



Dental Claim Form Instructions

Fax completed form to 1-855-400-9307

Questions? 1-888-729-5433, Ext. 2013
Mon. – Fri. 7:30 am to 8:30 pm
Sat. 9:00 am to 3:00 pm (CST)

Missing or inaccurate information on claim forms will cause delays in claim processing. The following blocks are required for reimbursement:

Part I. Information Provided by Employee:

- Block 1 — Patient's name (the person who received services)
- Block 2 — Patient's relationship to the insured
- Block 3 — Patient's gender
- Block 4 — Patient's date of birth
- Block 5 — Insured's name (the insured) and date of birth
- Block 6 — Insured's Social Security Number
- Block 7 — Insured's mailing address
- Block 8 — *Complete only if the dependent is over the age of 19*
- Block 9 — Employer's information
- Block 10 — Group number
- Block 11 — *Provide information only if the patient is covered by another insurance carrier*
 - a. Left signature line must be signed
 - b. Right signature line is signed **only if the reimbursement goes to the provider** (leave blank if the reimbursement goes to the insured)

Pretreatment Estimate of Benefits

A Pretreatment Estimate of Benefits lets you know in advance what your benefits will be. Before signing a course of treatment, have your dentist estimate the charges and submit for a pretreatment estimate. This will eliminate misunderstanding and let both you and your dentist know what the plan will pay. If your dental coverage terminates for any reason during treatment, only the procedures performed before the dental coverage terminated will be eligible for payment. We suggest you read the complete certificate and become acquainted with the benefits offered by your dental insurance. Actual payment will be based on available benefits at time of claims payment

We recommend a pretreatment estimate if your dental work will cost \$300 or more.

Part II. Information Provided by Dentist:

- Block 12 & Block 13 — Provider's name and mailing address
- Block 14 — Provider's Federal Tax ID Number
- Block 16 — Provider's telephone number

*** Proof of Payment is required for reimbursement.** A copy of a bill or statement can be attached with the claim form, if it includes type of services rendered, when the services were performed and the charged amounts.

Part III: You may submit your Dental Claim form in the following ways:

Mail:

AlwaysCare Dental
P.O. Box 80139
Baton Rouge, LA 70898-4389

Email:

Claims@AlwaysCareBenefits.com

Fax:

Local: (225) 400-9307
Toll Free: (855) 400-9307

Electronic Payer ID:

STR01

GROUP DENTAL CLAIM FORM
PART 1 – TO BE COMPLETED BY EMPLOYEE



Group Claim Office
P. O. Box 80139, Baton Rouge, LA 70898-0139
Toll Free No.: 1-888-729-5433 (B.R. 926-2888)

| | | | |
|--|--|---|--------------------------------------|
| 1. Patient's Full Name (First, Middle Initial, Last) _____ | 2. Relationship to Employee Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | 3. Sex M <input type="checkbox"/> F <input type="checkbox"/> | 4. Patient Birthdate Mo. Day Year |
| 5. Employee's Full Name (First, Middle Initial, Last) _____ | Employee's Birthdate Mo. Day Year | 6. Employee's Social Security Number | |
| 7. Employee's Mailing Address (Street, City, Zip) Street or P. O. Box _____ City, State, Zip _____ | 8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER. Is patient a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of School _____ Address of School _____ | | |
| 9. Employee's Company Name and Address _____ | 10. Group No. _____ | Div. No. _____ | Cert. No. _____ |

QUESTION 11. MUST BE COMPLETED WITH EACH CLAIM SUBMISSION

11. Is patient covered by another dental plan? Yes No If yes, Employer/Plan Name _____ Policy Number _____
 Name and Address of Insurance Carrier _____
 If yes, please complete below:

| | | | | |
|------------------|---|-------------------------------|----------------------------|-------------------------------|
| Name of Insured: | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child | Date of Birth Mo. Day Year | Social Security Number | Name and Address of Employer: |
|------------------|---|-------------------------------|----------------------------|-------------------------------|

I have reviewed the treatment plan, and I authorize release of any information relating to this claim. I understand I am responsible for all cost of dental treatment. I certify these statements to be true and complete to the best of my knowledge. I understand that 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. All work covered on this form has been completed.

I hereby authorize payment direct to the below named dentist of the group insurance benefits otherwise payable to me.

_____/_____/_____
 Signed (Patient, or parent if minor) _____ Date _____

_____/_____/_____
 Signed (Insured Person) (If signed here, signature also needed in box on left.) _____ Date _____

PART 2 – TO BE COMPLETED BY ATTENDING DENTIST – Please provide ADA Procedure Number to ensure accurate benefit determination.

| | |
|--|--|
| Name of Patient: _____ | DENTIST – CHECK ONE: <input type="checkbox"/> Pretreatment Estimate <input type="checkbox"/> Statement of Actual Services Has all work been completed? Y___N___ |
| Name of Insured Person: _____ | |
| 12. Dentist Name and 13. Mailing Address _____ | 20. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates. 21. Is treatment result of Auto Accident? 22. Other Accident? 23. Are any services covered by another plan? 24. If Prosthesis, is this initial placement? (If no, reason for replacement) Date of prior placement |
| 14. Dentist Soc. Sec. Or TIN | 15. Dentist License # _____ 16. Dentist Phone # _____ |
| 17. First Visit Date Current Series _____ | 18. Place of Treatment Office Hosp ECF Other |
| 19. Radiographs or Models enclosed? No Yes How Many? | 25. Is treatment for Orthodontics? Enter date appliances placed, if services already commenced. _____/_____/_____ Months of treatment remaining: _____ |

| Identify Missing Teeth with "X" Remarks for unusual services. | Tooth No. or Letter | Surfaces | DESCRIPTION OF SERVICES (including X-rays, Prophylaxis, Materials used, etc.) | ADA Procedure Number | Date Service Performed | | | Fee | |
|---|---------------------|----------|---|----------------------|------------------------|-----|-----|-----|--|
| | | | | | Mo. | Day | Yr. | | |
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CERTIFICATION: I certify that the services listed above have been completed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

TOTAL FEE CHARGED \$ _____

_____/_____/_____
 SIGNED (DENTIST) _____ DATE _____