

dental

group claim form

Group Claim Office / P.O. Box 82520 / Lincoln, NE 68501-2520
 Toll Free 800.487.5553 / Fax 402.467.7336 / Web ameritasgroup.com
 Ameritas' payer ID for electronic claims is 47009.



PART 1 – TO BE COMPLETED BY EMPLOYEE

For faster payment, submit electronically!

1. Patient's full name (first, middle initial, last)		2. Patient birthdate (MM/DD/YY)		3. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
5. Employee's full name (first, middle initial, last)		6. Employee's identification number		Employee's birthdate (MM/DD/YY)			
7. Employee's mailing address (Street address or P.O. Box, City, State, ZIP) Email address				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 and address of school			
9. Employer (company) name and address		10. Group number		Division number		Certificate number	
QUESTIONS 11 AND 12 MUST BE COMPLETED WITH EACH CLAIM SUBMISSION							
11. Is patient covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				Name and address of other carrier		Policy number	
12. Other employee/subscriber name				Employee/subscriber identification number		Date of birth (MM/DD/YY)	
13. I have reviewed the following treatment plan, and I authorize release of any information relating to this claim. I understand that I am responsible for all cost of dental treatment. I certify these statements to be true and complete to the best of my knowledge.				14. I hereby authorize payment directly to the below named dentist of group insurance benefits otherwise payable to me.			
X Signature (patient, or parent if minor)				Date		X Signature (insured person)	
				Date			

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

PART 2 – TO BE COMPLETED BY ATTENDING DENTIST. Please provide Current Dental Terminology © American Dental Association procedure codes.

15. Dentist name and mailing address			For Yes answers to questions 18-20, enter a brief description and dates.				
			18. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No				
			19. Is treatment result of auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Specialist designation		Phone #	General anesthesia permit #		20. Other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email		Fax number		21. If Prosthesis, is this initial placement? If no, reason for replacement, and date of prior replacement			
16. Dentist SSN or TIN		NPI (National Provider Identifier)	License #		22. Is treatment for orthodontics? If services already have begun, enter date appliances were placed, and months remaining		
17. Radiographs or models enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No How many?				23. This is a (please check one): <input type="checkbox"/> Statement of actual services <input type="checkbox"/> Pretreatment estimate			

24. EXAMINATION AND TREATMENT RECORD							
Tooth number, letter, quadrant or arch	Surfaces	DESCRIPTION OF SERVICES (including x-rays, prophylaxis, materials used, etc)	CDT © ADA Procedure Code	Date Service Performed			Fee
				Month	Day	Year	

25. Remarks for unusual services				26. Total fee charged		\$0.00	
27. CERTIFICATION: I hereby certify that the services listed above have been performed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.						28. Address where treatment was performed	
X Signature (Dentist)						Date	