



PO BOX 1028  
HOUSTON, TX 77251-1028  
800-653-4427  
PAYER ID#: CX032

## DENTAL CLAIM NOTICE

CHECK ONE:

- ☐ PRE DETERMINATION ESTIMATE  
☐ STATEMENT OF ACTUAL SERVICES  
☐ EPSDT / TITLE XIX

### PART 1 – EMPLOYEE – READ INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE

1. PATIENT NAME		2. PATIENT RELATIONSHIP TO EMPLOYEE SELF   SPOUSE   CHILD   OTHER		3. SEX M   F		4. PATIENT BIRTHDATE MO   DAY   YEAR		5. IF FULL TIME STUDENT NAME OF SCHOOL CITY	
6. EMPLOYEE NAME FIRST MIDDLE LAST		7. EMPLOYEE ID NO.							
9. EMPLOYEE MAILING ADDRESS					10. EMPLOYER (COMPANY) NAME AND ADDRESS				
CITY, STATE, ZIP					11. IS THIS CLAIM COVERED UNDER PATIENT'S MEDICAL CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SUBMIT MEDICAL EXPLANATION OF BENEFITS.				
12. GROUP NUMBER		13. ARE OTHER FAMILY MEMBERS EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE: EMPLOYEE NAME ID NO.			14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13				
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE:		DENTAL CARRIER		GROUP NO.		PHONE NO. AND ADDRESS OF CARRIER			
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.  SIGNED (PATIENT OR PARENT IF MINOR) DATE					I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE DENTAL PLAN BENEFITS OTHERWISE PAYABLE TO ME.  SIGNED (EMPLOYEE) DATE				

### PART 2 – DENTIST – READ INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE

16. DENTIST NAME		27. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
17. MAILING ADDRESS		28. IS TREATMENT RESULT OF AUTO ACCIDENT?					
18. CITY, STATE, ZIP		29. OTHER ACCIDENT?					
19. DENTIST PHONE NO.		20. DENTIST SOC SEC OR TIN NO.		30. ARE SERVICES RELATED TO TMJ?			
21. DENTIST LICENSE NO.		22. NPI		23. PROVIDER SPECIALTY CODE		31. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
24. FIRST VISIT DATE CURRENT SERIES		25. PLACE OF TREATMENT OFFICE   HOSP   ECF   OTHER		26. RADIOGRAPHS OR MODELS ENCLOSED?		32. DATE OF PRIOR PLACEMENT	
				NO	YES	33. IS TREATMENT FOR ORTHODONTICS?	
						IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

<p>INDICATE MISSING TEETH WITH AN X</p>	34. EXAMINATION AND TREATMENT PLAN – LIST IN DATE ORDER					
	TOOTH OR LETTER	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO DAY YEAR	ADA PROCEDURE NUMBER	FEE
35. REMARKS FOR UNUSUAL SERVICES						
TOTAL FEE					\$	

### PART 3

I HEREBY CERTIFY THAT SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE NAMED PATIENT ON THE DATES INDICATED AND THAT THE FEES SHOWN ARE THOSE CURRENTLY CHARGED TO THE MAJORITY OF MY PATIENTS.

SIGNED (DENTIST)

DATE

MUST BE FURNISHED UNDER AUTHORITY OF LAW WHEN BENEFITS ASSIGNED.

THE PLAN BENEFITS INDICATED WILL BE PAYABLE IF THE SERVICES LISTED ABOVE ARE PERFORMED WHILE THE PATIENT IS COVERED UNDER THIS PLAN. SUBJECT TO THE COORDINATION OF BENEFITS WITH OTHER PLANS, MEDICAL COVERAGE, TIMELY FILING, AND OTHER PLAN PROVISIONS.

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. (Except in D.C., Florida, Georgia, Kansas, Kentucky, Louisiana, Maine, Maryland, Nebraska, New Jersey, New Mexico, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Virginia, Vermont & Washington) In D.C., Louisiana & Rhode Island, 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. In Georgia, Kansas, Nebraska, Oregon & Utah, 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 may be guilty of insurance fraud (as determined by a court of law - in the state of Kansas). In Kentucky, any person who knowingly and with intent to defraud any insurance company or other person files a claim for insurance 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. In Maine & 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. In Maryland, any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. In New Jersey, any person who includes any false or misleading information on a claim for an insurance policy is subject to criminal and civil penalties. In 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. In Pennsylvania, 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 subjects such person to criminal and civil penalties. In Tennessee, 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 coverage. In Vermont, 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, may be proven guilty of fraud or may be found guilty of fraud.

In 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.

In Texas, 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 may be guilty of insurance fraud as determined by a court of law.

## **INSTRUCTIONS FOR FILING DENTAL CLAIMS**

### **INSTRUCTIONS TO EMPLOYEE**

Complete Part 1 in full (please type or print). Incomplete information may delay servicing of your claim.

Give this form to your dentist after you have completed Part 1.

If services will exceed \$300 you may request your dentist to submit a Pre-Determination Estimate to the Claim Department. The Claim Department will advise your dentist and yourself what the Plan will pay.

### **INSTRUCTIONS TO DENTISTS OFFICE**

Complete the Dentists portion of the claim form.

Have the employee sign the payment authorization block if payment is to be made directly to your office and forward original to the address shown on reverse.

If you are requesting a Pre-Determination of plan benefits, retain a copy of the Dental Claim Notice you have forwarded. Your office, and the employee will receive an explanation of benefits from the claim department. After the services have been performed, forward a copy of the Dental Claim Notice to the address shown on the reverse indicating the dates of service and any changes in the services originally reported.