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.

• You may fax your claim to us at 608-373-9503.

• You may mail your claim to: Assurant Supplemental Coverage
  P.O. Box 2829
  Clinton, IA 52733-2829

• Additional claim forms are available at assuranthealth.com.
1. ☐ Dentist’s pre-treatment estimates
☐ Dentist’s statement of actual services

2. ☐ Medicaid Claim
☐ Prior Authorization #
☐ EPSDT

3. Carrier Name
Assurant Supplemental Coverage
Fax Number: 608-373-9503

4. Carrier Address
P.O. Box 2829

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

8. Patient Name (Last, First, Middle)
9. Address

10. City
11. State

12. Date of Birth (MM/DD/YYYY)
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

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 (MM/DD/YYYY)
29. Marital Status
30. Sex
☐ Male ☐ Female

31. Is patient covered by another plan?
☐ No (Skip 32-37) ☐ Yes ☐ Dental or ☐ Medical

32. Policy #
☐ No (Skip 32-37) ☐ Yes ☐ Dental or ☐ Medical

33. Other Subscriber’s Name

34. Date of Birth (MM/DD/YYYY)
35. Sex
36. Plan Program Name

37. Employer/School Name

38. Subscriber/Employee Status
☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student

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 (MM/DD/YYYY)

40. Employer/School Name

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 (MM/DD/YYYY)

42. Name Of Billing Dentist 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

54. If service already commenced: Total months of treatment

55. If prosthesis (crown, bridge, dentures), is this initial placement?
☐ Yes ☐ No

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 (MM/DD/YYYY) Tooth Surface Diagnosis Index# Procedure Code Qty Description Fee

60. Identify all missing teeth with X

Permanents

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

Payment By Other Plan

Max. allowable

61. Remarks for unusual services.

Deductible
Carrier %
Carrier pays
Patient pays

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. 30037 (Rev. 12/2012) © 2012 Assurant, Inc. All rights reserved.
FRAUD WARNING NOTICES:

For states not listed below: 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 subject such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

DC, Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon: A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files claim containing false, incomplete, or misleading information may be prosecuted under state law.

Tennessee & Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.