920-9 Fax: (876) 929-	-4730/968-3						
1. Patient Name First M.I. Last			2. Relationship to ☐ Self ☐ Spouse	Employee  ☐ Child	3. Sex M F	4. Patient Birt		YYY
5. Employee Name 6. 1	Health Card Number		7. Employer Nan	ne & Addres	ss	8.	Group/Policy	Number
9. Is patient covered by another Insurance  ☐ Yes ☐ No If Yes, complete 9-a and 9-b	Co.: 9-a. Name an	nd Addre	ess of Other Carri	er(s):	9-b. Other G	roup/Policy No.	:	
I hereby authorize the release of any inf claim.	ormation relating to	o this	I hereby auth named Denta			ntal benefits di	rectly to the l	below
igned (Patient or Parent, in minor)  Date			Signed (Patie	nt or Parent	, if minor)		Date	
10. Name of Provider  11. Address where payment should be rem  City  12. Provider TRN: 13. Provider GCT		r Tel No.	Remarks:					
15. TO BE COMPLETED BY DENTIST:								
-07 08 09 10- -06 11-	Date of Service	Tooth # or Letter	Surface	Description	on of Service	Procedure #	Charges	
-05 Upper 12- -04 13-								<u>:</u>
-03 14- -02 15-								<del>:</del>
-01 Right 35- Left 16- -32 36- 17-								:
-31 37- 18- -30 38- 19-								<del>:</del>
-29 20-								<del>-</del> :-
-28 Lower 21- -27 22-								÷
-26 25 24 23-								:
16. CERTIFICATION - THIS FORM N AUTHORIZED PERSON	IUST BE SIGNED	BY THE	PROVIDER OI	R	GCT(if applica	lble) @16.5%	\$	-
I hereby certify that the above services, as indicated by date, have been completed.					TOTAL CHARGE + GCT		\$	
,	-		-		INSURANCE	PLAN PAYS	\$	
Signature of Provider or Authorized Person Provider Stamp				GCT ON INS. PAYMEN		S. PAYMENT	\$	
				TOT	AL PAYABLE	BY INS. CO.	\$	
Date	-				ME	MBER PAYS	\$	
PLEASE ATTACH ORIGINAL RECEIPT CLAIMS MUST BE SUBMITTED WITH SEE OVER FOR OPTICAL CLAIM FOR	IIN 90 DAYS OF FIF	RST SER	VICE DATE TO	ENSURE P	ROMPT PROC	CESSING		

EBD-CLM08-08-J01/0608



28-48 Barbados Avenue, Kingston 5, Jamaica Tel: (876) 929-8920-9 Fax: (876) 929-4730/968-3232

## **OPTICAL CLAIM FORM**

				2. Relationship to	Employee	3. Sex	4. Patient I	Birthdate		
First M.I. Last			□ Child	M . F	MM .	DD	YYYY			
				□ Spouse			:		:	
5. Employee Name 6. Health Card Number			7. Employer Name & Address 8. Group/Policy Nu							
								_		
9. Is patient covered	by another Insurar	nce Co.:	9-a. Name and Addı	ess of Other Carrier	r(s):	9-b. Other G	roup/Policy	No.:		
☐ Yes ☐ N If Yes, complete 9-a										
I hereby authorize the release of any information relating to this			I hereby autho	I hereby authorize payment of the Dental benefits directly to the below						
claim.				named Dental	provider.					
Signed (Patient or Parent, in minor)  Date			Signed (Patient	Signed (Patient or Parent, if minor)  Date						
10. Name of Provider			Remarks:							
11. Address where pa	armont should be	ramittadi		_						
11. Address where pa	ayment should be i	emmed.								
				_						
City										
12. Provider TRN:	13. Provider C	GCT No.	14. Provider Tel No	.:						
15 TO BE COMPLE	TED BY OPTOM	METRIST/	OPTHALMOLOGIS	<u></u>						
		METRIST/O	OPTHALMOLOGIS'  Description of S		Treatme	ent	Charge	Amour	nt Paid by	
15. TO BE COMPLI Diagnosis	ETED BY OPTOM  Date of Service	METRIST/0	OPTHALMOLOGIS'  Description of S		Treatmo		Charge		nt Paid by	
		METRIST/0	Description of S				Charge			
		Exami	Description of S				Charge			
		Exami	Description of S				Charge			
		Exami Type o	Description of S		Code		Charge			
		Exami Type o	Description of S		Code	GCT	Charge			
Diagnosis	Date of Service	Exami Type o	Description of S	TOTAL CHARC	Code	GCT GCT				
Diagnosis	Date of Service	Exami Type o	Description of S  nation  of Lens s	TOTAL CHARC	Code	GCT GCT				
Diagnosis  16. CERTIFICATION	Date of Service  ON - THIS FORM	Exami Type o Frame	Description of S  nation  of Lens s	TOTAL CHARCE PROVIDER OR	Code	GCT GCT				
Diagnosis  16. CERTIFICATION	Date of Service  ON - THIS FORM	Exami Type o Frame	Description of S ination of Lens s	TOTAL CHARCE PROVIDER OR	Code	GCT GCT				
Diagnosis  16. CERTIFICATION	Date of Service  ON - THIS FORM	Exami Type o Frame	Description of S ination of Lens s	TOTAL CHARCE PROVIDER OR	Code	GCT GCT				
Diagnosis  16. CERTIFICATION  I hereby certify that the second of the se	Date of Service  ON - THIS FORM the above services	Exami Type o Frame	Description of S ination of Lens s  BE SIGNED BY TH ed by date, have beer	TOTAL CHARCE PROVIDER OR	Code  (GE PLUS (	GCT GCT IZED PERSO				
Diagnosis  16. CERTIFICATION  I hereby certify that the second of the se	Date of Service  ON - THIS FORM	Exami Type o Frame	Description of S ination of Lens s  BE SIGNED BY TH ed by date, have beer	TOTAL CHARCE PROVIDER OR completed.	Code  (GE PLUS (	GCT GCT IZED PERSO		Pa		
Diagnosis  16. CERTIFICATION  I hereby certify that the second se	ON - THIS FORM the above services.  Provider Stamp	Exami Type of Frame  Must H	Description of S ination of Lens s  BE SIGNED BY TH ed by date, have beer	TOTAL CHARCE PROVIDER OR completed.	Code  (GE PLUS (	GCT GCT IZED PERSO		Pa		
Diagnosis  16. CERTIFICATION  I hereby certify that the properties of the properties	Date of Service  ON - THIS FORM the above services  Provider Stamp  ORIGINAL RECE	Exami Type of Frame  A MUST F , as indicat	Description of S  nation  of Lens  s  BE SIGNED BY TH  ed by date, have been  Signature	TOTAL CHARCE PROVIDER OR completed.  of Provider or Authors of CLAIMS	Code  (GE PLUS (AUTHOR	GCT GCT IZED PERSO	ON	Pa		