

# MEMBER DENTAL CLAIM FORM

Check One:  Dentist's pre-treatment estimate  
 Dentist's statement of actual services

**Please submit claim to:** Dental Claims  
P.O. Box 69421  
Harrisburg, PA 17106-9421

P A T I E N T	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					
S E C T I O N	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.						I hereby authorize payment directly to the below name dentist of the group insurance benefits otherwise payable to me.					
	Signature (patient or parent if minor) _____ Date _____						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.												

D E N T I S T  S E C T I O N	16. Dentist name				24. Is treatment result of occupational illness or injury?		No	Yes	If yes, enter brief description and dates					
	17. Mailing address  City, state, zip				25. Is treatment result of auto accident?									
					26. Other accident?									
					27. Are any services covered by another plan?									
18. Dentist soc. sec. or T.I.N.			19. Dentist license no.		20. Dentist phone no.		28. If prosthesis, is this initial placement?		(If no, reason for replacement)		29. 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?		30. Is treatment for orthodontics?		If services already commenced enter	Date appliances placed	Mos. treatment remaining

<p>Identify missing teeth with "X"</p>	31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.										Use charting system shown	FOR ADMINISTRATIVE USE ONLY		
	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED	PROCEDURE CODE	FEE								
												MO. DAY YR.		

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.										<b>TOTAL FEE CHARGED</b>	
Signature (Dentist) _____ Date _____											

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.

**AZ:** 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.

### **Discrimination is Against the Law**

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmark.com](mailto:CivilRightsCoordinator@highmark.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711).
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366 (TTY: 711) まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید.