

Dental Claim Statement



ASSURANT Employee Benefits

Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Carrier name and address: Assurant Employee Benefits, PO Box 2940, Clinton, IA 52733-2940 T 800.442.7742
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PATIENT COVERAGE INFORMATION	1 Patient name First M.I. Last	2 Relationship to employee <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete 12-a. Is patient covered by a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____		

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 Insurance Company to use and disclose protected health information.

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

_____ DATE
SIGNED (PATIENT OR PARENT, IF MINOR)

_____ DATE
SIGNED (INSURED PERSON)

BILLING DENTIST	16 Name of Billing Dentist or Dental Entity				24 Is treatment result of occupational illness or injury? No Yes				If "Yes," enter brief description and dates.			
	17 Address where payment should be remitted				25 Is treatment result of auto accident?							
	City, State, Zip				26 Other accident?							
	18 Dentist Soc. Sec. or TIN		19 Dentist license no.		20 Dentist phone no.		27 If prosthesis, is this initial placement?		If "No," reason for replacement		28 Date of prior placement	
	21 First visit date current series	22 Place of treatment Office Hosp ECF Other		23 Radiographs or models enclosed? No Yes How many?		29 Is treatment for orthodontics?		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.							For administrative use only	
	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	Total Fee Charged
_____ DATE SIGNED (TREATING DENTIST)	_____ Max. allowable
_____ LICENSE NUMBER	_____ Deductible
_____ DATE	_____ Carrier %
	_____ Carrier pays
	_____ Patient pays

A pre-treatment estimate is recommended for non-emergency treatment plans to forewarn a claimant if a certain item or service has limited or no coverage available.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

If you live in the states of Alaska or Oregon, the following statement applies to you:

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.

If you live in the states of Arizona or New Jersey, the following statement applies to you:

A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island the following statement applies to you:

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.

If you live in the state of California, the following statement applies to you:

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.

If you live in Colorado, the following statement applies to you:

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia the following statement applies to you:

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.

If you live in New Hampshire, the following statement applies to you:

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 in RSA 638:20.

If you live in New York the following statement applies to you:

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 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.

If you live in Minnesota, the following statement applies to you:

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

If you live in Texas, the following statement applies to you:

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.

If you live in a state other than mentioned above, the following statement applies to you:

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.