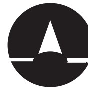
ATTACH ITEMIZED BILLS AND RETURN THIS FORM TO:



TELEPHONE (800) 877-2528

Zenith American
SOLUTIONS

9121 W. Russell Road, Suite 219 • Las Vegas, NV 89148

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

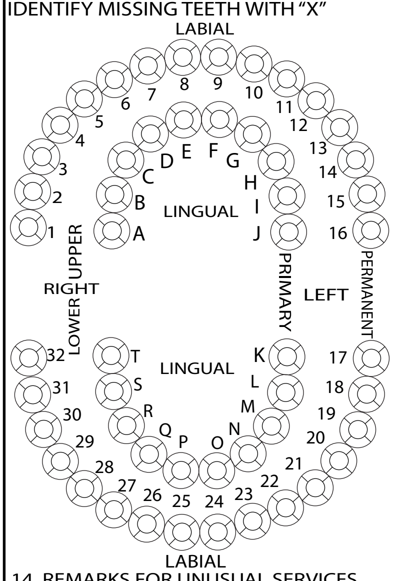
☐ OTHER

INDIVIDUAL PRACTITIONERS S.S. # _____ _____ _____ ALL OTHERS - EMPLOYEE I.D. $ _____ _____ DATE _____

DENTIST'S INFORMATION

				NO	YES	
1. DENTIST'S NAME			9. IS TREATMENT RESULT OF OCCUPATIONAL INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
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: _____

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

CARRIER USE ONLY

ELIGIBILITY VERIFIED BY _____ DATE: _____ CLAIM NUMBER _____