Dental Claim Statement

* Required Field

Clear fields

ASSURANT Employee Benefits

Check one: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

A Pretreatment Estimate is requested (not mandatory) by policy provisions for non-emergency treatment plans, $200.00 or $200.00 (See contracts). Utilization of this feature will forewarn a claimant if a certain item or service has limited or no coverage available. A pretreatment estimate is not a guarantee of payment.

PATIENT COVERAGE INFORMATION

1 Patient name * First M.I. Last

2 Relationship to employee ☐ Self ☐ Child ☐ Spouse ☐ Other _____

3 Sex M F

4 Patient birthdate MO DAY YR

5 If full-time student School City

6 Employee/subscriber name and mailing address

7 Employee/subscriber Soc. Sec. or I.D. no.

8 Employee/subscriber birthdate MO DAY YR

9 Employer (company) name and address

10 Group number

11 Is patient covered by another dental plan? ☐ Yes ☐ No If "Yes," complete 12-a. Is patient covered by a medical plan? ☐ Yes ☐ No

12-a Name and address of carrier(s)

12-b Group no(s).

13 Name and address of other employer(s)

14-a Employee/subscriber name *(if different than patient's)*

14-b Employee/subscriber Soc. Sec. or I.D. no.

14-c Employee/subscriber birthdate MO DAY YR

15 Relationship to patient ☐ Self ☐ Parent ☐ Spouse ☐ Other _____

NOTE: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. (I understand that I am responsible for all costs of dental treatment.) This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

▶ SIGNED (PATIENT OR PARENT, IF MINOR) DATE

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named entity.

▶ SIGNED (INSURED PERSON) DATE

BILLING DENTIST

16 Name of Billing Dentist or Dental Entity

17 Address where payment should be remitted

City, State, Zip

18 Dentist Soc. Sec. or TIN

19 Dentist license no.

20 Dentist phone no.

21 First visit date current series

22 Place of treatment Office Hosp ECF Other

23 Radiographs or models enclosed? No Yes How many?

24 Is treatment result of occupational illness or injury? No Yes If "Yes," enter brief description and dates.

25 Is treatment result of auto accident? No Yes

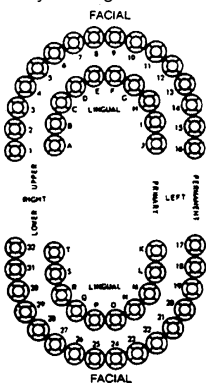
26 Other accident? No Yes

27 If prosthesis, is this initial placement? No Yes If "No," reason for replacement

28 Date of prior placement

29 Is treatment for orthodontics? No Yes If services already commenced, enter Date appliances placed Mos. treatment remaining

Identify missing teeth with "**X**"



30 Examination and treatment plan—List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of Service *(including x-rays, prophylaxis, materials used, etc.)*	Date Service Performed Mo Day Year	Procedure Number	Fee

31 Remarks for unusual services

For administrative use only

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

Total Fee Charged	
Max. allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York.

Union Security Life Insurance Company of New York

Administered by: **Assurant Employee Benefits** PO Box 2941 Clinton Iowa 52733