



**Federal
Health
Plan**

Submit claims electronically to: Payor ID 37259

Mail claims to: **SAMBA**
11301 Old Georgetown Road
Rockville, MD 20852-2800
(301) 984-1440 • (800) 638-6589

Standard Option Dental Claim Form

*To be completed by the member **AND** the service provider*

Member and Patient Information – to be completed by the member			
Member Name <i>(Last, First, MI)</i>	Member ID	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
Member Address <i>(Street, City, State, Zip)</i>			Daytime Telephone
Patient Name <i>(Last, First, MI)</i>	Patient's relationship to member <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
Patient Address <i>(Street, City, State, Zip)</i>			
Is this claim covered by any other group or dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide member name <i>(Last, First, MI)</i> If yes, provide other insurance carrier name and address		Policy Number
I hereby certify that the information shown is correct. I authorize release of any information related to this claim to the Plan and any of its authorized representatives.		I authorize payment of benefits directly to the provider of the services listed.	
Member's Signature _____	Date _____	Member's Signature _____	Date _____

Exam and Treatment Information – to be completed by dentist or attach itemized bill									
Provider Name <i>(First, Middle Initial, Last)</i>		Is treatment result of occupational illness or injury?		No	Yes	If yes, enter brief description and dates			
Mailing Address		Is treatment result of auto accident?							
City	State	Zip	Other accident?						
Provider FTIN or SSN		Dentist License Number		Provider Telephone Number					
Dentist – Check One <input type="checkbox"/> Pretreatment estimate <input type="checkbox"/> Statement of actual services		Tooth No. or Letter	Surface	DESCRIPTION OF SERVICES <small>(Including, X-Rays, Prophylaxis, Materials Used, etc.)</small>		Date Service Performed Mo Day Yr	A.D.A. Procedure Code	Fee	

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for these procedures.

Dentist's Signature _____ Date _____