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 <u>typed</u> 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 <u>entire</u> form. Blank fields will cause the form to be returned and the claim processing to be delayed. <u>We must have the following information:</u>
 - 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.
- 7. To file your claim online, upload documentation on an existing claim, check claim status or get paid fast by signing up for direct deposit, register on Aflac.com or download the MyAflac mobile app.

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

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1.		□ Dentist's statement of actual services													3. Carrier Name A Carrier Address																	
2.	□ EPSDT													4. C	. Carrier Address																	
														5. City					6. State						7	7. Zip						
																								City								
Ė	8. Patient Name (Last, First, Mlddle) 9. Address																				10. City							1. State				
PATIENT	12. Date of Birth (MM/DD/YYYY)														4. Sex				15. Phone Number ()							10	6. Zip Code					
PA.	17.	□ Self □ Spouse □ Child □ Other Name:																ool														
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ŏ	22. Subscriber/Employee Name (Last, First, Middle)															_[5	POLICI	33. (3. Other Subscriber's Name													
EMPLOYEE	23. Address 24. Phone Number																	{1}	ä	34. Date of B				f Birth (MM/DD/YYYY) 35. Sex 36					6. Plan/Program Name			
/	,														Code		١į		Nam	ne.	oloyer / School											
EB	28. Date of Birth (MM/DD/YYYY) 29. Marital Status ☐ Married ☐ Sing									le ☐ Other 30. Sex ☐ M ☐								ľ	_	38.	Subs	scriber/Employee Status ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐								Part	-time Student	
E E	39. 11	39. I have been informed of the treatment plan and associated fees. I agree to be														1		Nam	ne '	loyer/School Address												
SUBSCRIBER	benef	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.															41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.															
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S													()																	
DENTIST													17. Dentist License #							48. First visit date of current series					ent series	s: 49. Place of treatment Office Hosp. ECF Other						
핌	50. City 51. State 52. Zip Code 53											53. Radiographs or models enclosed? Yes, How many? □ No						d? No	,	54. Is treatment for orthodontics? ☐ Yes ☐ No If service already commenced:												
BILLING	55. If prosthesis (crown, bridge, dentures), is If no, reason for replacement												ent: Date of prior placement:									Date appliances placed Total months of treatment remaining:										
\exists	this initial placement? □ Yes □ No 56. Is treatment result of occupational illness or injury? □ No □ Yes 57. Is														troot	eatment result of: 🔲 Au							Othor /	\ccidont2	N							
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58. C	iagnosi	s Code I	ndex (optio	onal)																												
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 # Proc												cedur	re C	ode	C	ty					De	esc	scription				Fee)		Admin. Use Only		
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60. Identify all missing teeth with X Permanent Primary														Total Fee																		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A B C D E														G H I J Payment by other plan																		
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												K			lax. allowa	ble																
61. Remarks for unusual services:															eductible																	
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X Sigi	ned (Tre	eating De	ntist)				Lic	ense	#					Date	(M)	M/DD/	YYY	Y)			_	6	64. City 65. State					e 66. Zip Code				

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