

Policy #:

INSTRUCTIONS FOR FILING DENTAL CLAIMS

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION.
AFLAC NEW YORK 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 New York 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 New York's payer number (52080) is included on each claim submitted.

**Submit the typed claim form directly to Aflac New York at:
American Family Life Assurance Company of New York (Aflac New York)
Attention: Claims Department
1932 Wynnton Road
Columbus, GA 31999-7254
Fax: 1-877-844-0201 Attn: Dental Claims**

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services 2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT	Specialty (see backside) Prior Authorization #	3. Carrier Name Aflac New York 4. Carrier Address Claims Department • 1932 Wynnton Road 5. City Columbus 6. State GA 7. Zip 31999-7254
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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 <input type="checkbox"/> M <input type="checkbox"/> F			15. Phone Number () ()		
	17. Relationship to Subscriber / Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						18. Employer / School Name: _____ Address: _____					

SUBSCRIBER / EMPLOYEE	19. Subs. SSN #		20. Employer Name		21. Policy #		31. Is patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes <input type="checkbox"/> Dental or <input type="checkbox"/> Medical 32. Policy #						
	22. Subscriber/Employee Name (Last, First, Middle)												
	23. Address				24. Phone Number () ()			33. Other Subscriber's Name					
	25. City			26. State		27. Zip Code		34. Date of Birth (MM/DD/YYYY)		35. Sex <input type="checkbox"/> M <input type="checkbox"/> F		36. Plan/Program Name	
	28. Date of Birth (MM/DD/YYYY)			29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other			30. Sex <input type="checkbox"/> M <input type="checkbox"/> F			37. Employer / School Name: _____ Address: _____			
	38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> 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 <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other			
	50. City		51. State		52. Zip Code		53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced:			
	55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No				If no, reason for replacement: _____		Date of prior placement: _____		Date appliances placed _____		Total months of treatment remaining: _____	
	56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates: _____						57. Is treatment result of: <input type="checkbox"/> Auto Accident? <input type="checkbox"/> Other Accident? <input type="checkbox"/> 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.										Admin. Use Only	
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee				

60. Identify all missing teeth with X										Total Fee																	
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	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	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 1-877-844-0201 or return the form to Aflac New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255, as soon as possible in order to expedite claim review.

Policyholder Name:	Policy Number(s):	Date of Birth:
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Policyholder Address:

Claimant/Patient Name (if different from named policyholder listed above):	Date of Birth:
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<p>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:</p>	<p>Name and Address of health care provider(s), company, or individual authorized to release the requested information: (this section will be completed by Aflac New York):</p>
<p>Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.</p>	

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 New York (Aflac New York)** 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 New York, with respect to other Aflac New York 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 New York, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255**, except to the extent that:
 - a. Aflac New York has taken action in reliance to this authorization, or
 - b. Other law provides Aflac New York 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