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
Ameritas' payer ID for electronic claims is 47009.

AMERITAS
LIFE INSURANCE CORP.

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	4. Sex
		☐ self ☐ spouse ☐ child ☐ other	☐ M ☐ 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
	Is patient a full-time student? ☐ Yes ☐ No
Email address	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? ☐ Yes ☐ 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 _____ _____	**X** _____ _____
Signature (patient, or parent if minor) Date	Signature (insured person) Date

It is fraudulent to fill out this form with information you know to be false or to knowingly omit facts which may have a bearing on the benefits for which you are applying. Criminal and/or civil penalties can result from such acts.

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? . . . . ☐ Yes ☐ No
	19. Is treatment result of auto accident? . . . . ☐ Yes ☐ No

Specialist designation	Phone #	General anesthesia permit #	20. Other accident? . . . . ☐ Yes ☐ No

Email	Fax number	21. If Prosthesis, is this initial placement? . . . . ☐ Yes ☐ No If no, reason for replacement, and date of prior replacement

16. Dentist SSN or TIN	NPI (National Provider Identifier)	License #	22. Is treatment for orthodontics? . . . . ☐ Yes ☐ No If services already have begun, enter date appliances were placed, and months remaining

17. Radiographs or models enclosed? ☐ Yes ☐ No How many?	23. This is a (please check one): ☐ Statement of actual services ☐ Pretreatment estimate

24. EXAMINATION AND TREATMENT RECORD

Tooth number, letter, quadrant or arch	Surfaces	DESCRIPTION OF SERVICES (including x-rays, prophylaxis, materials used, etc)	CDT © ADA Procedure Code	Date Service Performed Month	Day	Year	Fee

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 _____	
Signature (Dentist) Date	

GC 140 Rev. 3-07

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
ez2000dental.com
nea-fast.com