dental Group Claim Form

Ameritas Life Insurance Corp. of New York
Dental Claims Adjusters / P.O. Box 82595 / Lincoln, NE 68501-2595
Toll Free 800-659-5556 / Fax 402-467-7336 / Web ameritasgroup.com/ny / Ameritas' payer ID for electronic claims is 72630.

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For faster payment, submit electronically!

PART 1 – TO BE COMPLETED BY EMPLOYEE

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

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.

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

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

PART 2 – TO BE COMPLETED BY ATTENDING DENTIST. Please provide Current Dental Terminology © American Dental Association procedure codes.

15. Dentist name and mailing address

Specialist designation	Phone #	General anesthesia permit #

Email	Fax number

16. Dentist SSN or TIN	NPI (National Provider Identifier)	License #

17. Radiographs or models enclosed? ☐ Yes ☐ No How many?

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

20. Other accident? ☐ Yes ☐ No

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

22. Is treatment for orthodontics? ☐ Yes ☐ No
If services already have begun, enter date appliances were placed, and months remaining

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.

X _____ _____
Signature (Dentist) Date

28. Address where treatment was performed