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

AlwaysCare℠
AlwaysDental℠ AlwaysVision℠
A Starmount Life Insurance Company

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

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___

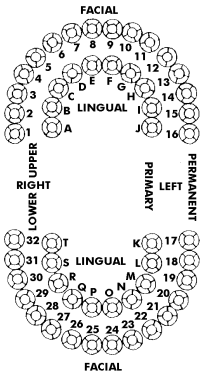
12. Dentist Name and 13. Mailing Address

	No	Yes	
20. Is treatment result of occupational illness or injury?	☐	☐	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?	☐	☐	
24. If Prosthesis, is this initial placement?	☐	☐	(If no, reason for replacement) Date of prior placement
25. Is treatment for Orthodontics?	☐	☐	Enter date appliances placed, if services already commenced. ____/____/____ Months of treatment remaining:_____

14. Dentist Soc. Sec. Or TIN	15. Dentist License #	16. Dentist Phone #

17. First Visit Date Current Series	18. Place of Treatment: Office / Hosp / ECF / Other	19. Radiographs or Models enclosed?	No	Yes	How Many?

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

Clear Form

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. You should review your booklet for full information regarding your coverage.

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

Tips to Speed Claims Processing

Part 1 – Employee

Missing or incomplete responses on claim forms cause delays in processing a claim. The items most frequently left out are:

#4 Date of Birth: Helps identify an insured and determine dependent eligibility.

#6 Social Security Number: This is the most important identifier for the plan member.

#8 Student Status: Required on every claim for a dependent age 19 years and older as student status is subject to change since the last claim was processed.

#11 Coordination of Benefits: The "No" box in Question 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 as required by most group insurance plans. This information is required on every claim as it is subject to change since the last claim was processed.

Signatures: There are two signature lines on the claim form. The left signature line is for the patient to sign which authorizes release of information by the dentist relative to the immediate claim. This signature line must always be signed.

The right signature line should be signed by the plan member if you want Starmount to pay your dentist. If not, this line should be left blank.

Part 2 – Information Provided by Dentist

Films and Charting: Certain procedures are reviewed by our Dental Consultants. Include films with surgical extractions, crowns, inlays, and bridges. Duplicate films should be labeled left and right. All films should be dated. Periodontal charting and/or films are required for all reported periodontal procedures.

If diagnostic films and charts are unavailable, a narrative should be included on, or attached to, the claim.

Prosthesis-Initial or Replacement: Required for crowns, inlays/onlays, bridges, and partial or complete dentures. If prosthesis is a replacement, the prior placement date is needed.

Pretreatment Estimate Or Actual Services: Appropriate box should be marked to ensure correct handling.

Tooth Number or Letters: Site-specific information is required to process claim. This also includes the listing of the specific quadrant or arch, and tooth number in accordance to the ADA coding.