

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.
 - $\circ\,$ 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 Health
 P.O. Box 2829
 Clinton, IA 52733-2829
- Additional claim forms are available at www.assuranthealth.com.

□ Dentist's pre-treatment estimates											3. Carrier Name Assurant Health Fax Number: 866-387-0486										
2. ☐ Medicaid Claim Prior Authorization #											4. Carrier Address PO Box 2948										
□ EPSDT											5. City Milwau				ee		6. Stat	te WI	7. ZIP 53 2	201	
PATIENT	8. Patient Name (Last, First, Middle) 9. Address													10. City				11.	State		
	12. Date of Birth (MMDDYYYY) 13. Patient ID # / SSN #							14. Sex			15. Phone Number				16.	16. ZIP Code					
	17. Relationship to Subscriber/Employee:										□ Male □ Female ()										
									Naı	NameAddress											
느	□ Self □ Spouse □ Child □ Other								Add		-										
	19. Subs. SSN# 20. Employer Name				2	21. Policy#				31. Is patient covered by another plan? □ No (Skip 32-37) □ Yes □ Dental or □ Medical											
SUBSCRIBER/EMPLOYEE	22. Subscriber/Employee Name (Last, First, Middle)									OTHER POLICIES	33. Other Subscriber's Name										
	23. Address 24. Phone Number							R P(34. Date of Birth			35. Sex			36. Plan Program Name						
						()				(MMDDYYYY)					☐ Male ☐ Female					
	25. City			2	26. State		27. ZIP		37. Employer/School Name				,	٨٨	dross	,					
	28. Date of Birth 29. Marital Status				tus	30. Sex					NameAddress										
	(N	MDDY /	YYY) ' /		Married □] Single	□ Othe		Male Female		☐ 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										40. Employer/School										
		paid	l by my der	ntal bene	fit plan, unl	ess the	treating de	entist or	dental			hereb				the denta		its other	wise payabl	e to me	
	practice has a contractual agreement with my plan prohibiting all or a portion of such charges.										directly to the below named dental entity.										
	Sig	gned (Patient/G	uardian)				Date (M	MDDYYYY)		Signed (Employee/Subscriber) Date (MMDDYYYY)										
	42. Name Of Billing Dentist Or Dental Entity 43. Ph									one 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												
BILLING DENTIST	50. City 51. State 52. ZIF				te 52. ZIP C] 3 !				If service already commenced: Total months of treatment											
	enclosed?																				
BILLIN	55. If prosthesis (crown, ☐ Yes If no, reason for replacement bridge, dentures), is this ☐ No initial placement?									t.	Date of prior placement										
	56. If prosthesis (crown, bridge, dentures), is this initial placement? Brief description and dates: No										57. Is treatment result of: ☐ Auto Accident? ☐ Other accident? ☐ Neither Brief description and dates:										
58	Di	agnos	is Code Ind	ley (ontio	nal)																
58. Diagnosis Code Index (optional)																					
59	1. 2. 3. 4. 59. Examination and treatment plans. List teeth in order.								_	<u> </u>								Admin	. Use Only		
					Tooth Surface		Diagnosis Ind		lex# Procedur		ode Qty		Desc	cription			Fee		,		
	4																				
	4																				
			L													-					
60	. Id	entify	all missing	g teeth wi Permane							Prima	ry				Total Fe	9				
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 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 Max.																					
32	31	30 2	9 28 27 2	26 25 24	23 22 21	20 19	18 17	Т	S R Q	Р		0	N M	L K		Max. allowabl	e				
61	. Re	marks	for unusu	al service	es.										Deductib Carrier 9						
																Carrier p					
62	. 11	nerehv	certify th	at the pro	ocedures as	indicate	ed by date	are in pr	ngress for n	roce	dures	that	require	multinle	63 A	Patient p		atment	was perform	ned.	
02	vi	sits or	have been	n complet	ed and that										03. A	aui (23 W	icie ue	aunent.	was periorii	icu.	
collect for those procedures. 64. City													65. State	66. ZIP Code							
X_																					
Sig	X Signed (Treating Dentist) License # Date (MM/DD/YYYY)											YY)	1								