Dental Claim Form And Instructions

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION.
PRECERTIFICATIONS ARE NOT REQUIRED FOR YOUR DENTAL POLICY. If you have any questions about completing this form, call us at 866-387-0484 7:00 A.M. to 5:30 P.M. Central Standard Time.

INSTRUCTIONS FOR FILING DENTAL CLAIM

- All claims must be submitted on an American Dental Association (ADA) Claim Form: a form is attached to these instructions.
- Please ask your dentist's office to complete the entire form. Blank fields will cause the claim processing to be delayed. We must have the following information:
  - The policyowner's Dental policy number.
  - The policyowner's complete name as it appears on the Dental Plan ID card.
  - The patient's full name, sex, date of birth and relationship to the policyowner.
  - The treatment date, tooth or surface, ADA code and charge for each procedure.
  - The patient's Social Security Number.
- If you are filing for the initial benefit under the Orthodontic Rider, the patient must be a covered dependent child less than 17 years of age. There is a two-year waiting period before benefits are payable under the Orthodontic Rider.
- You may **fax** your claim to us at **608-373-9503**.
- You may **mail** your claim to: **Assurant Health**
  P.O. Box 2829
  Clinton, IA 52733-2829
- Additional claim forms are available at www.voluntarymart.com.

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1. ☐ Dentist's pre-treatment estimates Specialty (see backside)
☐ Dentist's statement of actual services

2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT

3. Carrier Name **Assurant Health**
Fax Number: 608-373-9503

4. Carrier Address **PO Box 2829**

5. City **Clinton** **6.** State IA 7. ZIP **52733-2829**

PATIENT

8. Patient Name (Last, First, Middle)
9. Address
10. City
11. State
12. Date of Birth (MMDDYYYY) ______/______/______
13. Patient ID # / SSN #
14. Sex ☐ Male ☐ Female
15. Phone Number ( )
16. ZIP Code
17. Relationship to Subscriber/Employee:
☐ Self ☐ Spouse ☐ Child ☐ Other ______________________________
18. Employer/School
Name ______________________________
Address ______________________________

SUBSCRIBER/EMPLOYEE

19. Subs. SSN#
20. Employer Name
21. Policy#
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City
26. State
27. ZIP
28. Date of Birth (MMDDYYYY) ______/______/______
29. Marital Status ☐ Married ☐ Single ☐ Other
30. Sex ☐ Male ☐ Female
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.
X______________________________
Signed (Patient/Guardian) Date (MMDDYYYY)

OTHER POLICIES

31. Is patient covered by another plan? 32. Policy #
☐ No (Skip 32-37) ☐ Yes ☐ Dental or ☐ Medical
33. Other Subscriber's Name
34. Date of Birth (MMDDYYYY) ______/______/______
35. Sex ☐ Male ☐ Female
36. Plan Program Name
37. Employer/School
Name ______________________ Address ______________________
38. Subscriber/Employee Status
☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student
40. Employer/School
Name ______________________ Address ______________________
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X______________________________
Signed (Employee/Subscriber) Date (MMDDYYYY)

BILLING DENTIST

42. Name Of Billing Dental Or Dental Entity
43. Phone Number ( )
44. Provider ID#
45. Dental SS# or T.I.N.
46. Address
47. Dental License #
48 First visit date of current series
49. Place of Treatment ☐ Office ☐ Hosp ☐ ECF ☐ Other
50. City
51. State
52. ZIP Code
53. Radiographs or models enclosed? ☐ Yes, how many?______ ☐ No
If service already commenced: Total months of treatment
Date appliances placed:______________________ Remaining______________
Date of prior placement ______________________
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No If no, reason for replacement.
56. If prosthesis (crown, bridge, dentures), is this initial placement? Brief description and dates: ☐ Yes ☐ No
____
57. Is treatment result of: ☐ Auto Accident? ☐ Other accident? ☐ Neither
Brief description and dates:
____

58. Diagnosis Code Index (optional)

1.________ 2.________ 3.________ 4.________ 5.________ 6.________ 7.________ 8.________

59. Examination and treatment plans. List teeth in order.

Date (MMDDYYYY)	Tooth	Surface	Diagnosis Index#	Procedure Code	Qty	Description	Fee	Admin. Use Only
							Total Fee	

60. Identify all missing teeth with X

Permanent		Primary	
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	A B C D E	F G H I J
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	T S R Q P	O N M L K

Payment By Other Plan	
Max. allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services.

62. I hereby certify that the procedures as indicated by date are in progress for procedures that require multiple visits or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X______________________________
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed.
64. City
65. State
66. ZIP Code

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company and John Alden Life Insurance Company.
Form 30037 (4/2009)