Policy #:

INSTRUCTIONS FOR FILING DENTAL CLAIMS

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION.
AFLAC DOES NOT REQUIRE PRECERTIFICATIONS AND WILL NOT COMPLETE THE FORM FOR PRECERTIFICATION.

1. All claims must be submitted on a typed ADA claim form; a copy is on the back of these instructions. Your dentist may prefer to file your claims electronically.

2. Only dental claims may be filed with this claim form. If you need to file a claim under another Aflac policy, please submit the appropriate claim form.

3. Please ask your dentist's office to complete the entire form. Blank fields will cause the form to be returned and the claim processing to be delayed. We must have the following information:

- The policyholder's dental policy number (Please leave the Group Field blank).
- The policyholder's complete name as it is printed on the Dental Plan ID card.
- The patient's full name, sex, date of birth and relationship to the insured.
- The treatment date, tooth or surface, oral cavity and if initial placement, ADA code and charge for each procedure.
- The patient's Social Security number. (This will speed up claim processing.)

4. If the patient is a full-time student and over age 19, please indicate this on the form.

5. If you are filing for the initial benefit under the Orthodontic Rider or a cosmetic rider benefit, there is a two-year waiting period before benefits are payable under these riders.

6. Your dentist may submit the claim electronically. Make sure that Aflac's payer number (58066) is included on each claim submitted.

Submit the typed claim form directly to Aflac at:
Aflac Worldwide Headquarters
Attention: Claims Department
1932 Wynnton Road
Columbus, GA 31999-7254
Fax: 1.877.44.AFLAC (1.877.442.3522) Attn: Dental Claims

1. ❑ Dentist's pre-treatment estimate ❑ Dentist's statement of actual services — Specialty (see backside)

2. ❑ Medicaid Claim ❑ EPSDT — Prior Authorization #

3. Carrier Name **Aflac**

4. Carrier Address **Claims Department • 1932 Wynnton Road**

5. City **Columbus** 6. State **GA** 7. Zip **31999-7254**

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State

12. Date of Birth (MM/DD/YYYY) ____/____/____ | 13. Patient ID # / SSN # | 14. Sex ❑ M ❑ F | 15. Phone Number ( ) | 16. Zip Code

17. Relationship to Subscriber / Employee: ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

18. Employer / School Name: ____________ Address: ____________

SUBSCRIBER / EMPLOYEE

19. Subs. SSN # | 20. Employer Name | 21. Policy #

22. Subscriber/Employee Name (Last, First, Middle)

23. Address | 24. Phone Number ( )

25. City | 26. State | 27. Zip Code

28. Date of Birth (MM/DD/YYYY) ____/____/____ | 29. Marital Status ❑ Married ❑ Single ❑ Other | 30. Sex ❑ M ❑ F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

X ____________
Signed (Patient/Guardian) Date: (MM/DD/YYYY)

OTHER POLICIES

31. Is patient covered by another plan ❑ No (Skip 32-37) ❑ Yes ❑ Dental or ❑ Medical | 32. Policy #

33. Other Subscriber's Name

34. Date of Birth (MM/DD/YYYY) ____/____/____ | 35. Sex ❑ M ❑ F | 36. Plan/Program Name

37. Employer / School Name: ____________ Address ____________

38. Subscriber/Employee Status ❑ Employed ❑ Part-time Status ❑ Full-time Student ❑ Part-time Student

40. Employer/School Name ____________ Address ____________

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X ____________
Signed (Employee/ Subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.

46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ❑ Office ❑ Hosp. ❑ ECF ❑ Other

50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ❑ Yes, How many?______ ❑ No

54. Is treatment for orthodontics? ❑ Yes ❑ No
If service already commenced:
Date appliances placed ____________ Total months of treatment remaining: ______

55. If prosthesis (crown, bridge, dentures), is this initial placement? ❑ Yes ❑ No | If no, reason for replacement: ____________ | Date of prior placement: ____________

56. Is treatment result of occupational illness or injury? ❑ No ❑ Yes
Brief description and dates: ____________

57. Is treatment result of: ❑ Auto Accident? ❑ Other Accident? ❑ Neither
Brief description and dates: ____________

58. Diagnosis Code Index (optional)
1. ______ 2. ______ 3. ______ 4. ______ 5. ______ 6. ______ 7. ______ 8. ______

59. Examination and treatment plans. List teeth in order.

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with X

Permanent		Primary		
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	A B C D E	F G H I J	Total Fee
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	T S R Q P	O N M L K	Payment by other plan
				Max. allowable

61. Remarks for unusual services:

Deductible	
Carrier %	
Carrier pays	
Patient pays	

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X ____________
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed.

64. City | 65. State | 66. Zip Code

Claims Authorization to Obtain Information

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.**

Policyholder Name:	**Policy Number(s):**	**Date of Birth:**
Policyholder Address:		
Claimant/Patient Name (if different from named policyholder listed above):		**Date of Birth:**

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:	**Name and Address of health care provider(s), company, or individual authorized to release the requested information:** (this section will be completed by Aflac):
Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.	

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**