dental Group Claim Form

Ameritas Life Insurance Corp. of New York

Ameritas.

Group Claim Office / P.O. Box 82595 / Lincoln, NE 68501-2595 / Toll Free 800-659-5556 / Fax 402-467-7336 / Web ameritas.com
Ameritas' payer ID for electronic claims is 72630.

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 ☐ Self ☐ Spouse ☐ Child ☐ Other	4. Sex ☐ 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 If Yes, name and address of school:
Email address:	

9. Employer (company) name and address	10. Group number	Division number	Certificate number
	026-301542		

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 _____ Signature (patient, or parent if minor) _____ Date	X _____ Signature (patient, or parent if minor) _____ Date

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 / General anesthesia permit #	20. Other accident? ☐ Yes ☐ No
Phone number / Fax number	21. If Prosthesis, is this initial placement? ☐ Yes ☐ No If no, reason for replacement and date of prior replacement:
Email	22. Is treatment for orthodontics? ☐ Yes ☐ No If services have begun, enter date appliances placed and months remaining:
16. Dentist ☐ SSN ☐ TIN / NPI (Nat. Provider Identifier)	
License # / 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 subm itted are the fees I have charged and Intend to collect for those purposes. X _____ Signature (Dentist) _____ Date	28. Address where treatment was performed