CLAIM NO.

OFFICE USE ONLY

PUPIL BENEFITS PLAN, INC.

Student accident insurance
101 Dutch Meadows Lane
Glenville, NY 12302
TELEPHONE (518) 377-5144
1-800-393-3301
FAX (518) 377-3291
www.pupilbenefits.com

pupil benefits plan, inc.
Insuring students since 1932

DENTAL CLAIM FORM

SCHOOL SECTION

1. The school authority shall complete the top portion of this claim form. **Please MAIL ORIGINAL claim form and print legibly.**
2. Give original form to the pupil or send to the parent, along with a parent information brochure. The parent must mail original form to us.

Please Print Legibly

School District (full name) Baldwinsville Central School District

School Contact _____ **Phone #** _____ **Grade** _____

Student's Name _____ **DOB** _____

Date of Injury ___/___/___ **Bodily Part Injured** _____

☐ Interscholastic Sport _____
☐ Non-Interscholastic _____
☐ School-Sponsored Activity _____

☐ Game ☐ Practice ☐ Scrimmage
☐ Noon Hour Rec ☐ Intramural
☐ Phys. Ed. ☐ Classroom ☐ Other

State exactly what student was doing and how the injury was sustained: _____

Was activity supervised by an employee of the district? ☐ Yes ☐ No

I certify that the above named student was enrolled in our district and verify the accident occurred as stated above.

Signature of principal or designated school authority: _____ **Date** _____

Please print name of school authority: Kimberly Vile **Title:** Asst. Supt.

PROVIDER SECTION

Please attach your itemized bill showing dates, types of treatment, charges, source and amounts of payments received to date. Balance due statements and receipts are not sufficient and will not be accepted. If other insurance is available, explanation of benefits or rejection notice for all charges must be attached. Expenses resulting from an accidental dental injury must be submitted to your medical coverage for accidental dental. Remaining expenses should then be submitted to your dental coverage, if available.

Please have Dental office complete this section. Thank you.

1. State exactly which teeth were involved by number _____ Date of First Treatment _____
2. Nature of teeth prior to date of injury. Sound & Natural ☐ Deciduous ☐ Permanent ☐ Previously Restored ☐
3. I certify that the care and services submitted with this form have been rendered to the patient.
   Signature (Attending Physician) X _____ Date _____
4. Please print name of attending physician _____ Social Security or Tax ID # _____
5. Address _____ City _____ Zip Code _____
   Dental Claims Classified as "Open Dental" are eligible for benefits until 90 days after graduating or leaving school.
6. Please indicate if future restorations will be needed. State treatment and approximate date _____
7. Indicate names of other Insurance Carriers (including medical) for accidental dental _____

MULTIPLAN
Call
1-800-546-3887
For network
Referral.

Claims must be filed with us in a timely manner.
Pupil Benefits Plan, Inc. is primary to Medicaid and Child Health Plus.

ZELIS
1-908-658-3535

PARENT SECTION

BENEFITS PAID ONLY IN EXCESS OF THOSE OF FAMILY and/or EMPLOYER POLICY(S).

TO FILE A CLAIM, USE THE FOLLOWING PROCEDURE:

1. Parent shall first complete the box below. Parent shall make claim under family and/or employer policy(s).
2. For charges in excess of payments under other policy(s) **submit by MAIL:**
   - A. Completed **ORIGINAL** claim form-**Copies or faxes of original claim form are not acceptable.**
   - B. Itemized bills– Receipts and balance due statements are not sufficient; they will not be accepted.
   - C. Copy of explanation of benefits or rejection of benefits from primary insurance. --MEDICAL AND DENTAL (If accidental dental injury) .
   - D. If no other coverage is available, comply with steps A & B.
3. **Please submit claim form in a timely manner in order to establish a claim number.**
4. **Expenses resulting from an accidental dental injury must be submitted to your medical coverage first for accidental dental. Remaining expenses should then be submitted to your dental coverage, if available.**
5. **Pupil Benefits Plan, Inc. is primary to Medicaid and Child Health Plus.**

ALL ITEMS MUST BE ANSWERED, DO NOT LEAVE BLANKS

(if not applicable, answer "none")

PLEASE PRINT LEGIBLY/ N/A IS NOT ACCEPTABLE

AS OF DATE OF INJURY:

Legal Names: (PARENT/GUARDIAN #1) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email address: _____

(PARENT/GUARDIAN #2) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email address: _____

Is this child insured under other insurance coverage? ☐ **yes** ☐ **no** **Medicaid #** _____

Child Health Plus # _____

Name of Insurance Carriers:

Medical #1 _____ **ID#** _____ **Phone#** _____

Medical #2 _____ **ID#** _____ **Phone#** _____

Dental _____ **ID#** _____ **Phone#** _____

Name and Address of Employers, At the time of the injury:

PARENT/GUARDIAN #1 Company _____

Address _____ City _____ State _____ Zip _____

PARENT/GUARDIAN #2 Company _____

Address _____ City _____ State _____ Zip _____

I authorize Pupil Benefits Plan to issue benefits in connection with this claim directly to the doctor, hospital or any other person rendering services, and such payment shall release Pupil Benefits Plan from liability as to amounts so paid.

Please pay providers. (check YES box)

☐ **Yes**

Please pay ME, the parent or guardian. I have already paid the providers on these charges. (check NO box)

☐ **No**

I hereby certify that I have read the answers to all parts of this form and attest that all information supplied is accurate and truthful.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE AND DATE REQUIRED:

Signature of Parent or Guardian X _____ **Date** _____

Please print name: _____

EXCLUSIONS: NO BENEFITS SHALL BE PROVIDED FOR:

1. Cosmetic surgery, (cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma) sickness, disease, orthodontia treatment.
2. Intentionally self inflicted injuries.
3. Injuries sustained during participation in a felony, riot or insurrection.

LIMITATIONS:

1. No benefits will be paid unless the first treatment has been provided within 90 days from the date of injury.
2. No benefits will be paid for treatment after 3 years have elapsed from the date of injury. (Except Open Dental)
3. Covered expenses are payable up to the maximum of policy in force; maximum aggregate dental benefits will be limited to $1000.00 when treatment extends over 12 months from the date of injury.

Pupil Benefits Plan, Inc. does not have relationships with any third party, affiliated or non-affiliated, where nonpublic financial or health information could be exchanged. Our privacy policy applies to all products and services. All information will be protected as required by law.