UNITED CONCORDIA® DENTAL

Instructions for Completing Dental Claim Form

1. Completion of this form is only necessary if you visit **a non-network dentist**. Network dentists will complete and submit all necessary paperwork for you.

2. Please print clearly or type all required information.

3. **Patient Section:** The subscriber or spouse should complete the Patient Section of the form (Items 1 through 15) to assure positive identification and prompt payment.

4. **Patient Consent:** The patient consent statement is located below Item 15 on the form. If the patient is a minor, a parent must sign the statement. Other authorized representatives include caretaker, guardian or other individual as appropriate under state law and the circumstances of the case.

   By signing the statement, the patient (or parent or other authorized representative), consents to the use and disclosure of information relating to the services provided by the dentist or health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for dental benefits to a provider or administrator of dental benefits.

5. **Assignment of Benefits:** The Assignment of Benefits statement is located to the right of the Patient Consent Statement on the claim form. If you wish United Concordia to make payment directly to the dentist, please sign and date this statement. If you wish benefits to be paid directly to yourself, do not sign the statement.

6. **Dentist Section:** Your dentist should complete Items 16 through 31 on the claim form; then sign and date the form. If your dentist does not agree to complete the Dentist Section, you need only to complete the following items on the claim form and *attach a copy of the bill* you receive from the dentist. This information will serve as proof that you were seen and had services performed by this dentist:

   Item 16: Dentist name
   Item 17: Dentist mailing address
   Item 20: Dentist office phone number

Please mail your completed Claim Form to:

Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

Check One

- ❑ Dentist's pre-treatment estimate
- ❑ Dentist's statement of actual services

UNITED CONCORDIA

Insuring America's Dental Health

Please submit claim to: Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9416

PATIENT SECTION

1. Patient name | 2. Relationship to employee: self spouse child other | 3. Sex: m f | 4. Patient birth date: mo day year | 5. If full time student: school city

6. Employee/subscriber name: First middle last

9. Contract ID #

8. Employee/subscriber mailing address

City, State, Zip

10. Employer (company) name and address

11. Group Number | 12. Location (Local) | 13. Are other family members employed? Employee name Contract ID # | 14. Name and address of employer in item 13

15. Is patient covered by another dental plan? | Dental plan name | Union local | Group no. | Name and address of carrier

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.

Signature (patient or parent if minor) Date

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

Signature (insured person) Date

The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, United Concordia may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.

DENTIST SECTION

16. Dentist name

17. Mailing address

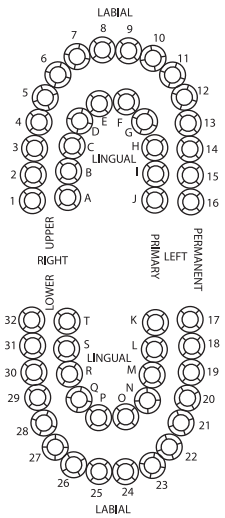
City, state, zip

18. Dentist soc. sec. or T.I.N. | 19. Dentist license no. | 20. Dentist phone no.

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)** **29. Date of prior placement**
30. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed; Mos. treatment remaining

Identify missing teeth with "X"



31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.

Use charting system shown

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED,ETC.) LINE NO.	DATE SERVICE PERFORMED MO.	DAY	YR.	PROCEDURE CODE	FEE	FOR ADMINISTRATIVE USE ONLY

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.

Signature (Dentist) _____ Date _____

TOTAL FEE CHARGED

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.

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

DC: 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.

FL: 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 in the third degree.

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

NY: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

LA: 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.

IN & OK: WARNING: Any person who knowingly and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

VA: Any person who within the 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 have violated the state law.

TN & WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.