

## 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 855-323-4750 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.
  - The patient's Social Security Number.
- You may **fax** your claim to us at **317-284-7281**.
- You may **mail** your claim to: **National General Accident & Health**  
**P.O. Box 3252**  
**Milwaukee, WI 53201-3252**

1. <input type="checkbox"/> Dentist's pre-treatment estimates Specialty (see backside) <input type="checkbox"/> Dentist's statement of actual services		3. Carrier Name <b>National General Accident &amp; Health</b> Fax Number: 317-284-7281	
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT		4. Carrier Address <b>P.O. Box 3252</b>	
9. Address		5. City <b>Milwaukee</b>	6. State <b>WI</b>
8. Patient Name (Last, First, Middle)		7. ZIP <b>53201-3252</b>	10. City
11. State		12. Date of Birth (MMDDYYYY) ____/____/____	
13. Patient ID # / SSN #		14. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
15. Phone Number ( )		16. ZIP Code	
17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		18. Employer/School Name _____ Address _____	

  

<b>SUBSCRIBER/EMPLOYEE</b>	19. Subs. SSN#	20. Employer Name	21. Policy#	<b>OTHER POLICIES</b>	31. Is patient covered by another plan? <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes <input type="checkbox"/> Dental or <input type="checkbox"/> Medical		32. Policy #		
	22. Subscriber/Employee Name (Last, First, Middle)				33. Other Subscriber's Name				
	23. Address		24. Phone Number ( )		34. Date of Birth (MMDDYYYY) ____/____/____	35. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		36. Plan Program Name	
	25. City	26. State	27. ZIP		37. Employer/School Name _____ Address _____				
28. Date of Birth (MMDDYYYY) ____/____/____		29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		30. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student			
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) _____				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) _____	

  

<b>BILLING DENTIST</b>	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 <input type="checkbox"/> Office <input type="checkbox"/> Hosp <input type="checkbox"/> ECF <input type="checkbox"/> Other	49. Total months of treatment				
	50. City	51. State	52. ZIP Code	53. Radiographs or models enclosed? <input type="checkbox"/> Yes, how many? _____ <input type="checkbox"/> No		53. If no, reason for replacement.
54. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No			54. Date appliances placed: _____ Remaining _____		54. Date of prior placement	
55. If prosthesis (crown, bridge, dentures), is this initial placement? Brief description and dates: <input type="checkbox"/> Yes <input type="checkbox"/> No			55. Is treatment result of: <input type="checkbox"/> Auto Accident? <input type="checkbox"/> Other accident? <input type="checkbox"/> Neither			
55. Brief description and dates:						55. 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.								Admin. Use Only																				
Date (MMDDYYYY)	Tooth	Surface	Diagnosis Index#	Procedure Code	Qty	Description	Fee																					
60. Identify all missing teeth with X							Total Fee																					
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		
61. Remarks for unusual services.							Deductible																					
							Carrier %																					
							Carrier pays																					
							Patient pays																					
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.