

Dental Claim Statement



Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services					Carrier name and address: <b>Fortis Benefits Insurance Company</b>					
PATIENT INFORMATION	1 Patient name First M.I. Last		2 Relationship to employee <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____		3 Sex M F	4 Patient birthdate MO DAY YR		5 If full-time student School City		
	6 Employee/subscriber name and mailing address		7 Employee/subscriber Soc. Sec. or I.D. no.		8 Employee/subscriber birthdate MO DAY YR		9 Employer (company) name and address		10 Group number	
PATIENT COVERAGE INFORMATION	11 Is patient covered by another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete 12-a. Is patient covered by a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		12-a Name and address of carrier(s)		12-b Group no(s).		13 Name and address of other employer(s)			
	14-a Employee/subscriber name (if different than patient's)		14-b Employee/subscriber Soc. Sec. or I.D. no.		14-c Employee/subscriber birthdate MO DAY YR		15 Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____			
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 costs of dental treatment.) This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Fortis Benefits Insurance Company to use and disclose protected health information.					I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named entity.					
SIGNED (PATIENT OR PARENT, IF MINOR) _____ DATE _____					SIGNED (INSURED PERSON) _____ DATE _____					
BILLING DENTIST	16 Name of Billing Dentist or Dental Entity				24 Is treatment result of occupational illness or injury?		No	Yes	If "Yes," enter brief description and dates.	
	17 Address where payment should be remitted				25 Is treatment result of auto accident?					
	City, State, Zip				26 Other accident?					
	18 Dentist Soc. Sec. or TIN		19 Dentist license no.		20 Dentist phone no.		27 If prosthesis, is this initial placement?		28 Date of prior placement	
21 First visit date current series		22 Place of treatment Office Hosp ECF Other		23 Radiographs or models enclosed? No Yes How many?		29 Is treatment for orthodontics?		If services already commenced, enter Date appliances placed Mos. treatment remaining		
Identify missing teeth with "X" 		30 Examination and treatment plan—List in order from tooth no. 1 through tooth no. 32—Use charting system shown.						For administrative use only		
		Tooth # or letter	Surface	Description of Service (including x-rays, prophylaxis, materials used, etc.)		Date Service Performed Mo Day Year		Procedure Number	Fee	
31 Remarks for unusual services										
I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.								Total Fee Charged		
SIGNED (TREATING DENTIST)		LICENSE NUMBER		DATE				Max. allowable		
								Deductible		
								Carrier %		
								Carrier pays		
								Patient pays		

Fortis Benefits Insurance Company  
Telephone (800) 442-7742

KC2147A (3/2003)

1. A pre-treatment estimate is recommended for non-emergency treatment plans to forewarn a claimant if a certain item or service has limited or no coverage available.
2. Once the claim statement is completed, it should be mailed to the Benefit Center identified on the back of the Insured's Fortis Benefits Dental Identification Card. If not available, you can obtain the correct address by contacting the Benefit Center closest to you at one of the telephone numbers listed below:

Fortis Benefits Insurance Company  
P.O. Box 2940  
Clinton, IA 52733-2940  
1-800-442-7742

☞ **If you live in the state of Arizona, the following statement applies to you:**

For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

☞ **If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☞ **If you live in the state of California, the following statement applies to you:**

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

☞ **If you live in the state of Colorado, the following statement applies to you:**

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

☞ **If you live in the District of Columbia, the following statement applies to you:**

**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

☞ **If you live in the state of Florida, the following statement applies to you:**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

☞ **If you live in the state of New Jersey, the following statement applies to you:**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

☞ **If you live in the state of Oregon, the following statement applies to you:**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

☞ **If you live in a state other than mentioned above, the following statement applies to you:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.