Allstate HEALTH SOLUTIONS

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 the number listed on your id card 7:00 A.M. to 6:00 P.M. Central Standard Time.

INSTRUCTIONS FOR FILING DENTAL CLAIMS

- 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.

Please refer to the back of your ID card for claim submission information

1. ☐ Dentist's pre-treatment estimates Specialty (see backside) ☐ Dentist's statement of actual services	3. Carrier Name
2. ☐ Medicaid Claim Prior Authorization # ☐ EPSDT	4. Carrier Address 5. City | 6. State | 7. ZIP

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	Payment By Other Plan	
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	Max. allowable	

Total Fee		
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

FRAUD WARNING NOTICES:

For states not listed below: 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 subject such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an 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 false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, District of Columbia & West Virginia: Warning **-** 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 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, Idaho & Oklahoma: Warning - 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.

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.

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

Kansas: Any person who knowingly files a statement of claim containing any misrepresentation or any false,incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: A 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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Virginia & 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 may include imprisonment, fines or a denial of insurance benefits.

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

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.

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.