ASSURANT Health®

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

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1. ☐ Dentist's pre-treatment estimates Specialty (see backside)
☐ Dentist's statement of actual services

2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT

3. Carrier Name **Assurant Health**
Fax Number: 866-387-0486

4. Carrier Address **PO Box 2948**

5. City **Milwaukee** 6. State **WI** 7. ZIP **53201**

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State

12. Date of Birth (MMDDYYYY) ______/______/______ | 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 ________________________________
Address ________________________________

SUBSCRIBER/EMPLOYEE

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 (MMDDYYYY) ______/______/______ | 29. Marital Status ☐ Married ☐ Single ☐ Other | 30. Sex ☐ Male ☐ Female

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 (MMDDYYYY)

OTHER POLICIES

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

33. Other Subscriber's Name

34. Date of Birth (MMDDYYYY) ______/______/______ | 35. Sex ☐ Male ☐ Female | 36. Plan Program Name

37. Employer/School
Name ________________________ Address________________________

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

40. Employer/School
Name ________________________ Address________________________

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 (MMDDYYYY)

BILLING DENTIST

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

If service already commenced: Total months of treatment
Date appliances placed:______________________ Remaining__________________

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

Date of prior placement
____

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 (MMDDYYYY)	Tooth	Surface	Diagnosis Index#	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with X

Permanent		Primary	
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
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

	Fee	Admin. Use Only
Total Fee		
Payment By Other Plan		
Max. allowable		
Deductible		
Carrier %		
Carrier pays		
Patient pays		

61. Remarks for unusual services.

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

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