univera HEALTHCARE

Customer Submitted Dental Claim Form

Mail Completed Forms to:
P.O. Box 211256, Eagan, MN 55121

For Internal Use

Subscriber Information (from ID card)

Subscriber ID	Subscriber Last Name	Subscriber First Name

Subscriber Address	Subscriber City, State, Zip

Patient Information (who received services?)

Patient Name	Patient Date of Birth	Relationship to Subscriber (select one)
		☐ Self ☐ Spouse ☐ Dependent ☐ Other

Patient Address	Patient City, State, Zip

Is another insurance primary?	☐ No ☐ Yes	If yes, please provide carrier name:

About Your Visit

Type of Claim Being Submitted	☐ Pretreatment Estimate for Services to be rendered in the future ☐ Services already performed	
Is treatment due to an accident?	☐ No ☐ Yes (enter accident date)	Accident Date:

Name of Treating Dentist	Treating Dentist NPI	Treating Dentist Tax ID

Treatment Location Address	Treatment Location City, State, Zip

Is the dentist part of a group?	☐ No ☐ Yes	Group Name:

Date of Service	CDT Procedure code or description of service	Tooth # (if applicable)	Tooth Surface (if applicable)	Oral Cavity (if applicable)	Cost

Please attach itemized bill from the provider

Total

Payment and Signature

Have you already paid for this service?	☐ No ☐ Yes
If no, would you like us to pay the provider directly?	☐ No, pay me directly ☐ Yes, I authorize my insurer to make payments directly to the provider on my behalf

I CERTIFY THAT THE INFORMATION SUBMITTED IS ACCURATE TO THE BEST OF MY KNOWLEDGE, I AUTHORIZE THE RELEASE OF ANY RELEVANT INFORMATION TO MY INSURANCE CARRIER.

SUBSCRIBER SIGNATURE:	DATE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation.

Mail completed form and any supporting documentation to: P.O. Box 211256, Eagan, MN 55121

INSTRUCTIONS

ITEMIZED BILL(S) FOR SERVICES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED.

Original itemized receipts including all pertinent information **must be submitted** with this claim form. The itemized bill must clearly indicate all of the following:

- Patients full name and address on the letterhead of the provider of service or supply
- Treating provider Tax identification number and National Provider Identifier (NPI)
- Type of service performed
- Place of service
- Date and charge for each service provided

Complete this form with the following information:

- Identification Number
- Subscriber Last Name
- Subscriber First Name
- Patient's full name
- Patient's date of birth
- Patient's relationship to the Subscriber Holder
- Treating providers name and address
- Treating providers tax identification number and National Provider Identifier (NPI)
- For coordination of benefits (secondary insurance payment) a copy of the primary insurance explanation of payment **must be included** with this form.
- Tooth Number(s) are required for Fillings, sealants, extractions, crowns and root canals.
- Tooth Surface Letter(s) are required for Fillings
- Sign and date the form