Dental Claim Form Instructions

Fax completed form to 1-855-400-9307

Questions? 1-888-729-5433, Ext. 2013
Mon. – Fri. 7:30 am to 8:30 pm
Sat. 9:00 am to 3:00 pm (CST)

Missing or inaccurate information on claim forms will cause delays in claim processing. The following blocks are required for reimbursement:

Part I. Information Provided by Employee:

Block 1 — Patient's name (the person who received services)
Block 2 — Patient's relationship to the insured
Block 3 — Patient's gender
Block 4 — Patient's date of birth
Block 5 — Insured's name (the insured) and date of birth
Block 6 — Insured's Social Security Number
Block 7 — Insured's mailing address
Block 8 — *Complete only if the dependent if over the age of 19*
Block 9 — Employer's information
Block 10 — Group number
Block 11 — *Provide information only if the patient is covered by another insurance carrier*

a. Left signature line must be signed
b. Right signature line is signed **only if** the reimbursement goes to the provider (leave blank if the reimbursement goes to the insured)

Pretreatment Estimate of Benefits

A Pretreatment Estimate of Benefits lets you know in advance what your benefits will be. Before signing a course of treatment, have your dentist estimate the charges and submit for a pretreatment estimate. This will eliminate misunderstanding and let both you and your dentist know what the plan will pay. If your dental coverage terminates for any reason during treatment, only the procedures performed before the dental coverage terminated will be eligible for payment. We suggest you read the complete certificate and become acquainted with the benefits offered by your dental insurance. Actual payment will be based on available benefits at time of claims payment

We recommend a pretreatment estimate if your dental work will cost $300 or more.

Part II. Information Provided by Dentist:

Block 12 & Block 13 — Provider's name and mailing address
Block 14 — Provider's Federal Tax ID Number
Block 16 — Provider's telephone number

*** Proof of Payment is required for reimbursement.** *A copy of a bill or statement can be attached with the claim form, if it includes type of services rendered, when the services were performed and the charged amounts.*

Part III: You may submit your Dental Claim form in the following ways:

Mail:
AlwaysCare Dental
P.O. Box 80139
Baton Rouge, LA 70898-4389

Email:
Claims@AlwaysCareBenefits.com

Fax:
Local: (225) 400-9307
Toll Free: (855) 400-9307

Electronic Payer ID:
STR01

GROUP DENTAL CLAIM FORM
PART 1 – TO BE COMPLETED BY EMPLOYEE

AlwaysCare

Group Claim Office
P. O. Box 80139, Baton Rouge, LA 70898-0139
Toll Free No.: 1-888-729-5433 (B.R. 926-2888)

1. Patient's Full Name (First, Middle Initial, Last)	2. Relationship to Employee: Self / Spouse / Child / Other	3. Sex: M / F	4. Patient Birthdate: Mo. / Day / Year

5. Employee's Full Name (First, Middle Initial, Last)	Employee's Birthdate: Mo. / Day / Year	6. Employee's Social Security Number

7. Employee's Mailing Address (Street, City, Zip)

Street 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.

Is patient a full time student? ☐ Yes ☐ No

If yes, Name of School_____

Address of School_____

9. Employee's Company Name and Address	10. Group No.	Div. No.	Cert. No.

QUESTION 11. MUST BE COMPLETED WITH EACH CLAIM SUBMISSION

11. Is patient covered by another dental plan? ☐ Yes ☐ No If yes, Employer/Plan Name_____ Policy Number_____

Name and Address of Insurance Carrier_____

If yes, please complete below:

Name of Insured:	Relationship: ☐ Spouse ☐ Child	Date of Birth: Mo. / Day / Year	Social Security Number	Name and Address of Employer:

I have reviewed the treatment plan, and I authorize release of any information relating to this claim. I understand I am responsible for all cost of dental treatment. I certify these statements to be true and complete to the best of my knowledge. I understand that 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. All work covered on this form has been completed.

_____ _____/_____/_____
Signed (Patient, or parent if minor) Date

I hereby authorize payment direct to the below named dentist of the group insurance benefits otherwise payable to me.

_____ _____/_____/_____
Signed (Insured Person) (If signed here, signature also needed in box on left.) Date

PART 2 – TO BE COMPLETED BY ATTENDING DENTIST – Please provide ADA Procedure Number to ensure accurate benefit determination.

Name of Patient:

Name of Insured Person:

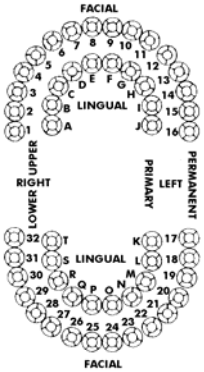
DENTIST – CHECK ONE:
☐ Pretreatment Estimate
☐ Statement of Actual Services
Has all work been completed? Y____N____

12. Dentist Name and 13. Mailing Address	20. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.
	21. Is treatment result of Auto Accident?			
	22. Other Accident?			
	23. Are any services covered by another plan?			

14. Dentist Soc. Sec. Or TIN	15. Dentist License #	16. Dentist Phone #	24. If Prosthesis, is this initial placement?		(If no, reason for replacement) Date of prior placement

17. First Visit Date Current Series	18. Place of Treatment: Office / Hosp / ECF / Other	19. Radiographs or Models enclosed?	No	Yes	How Many?	25. Is treatment for Orthodontics?		Enter date appliances placed, if services already commenced. ____/____/____ Months of treatment remaining:_____

Identify Missing Teeth with "X"
Remarks for unusual services.



Tooth No. or Letter	Surfaces	DESCRIPTION OF SERVICES (including X-rays, Prophylaxis, Materials used, etc.)	ADA Procedure Number	Date Service Performed: Mo. / Day / Yr.	Fee
					$

CERTIFICATION: I certify that the services listed above have been completed on the dates indicated and that the fees submitted are the fees I have charged and intend to collect for those purposes.

TOTAL FEE CHARGED $

_____ _____/_____/_____
SIGNED (DENTIST) DATE