ATTACH ITEMIZED BILLS AND RETURN THIS FORM TO:

TELEPHONE (800) 877-2528

Zenith American
SOLUTIONS
1325 N. Grand Ave., Suite 200 • Covina, Ca. 91724

ORANGE COUNTY FIRE AUTHORITY

Complete the following section for processing of your dental or vision claim

TO BE COMPLETED BY EMPLOYEE

NAME OF PARTICIPANT				DATE OF BIRTH	SEX
HOME ADDRESS	NO. & STREET	CITY	STATE	ZIP CODE	
PARTICIPANT'S SOCIAL SECURITY NO.			ENROLLED DATE		

TO BE ANSWERED IF CLAIM IS THE RESULT OF AN ACCIDENTAL BODILY INJURY

WHERE DID THE ACCIDENT HAPPEN	DATE OF ACCIDENT
DESCRIBE THE ACCIDENT, TELL HOW AND WHEN IT HAPPENED.	

OTHER INSURANCE **THIS QUESTION MUST BE ANSWERED BEFORE CLAIM CAN BE PROCESSED.**

Is the expense of this claim covered by any other group insurance, or any other arrangement of coverage for individuals in a group?

☐ Yes ☐ No IF "YES", ANSWER THESE QUESTIONS FULLY

Name of Insurance Company_____ Policy Number _____

Address of Insurance Company_____ Name of Insured_____

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer, having information avalible as to diagnosis, treatment and prognosis, with respect to any physical or mental condition and/or treatment of me, or my minor children, to give to American Benefit Plan Administrators, Inc. thr group insurance carrier, or their legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by American Benefit Plan Administrators, Inc. to determine eligibility for benefits under an existing policy. Any information obtained will not be released by American Benefit Plan Administrators, Inc. to any person or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may futher authorized.

I KNOW that I may request to request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid one year from from the date shown below.

I AGREE to reimburse the Plan of any over payment made to me or in my behalf due to error.

Signed this_____ day of _____ 20_____

_____
SIGNATURE OF CLAIMANT PARTICIPANT

PARTICIPANT INFORMATION

PATIENT NAME | PATIENT'S DATE OF BIRTH

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICAN OR SUPPLIER FOR SEVICE DESCRIBED BELOW

SIGNED *(Participant)* | DATE

TO BE COMPLETED BY THE DOCTOR OR PROVIDER OF VISION CARE SERVICE

	NO	YES
INCLUDING TONOMETRY	☐	☐
INCLUDING REFRACTION	☐	☐

$______ EXAMINATION

$______ FRAMES

ADMINISTRATIVE USE ONLY

DATE SERVICE BEGAN ______ DATE SERVICE COMPLETED ______

IS THIS A REPLACEMENT? YES ☐ NO ☐

IF "YES", PLEASE GIVE REASON FOR REPLACEMENT ______

ONE	TWO	
☐	☐	LENSES-SINGLE VERSION
☐	☐	LENSES - BIFOCAL
☐	☐	LENSES - TRIFOCAL
☐	☐	LENSES - CONTACT
☐	☐	LENSES - LENTICULAR

PRINT OR TYPE DOCTOR'S OR PROVIDER'S NAME

DOCTOR'S OR PROVIDER'S ADDRESS

CITY - STATE - ZIP DEGREE

DOCTOT'S OR PROVIDERS SIGNATURE TELEPHONE NUMBER TOTAL CHARGES $ ______

☐ FIRST PAYMENT

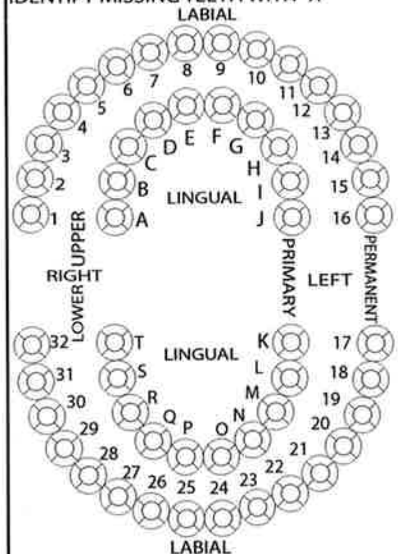
INDIVIDUAL PRACTITIONERS S.S. #____ ____ ____ ALL OTHERS - EMPLOYEE I.D. $ ____ ____DATE ____

☐ OTHER

DENTIST'S INFORMATION

				NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
1. DENTIST'S NAME			9. IS TREATMENT RESULT OF OCCUPATIONAL INJURY?			
2. MAILING ADDRESS			10. IS TREATMENT RESULT OF AUTO ACCIDENT?			
			11. OTHER ACCIDENT?			
CITY, STATE, ZIP			12. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
3. DENTIST SOC. SEC OR T.I. NO.	4. DENTIST LICENSE NO.	5. DENTIST PHONE NO.	13. IF PROTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACMENT) DATE OF PRIOR PLACEMENT
6. FIRST VISIT DATE	7. PLACE OF TREATMENT OFFICE HOSP. ECS OTHER	8. RADIOLOGY OR MODELS ENCLOSED NO YES HOW MANY	14. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED MOS.TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



15. EXAMINATION AND TREATMENT RECORD, LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICES INCLUDING X-RAYS. PROPHYLAXIS, MATERIALS USED FOR GRIDGEWORK: INDICATES WHETHER FIXED OR REMOVABLE	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	DO NOT USE THIS COLUMN

14. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED.

DENTIST'S SIGNATURE______ DATE:______

CARRIER USE ONLY

ELIGIBILITY VERIFIED BY______ DATE:______ CLAIM NUMBER______

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER%	
CARRIER PAYS	
PATIENT PAYS	