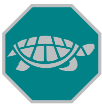


BRITCAY

Dental Insurance Claim Form

1. CERTIFICATE NUMBER | 2. GROUP NUMBER | 3. PATIENT'S NAME (Last Name, First Name, Middle Initial)

4. PATIENT'S DATE OF BIRTH DD | MM | YY

5. PATIENT'S SEX Female Male

6. PATIENT'S RELATIONSHIP TO EMPLOYEE Self Spouse Child Other Explain:

7. INSURED'S NAME (Last Name, First Name, Middle Initial)

8. DAYTIME TELEPHONE NUMBER (Include Area Code)

INSURED'S ADDRESS (Street and Apt. or Box Number)

9. IS PATIENT COVERED UNDER OTHER DENTAL INSURANCE? YES ☐ NO ☐

If yes, name of other Insurance: Name of Policy Holder: Other Policy ID Number:

10. WAS PATIENT'S CONDITION DUE TO: Work related accident? Yes ☐ No ☐ An auto accident? Yes ☐ No ☐ Other accidental injury? Yes ☐ No ☐ Was another party at fault? Yes ☐ No ☐

If yes, give the date of accident: DD | MM | YY Please attach a statement with details indicating when, where and the manner in which the injury occurred.

11. **THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED.** I certify that the above information is correct and apply for benefits under my dental coverage with BritCay. I authorize any dentist or physician in possession of information concerning the patient to furnish such information to BritCay upon request.

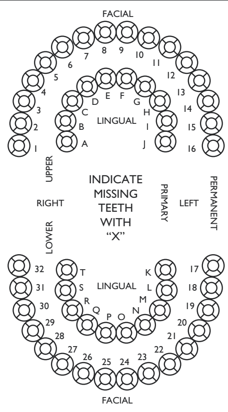
Signature of Employee or Spouse Date DD | MM | YY

12. ASSIGNMENT OF BENEFITS: (Please see the reverse side of this form for further information.) Yes ☐ No ☐ If "yes" is marked, I authorize BritCay to pay benefits directly to the provider of the services listed below.

Signature of Employee or Spouse Date DD | MM | YY The policy may, at its discretion, accept or deny an assignment of benefits.

TO BE COMPLETED BY DENTIST

(See instructions on reverse)



13. MISSING TEETH: Identify missing teeth on chart with an "X". Indicate by tooth number, the date each tooth was lost or extracted, if known:

TOOTH DATE DD | MM | YY TOOTH DATE DD | MM | YY TOOTH DATE DD | MM | YY

14. ORTHODONTIA: Is orthodontic treatment included in the services listed below? Yes ☐ No ☐ If yes, is this initial treatment? Yes ☐ No ☐

Date appliance was placed: DD | MM | YY Expected completion date of treatment: DD | MM | YY Total charge for active treatment:$

15. CROWNS, BRIDGES AND DENTURES: Do services include the replacement of a prosthesis? Yes ☐ No ☐ If yes, was the original prosthesis? Yes ☐ No ☐
See item 20 on the back of this form for x-ray requirements.

Reason for replacement: Original damaged ☐ Lost/Stolen ☐ Other (Explain) ☐

Indicate date of original placement or restoration and original teeth involved: DD | MM | YY Tooth Number(s)

16. Do charges include a consultation? Yes ☐ No ☐ If yes, name of referring provider
A report from the consulting specialist is required. See item 16 on the back of this form for additional information required for a consultation.

17. Description of Services (See instructions on reverse.)

Date of Service DD MM YY	A.D.A. Procedure Code	Detailed Description of Services	Tooth # or Letter	Surfaces	No. of Time Perf.	Place of Treatment Office, Hospital, EFC, Other	Charge

18. Please check the appropriate box.

☐ PREDETERMINATION OF BENEFITS: The treatment listed is necessary in my professional judgement and I request Estimate of Eligible Benefits. Note: Dentist's Tax ID Number or Social Security Number is required.

☐ WORK COMPLETED – PAYMENT REQUESTED: I certify that the services have been performed by me or under my personal supervision and are necessary in my professional judgment. Charges shown are my usual charges.

19. TOTAL CHARGE

20. ARE X-RAYS ENCLOSED? Yes ☐ No ☐
(See item 20 on the back of this form.)

DENTIST SIGNATURE DATE DD | MM | YY

DENTIST NAME ADDRESS PHONE TAX ID # OR SSN

BRITISH CAYMANIAN INSURANCE AGENCIES LIMITED
BritCay House, 236 Eastern Avenue, George Town P.O. Box 74 Grand Cayman KY1-1102 Cayman Islands
tel. (345) 949 8699 fax. (345) 945 0658 medical@britcay.ky www.britcay.ky

A member of Colonial Group International Ltd.
insurance, health, pensions, life

Dental Insurance Claim Form

GENERAL INFORMATION

Use this claim form to submit a claim for services which are covered under your dental program. To avoid delay in having your claim processed, please complete a separate claim form for each patient, and be sure that all information is complete and correct. Items 1 through 12 of this form must be completed by the subscriber or spouse, and items 13 through 21 are to be completed by the dentist.

When the claim form has been completed and signed, please mail or deliver it to: **BritCay**
P. O. Box 74
Grand Cayman
KY1 – 1102
The Cayman Islands

INSTRUCTIONS FOR COMPLETING PATIENT AND SUBSCRIBER INFORMATION

Items 1-11: Complete all items as indicated on the front of the form.

Item 9: Please check yes or no in item 9. If yes, please provide information requested regarding your other dental insurance coverage. If payment has been received from another insurance company, please attach a copy of their Explanation of Benefits.

Item 12: ASSIGNMENT OF BENEFITS – If you would like benefits due you for this claim sent directly to the dentist, complete item 12 on the reverse side of this form.

INSTRUCTIONS FOR COMPLETING DENTIST INFORMATION

Item 13: MISSING TEETH – Each claim for services involving missing or extracted teeth must include the information requested in item 13. To assist us in updating our records, with the submission of an initial oral exam, please include a complete charting of the patient's dentition.

Item 14: ORTHODONTIA – Claims for orthodontic services must include the information requested in item 14. It is not necessary for the orthodontic treatment to be completed before submitting the claim.

Item 15: CROWNS, BRIDGES, AND DENTURES – Please complete this information on any claim for a crown, bridge or denture. See item 20 below for x-ray requirements.

Item 16: CONSULTATIONS – Claims for consultations must include a report from the consulting specialist indicating the name of the referring dentist or physician, the reason for the consultation, the treatment being considered and a description of the patient's oral condition.

Item 17: ADA PROCEDURE CODES – American Dental Association codes

TOOTH NO. OR LETTER – Refer to tooth chart on front of this claim form.

SURFACES – Use the following codes to identify tooth surfaces:
B = Buccal or facial D = Distal O = Occlusal
M = Mesial I = Incisal L = Lingual

PLACE – Please check the appropriate column on the claim form to indicate the place of service:
Off = Office IN = Inpatient Hospital OP = Outpatient Hospital

CHARGE – Indicate the individual charge for each service listed.

Item 18: DENTIST'S CERTIFICATION AREA – Please check the appropriate box to indicate whether the services listed have been completed. The dentist's signature and telephone number must also be completed in item 18.

PREDETERMINATION OF BENEFITS – If no dates of service are indicated on the claim, we will provide an estimate of the benefits available for the services listed. The estimates are based on the information we have at the time the claim is reviewed. Estimates will be subject to eligibility, deductibles, and Plan maximums. Therefore, they may be affected by other payments made between the time the estimate is given and the time that the services are rendered. Actual payments will be made in the order that claims are received.

If you are requesting a Predetermination of Benefits, mark the Predetermination of Benefits box in item 18. In addition the dentist's name, address, and Tax ID Number or Social Security Number must be clearly written in item 21 of this claim form.

Item 20: X-RAYS – Postoperative x-rays are required for the review of claims for root canals. These x-rays are also needed to review claims for posts and cores following the root canals. Pre-operative x-rays are required for review of claims for crowns, crown build-ups, bridges, partial dentures and apicoectomies. For periodontal procedures, we need the most recent pre-operative x-rays and complete periodontal charting of the teeth involved in the treatment. We may also occasionally request x-rays for certain other procedures. All x-rays will be returned to the dentist's after the claim has been reviewed. To expedite the processing of your claim and to assist us in the return of the x-rays, please include the patient's name and identification number as well as the dentist's name and address on the x-ray or x-ray envelope.

Item 21: Each claim must include the dentist's name, address and Tax ID Number or Social Security Number. Please also check the appropriate box in item 21 to indicate the type of identification number used.