1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL OR FAX TO:

Prodegi
P.O. Box 98
Worland, Wyoming 82401

Toll 800-246-4622
Fax 307-347-6227

Dental Claim Form

THIS FORM IS TO BE COMPLETED BY EMPLOYEE

PARTICIPANT'S NAME	PARTICIPANT'S ID NUMBER	NAME OF EMPLOYER	
HOME STREET ADDRESS	EMPLOYEE DATE OF BIRTH	IS PATIENT FULL-TIME STUDENT? YES ☐ NO ☐	NAME & ADDRESS OF SCHOOL
CITY & STATE ZIP	IS PATIENT COVERED BY MEDICARE? YES ☐ NO ☐	PHONE NUMBER	

PATIENT NAME (IF OTHER THAN EMPLOYEE)	MALE ☐ FEMALE ☐	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE	IS PATIENT MARRIED? YES ☐ NO ☐

FOR ADDITIONAL INFORMATION DURING BUSINESS HOURS, 8:00 A.M. TO 5:00 P.M., MY SPOUSE MAY BE REACHED AT:

TELEPHONE:______________________ LOCATION:______________________

MY SPOUSE''S NAME:

DATE ACCIDENT/ SICKNESS BEGAN	IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?	WAS MOTOR VEHICLE INVOLVED? YES ☐ NO ☐	DID ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐

NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL CALL	PHYSICIAN'S NAME

ARE YOU, THE PATIENT OR THE SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS. YES ☐ NO ☐	NAME AND ADDRESS	POLICY NUMBER

IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

A AUTHORIZATION TO RELEASE INFORMATION:

I certify that this information is complete and accurate and authorize release of medical information necessary to process this claim. A photocopy of this authorization shall be valid as the original.

X______________________
Patient or Parent (If minor) Date

B AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X______________________
Patient or Parent (If minor) Date

PROCEDURE FOR FILING A MEDICAL CLAIM

I. Complete "Employee" portion of the Medical Claim Form.
   a. If the patient is your dependent be sure to complete all questions, including if married and a full-time student.
   b. It is important to know when, how and where your accident, illness or disability began, especially if it is job-related.
   c. If payment is to be made to provider, you must always sign Section B.
   d. Patient (or parent if patient is a minor) must always sign Section A. A claim form cannot be processed without this authorization and verification.

II. Make a final check to ensure that all parts of the "Employee" portion of the claim form are complete.

III. If primary coverage is through another insurance, submit your claim to them first. When you receive their payment statement or denial letter send that information with all bills and this form to Prodegi (for assistance in determining primary insurance, contact customer service).

IV. Attach all medical bills related to the claim.
   a. Make sure all bills identify patient and always include your policy number.
   b. All bills should show date of treatment, type of service, diagnosis and amount of charges.
   c. Prescription drug bills should be on regular receipts, showing name and address of pharmacy, name of patient, date of purchase, prescription number, name of medication and charge.

V. Submit this form, with medical bills attached, to Prodegi, P.O. Box 98, Worland, Wyoming 82401.