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

AMERITAS LIFE INSURANCE CORP.

Group Claim Office
P.O. Box 82520, Lincoln, NE 68501
Toll Free No.: (800) 487-5553
www.YourDentalSolutions.com

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 and Claimant's Social Security Numbers

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

Street or P.O. Box _____

City, State, Zip _____

Email _____

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. Employer (Company) Name and Address	10. Group No.	Div. No.	Cert. No.
DUKE UNIVERSITY	**G-350003**		

QUESTIONS 11. AND 12. 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 _____

12. Are other family members employed? ❑ Yes ❑ No If yes, please complete the following information for the individual that is employed:

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

I have reviewed the following treatment plan, 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.

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

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

Signed (Insured Person) _____ Date _____

FOR YOUR PROTECTION, ARIZONA LAW, CALIFORNIA LAW, AND THE LAWS OF OTHER STATES REQUIRE THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM: 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 ADA Procedure Number to ensure accurate benefit determination.**

Name of Patient:

Name of Insured Person:

16. Dentist Name and 17. Mailing Address

Specialist Designation: _____

Email: _____ Fax: _____

18. Dentist Soc. Sec. or TIN	19. Dentist License #	20. Dentist Phone #

21. First Visit Date Current Series	22. Place of Treatment: Office / Hosp / ECF / Other	23. Radiographs or Models enclosed? No / Yes / How Many?

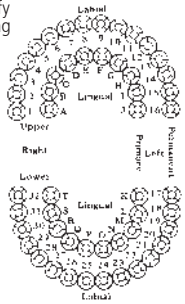
		No	Yes	
24.	Is treatment result of occupational illness or injury?			If yes, enter brief description and dates
25.	Is treatment result of Auto Accident?			
26.	Other Accident?			
27.	Are any services covered by another plan?			
28.	If Prosthesis, is this initial placement?			(If no, reason for replacement) Date of prior placement
29.	Is treatment for Orthodontics?			If services already commenced, enter date appliances placed.

DENTIST - CHECK ONE:

❑ Pretreatment Estimate

❑ Statement of Actual Services

Identify Missing Teeth with "X"



30. Remarks for unusual services

31. EXAMINATION AND TREATMENT RECORD - List in order from tooth No. 1 through No. 31. Use Charting System Shown.

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

TOTAL FEE CHARGED _____

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.

SIGNED (DENTIST) _____ DATE _____

Form approved by the Council on Dental Care Programs of the A.D.A. 1975