

# 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](http://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<br><input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other |  | 4. Sex<br><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)                                                                                                                                                                                              |  | 8. THIS SECTION MUST BE COMPLETED WITH EACH CLAIM SUBMISSION ONLY IF THE CLAIM IS FOR A DEPENDENT CHILD AGE 19 OR OVER<br>Is patient a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                |  | Name and address of other carrier                                                                                                                                                                                                                        |  | Policy number                                                                                                                                              |  | Name and address of other employer                              |  |
| 12. Other employee/subscriber name                                                                                                                                                                                                                                        |  | Employee/subscriber identification number                                                                                                                                                                                                                |  | Date of birth (MM/DD/YY)                                                                                                                                   |  | Relationship to patient                                         |  |
| 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<br>Signature (patient, or parent if minor) _____ Date _____                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                          |  | X<br>Signature (patient, or parent if minor) _____ Date _____                                                                                              |  |                                                                 |  |

### 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                                                                                 |  |  | 20. Other accident? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                           |  |  |
| Phone #                                                                                                |  |  |                                                                                                                                                                                                  |  |  |
| General anesthesia permit #                                                                            |  |  |                                                                                                                                                                                                  |  |  |
| Email                                                                                                  |  |  | 21. If Prosthesis, is this initial placement? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If no, reason for replacement, and date of prior replacement                 |  |  |
| Fax number                                                                                             |  |  |                                                                                                                                                                                                  |  |  |
| 16. Dentist SSN or TIN                                                                                 |  |  | 22. Is treatment for orthodontics? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If services already have begun, enter date appliances were placed, and months remaining |  |  |
| NPI (National Provider Identifier)                                                                     |  |  |                                                                                                                                                                                                  |  |  |
| License #                                                                                              |  |  |                                                                                                                                                                                                  |  |  |
| 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<br>(including x-rays, prophylaxis, materials used, etc) | CDT © ADA<br>Procedure Code | Date Service Performed |     |      | Fee |
|                                        |          |                                                                                 |                             | Month                  | Day | Year |     |
|                                        |          |                                                                                 |                             |                        |     |      |     |
|                                        |          |                                                                                 |                             |                        |     |      |     |
|                                        |          |                                                                                 |                             |                        |     |      |     |
|                                        |          |                                                                                 |                             |                        |     |      |     |
|                                        |          |                                                                                 |                             |                        |     |      |     |
|                                        |          |                                                                                 |                             |                        |     |      |     |

|                                                                                                                                                                                                                 |  |  |                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------|--|
| 25. Remarks for unusual services                                                                                                                                                                                |  |  | 26. Total fee charged                     |  |
| 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<br>Signature (Dentist) _____ Date _____                                                                                                                                                                       |  |  |                                           |  |

# tips

## how to speed claims processing

### part 1 – employee

Missing or incomplete information will slow down claims processing.  
To avoid this, please be sure to include:

**#2 Patient birthdate**

Helps identify an insured and determine dependent eligibility.

**#6 Employee's identification number**

This is the most important identifier for the plan member.

**#8 Student status**

Because this information often changes, it is required on every claim for dependents age 19 years and older.

**#11 and #12 Coordination of benefits for dental**

The "No" box under #11 should be checked if no other **dental** coverage exists. If there is other dental coverage, the additional information requested is necessary for coordination of benefits. This information is required on every claim.

### part 2 – dentist

Some dental claims require dental consultant review for accurate processing.  
To help expedite the claims process, please be sure to include:

**#16 National Provider Identifier**

There are two types of NPI. Type 1 is for individual providers who operate independently. Type 2 is for health care providers such as group practices or corporations including incorporated dental practices. Type 2 organization providers may want their individual provider employees to have Type 1 NPIs to distinguish them individually.

**#17 and #24 Supporting Documentation**

In addition to the following list, narratives or photos also may be submitted. Documents should be dated and legible. Original radiographs will be returned. Please label duplicate films left and right. All supporting documentation should be current within one year. Procedure codes listed are based on CDT © ADA.

- Pre-operative radiographs for D2510-D2664, D6600-D6634, D2710-D2794, D6710-D6794, D6205-D6252, D2950, D6973, D2952-D2954, D6970-D6972, D2960-D2962, D3346-D3348, D3351-D3353 and D6010.
- Pre-operative radiographs and legible surgical notes for D7210-D7241.
- Legible surgical notes only for D7310-D7321.
- Numerical 6-point periodontal charting for D4210-D4211, D4240-D4241, D4341-D4342 and D4381.
- Radiographs and numerical 6-point periodontal charting for D4260-D4261 and D4263-D4264.
- Gingival grafting procedures and measurements for D4270-D4271, D4273, D4275 and D4276.

**#21 Prosthesis - Initial or Replacement**

Required for crowns, onlays, bridges and partial or complete dentures.  
If a replacement, prior placement date is needed.

**#23 Statement of actual services, or Pretreatment estimate**

Appropriate box should be marked to ensure correct handling.

**#24 Tooth number, letter, quadrant or arch**

Site-specific information is required using the Universal/National Tooth Numbering System.

### pretreatment

#### estimate of benefits

We recommend a pretreatment estimate of benefits when a plan member considers the dental work to be expensive. A pretreatment estimate lets both the member and dental provider know in advance how much insurance will pay.

If dental coverage terminates for any reason during treatment, only procedures performed before coverage ended will be eligible for payment.

For full information regarding coverage, plan members may refer to their insurance plan booklet.

### website

Visit our website for benefit information, electronic forms, a dental provider list and more.

Please note, the free software Adobe Reader® (available through the internet) is needed to view and print the electronic forms.

### electronic claims and attachments

Dental providers, with electronic claims we can process the same day received and send a check within seven business days. Plus, most software can submit claims and attachments while simultaneously creating accounting records. For more information, please visit the following websites:

[ndedic.org](http://ndedic.org)  
[ez2000dental.com](http://ez2000dental.com)  
[nea-fast.com](http://nea-fast.com)

# fraud warning statements

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive any insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas:** 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.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**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.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana:** A person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Louisiana:** 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.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

**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.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638.20

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**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.

**New York:** 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.

**Ohio:** 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.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**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.

**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.

**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 insurance benefits.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Virginia:** 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.

**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.

**If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim are provided by the claimant.