# Dental Claim Form



CONTINENTAL AMERICAN INSURANCE COMPANY
P.O. BOX 84075 • COLUMBUS, GA • 31993
Toll-Free: 1-866-849-0017 Fax: 1-866-849-2970

1. ☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services
2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT

3. Carrier Name: Continental American Insurance Company
4. Carrier Address: P.O. Box 8749
5. City: Columbia | 6. State: SC | 7. Zip: 29202

**PATIENT**

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Certificate # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Certificateholder/Employee:
☐ Self ☐ Spouse ☐ Child ☐ Other_____
18. Employer
Name_____ Address_____

**CERTIFICATEHOLDER / EMPLOYEE**

19. Cert.Hldr./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Certificateholder/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

**OTHER POLICIES**

31. Is Patient covered by another plan
☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | 32. Certificate #
33. Other Certificateholder's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School
Name_____ Address_____

38. Certificateholder/Employee Status
☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

39. I have been informed of the treatment 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. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

40. Employer/School
Name_____ Address_____PO

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

X_____
Signed (Employee/certificateholder) 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 mos. 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 |
|---|---|---|---|---|---|---|---|
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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 | | | | | | |
| 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 | | | | | | |

| | |
|---|---|
| Total Fee | |
| Payment by other plan | |
| Max. Allowable | |
| Deductible | |
| Carrier % | |
| Carrier pays | |
| Patient pays | |

61. Remarks for unusual services

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

# GROUP DENTAL PLAN

Dear Certificateholder/Claimant:

Enclosed is a claim form for filing for dental benefits. Please have the claim form completed as follows:

**FILING FOR DENTAL BENEFITS:**

1. Please complete the Patient section, boxes 8-18.

2. Please complete the Certificateholder/Employee section**. Excluding boxes 31-38 and 40.**

3. Please have your dentist complete the Billing Dentist section, Boxes 42- 66. **Excluding box 53.**

**Processing time for a routine claim is 10 business days. Failure to have this form properly completed may delay processing of your claim. Please mail completed form to the address noted in boxes 3 through 7. You may fax your completed claim to 1-866-849-2970.**

**Should you have any questions, please do not hesitate to contact the Customer Service Center at 1-866-849-0017.**