CLAIM FOR DENTAL, VISION, AND HEARING EXPENSE BENEFITS

Any person who knowingly and with intent to injure, defraud, or deceive any insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

MAIL TO:
MANHATTANLIFE
CLAIMS DEPARTMENT
P.O. BOX 925309
HOUSTON, TX 77292-2728
FAX: 713-583-0677

PART 1

1. Patient Name	2. Relationship to Employee				3. Sex		4. Patient Birthday			5. If full time student	
	Self	Spouse	Child	Other	M	F	MO	Day	Year	School	City

6. Employee			7. Employee Social Security No.			8. Group number if known
First	Middle	Last				

9. Employee Mailing Address	City, State	Zip

10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim. Patient's Signature (Parent if minor).

PART 2

11. Dentist Name		
First	Middle	Last

12. Mailing Address	City, State	Zip

TO BE COMPLETED BY DENTIST

13. Dentist Soc. Sec. or ITIN	14. Dentist License No.	15. Dentist Phone No.	16. First Visit Date Current Series	17. Place of Treatment				18. Radiographs or Models Enclosed?	No	Yes	How Many?
				Office	Hosp.	ECF	Other				

19. Dentist - Check One

- ❑ Pretreatment Estimate
- ❑ Statement of Actual Services

FACIAL
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
LINGUAL
UPPER
RIGHT
LOWER
PRIMARY
LEFT
PERMANENT
LINGUAL
T S R Q P O N M L K
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
FACIAL

32. Examination and treatment Plan - List in order from tooth number 1 through tooth number 32
Use chart system shown

Tooth No. or Ltr.	Surface	Description of Services (including X-rays, Prophyaxis Materials Used, etc.)	Date Service Performed Mo.	Day	Yr.	Procedure Code	Fee		For Home Office Only ❑ Schedule ❑ Other	

Dental Unit Use

Employee Eligible Date ______
Employee Effective Date ______
Termination Date ______
Verified By ______
Date ______

These benefits will, subject to Policy provisions, be payable if the described procedures are performed while the patient is insured with ManhattanLife Assurance Company of America

Total Fee Actually Charged		
Deductible		
Patient pays		
Insurance will pay		

Part 3

TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the above named patient on the dates indicated

Dentist Signature______________________ Date ______

Dental

Claim Filing

A dental insurance claim form is submitted to request payment for services rendered or to file for per-authorization of services to be performed. We accept the ADA's (American Dental Association) standardized dental insurance claim form.

In the information section of the form, you or the dentist must fill in the following information.

- Insured's full name and address
- Insured's ID Number
- The name and date of birth of the insured receiving the dental services.

Attachment of Supporting Documentation

You should substantiate your dental insurance claim expenses by attaching itemized bills and receipts, which contain the following information.

- Insured's full name and address
- Insured's ID number
- Provider's name and address
- Dates that dental care or treatment was provided
- Dentist's Tax ID Number
- Dates that services or treatment were received
- Tooth surface(s) and tooth number(s), arch, quadrant
- ADA procedure codes
- Description of each treatment
- Charge for each service

If your Dental Care Provider Files the Claim for You

Many dental offices will file the claim on your behalf. Some may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Assurance Company of America ID card to your dental care provider.

All claims be submitted to ManhattanLife Assurance Company of America by mail or fax.

ManhattanLife Assurance Company of America

Claims Department

P.O. Box 925309

Houston, Texas 77292-4408

Fax: 713-583-0677