Member Reimbursement Form for Dental Services

Instructions

- If you have paid your provider for dental services, please consult with your dentist to complete this form in its entirety. If information is missing or incomplete, it will result in a delay in consideration of payment. Acknowledgement is required below by both you, and your dental provider. **NOTE:** Box 25 below should reflect the amount **you** paid out of pocket to your dental office **after** any discounts/adjustments.
- Completed forms are to be mailed to:

  AFLAC Claims
  PO BOX 45
  Milwaukee, WI 53201

Important Information: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PATIENT INFORMATION		
1. Patient Name (Last, First, Middle Initial, Suffix)	2. Phone Number	
3. Address, City, State, Zip Code		
4. Date of Birth (MM/DD/YYYY)	5. Subscriber/Member ID (refer to your member ID card)	
6. Group Number	7. Name of Employer (if applicable)	
8. Do you have additional dental insurance? Yes/No – If **Yes**, complete the below (lines 9-12) and include a copy of the payment breakdown(s)/Explanation of Benefits (EOB) from your other insurance.		
9. Name of Other Dental Insurance	10. Policy Number	11. Group Number
12. Address, City, State, Zip Code		

DENTAL PROVIDER INFORMATION		
13. Dentist Name	14.Phone Number	
15. Address, City, State, Zip Code		
16. NPI Number	17. License Number	18. Tax ID Number

DENTAL SERVICES RECEIVED

	19. Date of Service (MM/DD/YYYY)	20. Area of Oral Cavity	21.Tooth Number(s) or Letter(s)	22.Tooth Surface	23.Procedure Code	24.Description	25. Amount **you** paid to dental office
1							
2							
3							
4							
5							
6							
7							
8							
9							

ACKNOWLEDGEMENT OF SERVICES AND PAYMENT (Signatures are required as proof that services noted above have been rendered and paid in full)	
Member Acknowledgement: I acknowledge that I received the dental services noted above, and have paid my dental provider in full. The amount(s) noted in Box 25 represents what I paid out of pocket to my dental office excluding any discounts/adjustments.	
26. Member/Authorized Representative Signature	*27. Date*
Dental Provider Acknowledgement: I acknowledge that the service(s) noted above, have been rendered. In addition, that box 25 reflects the full payment made by the member less any discounts/adjustments.	
28. Dental Provider Signature	*29. Date*

Aflac Dental & Vision group plans are underwritten by American Family Life Assurance Company of Columbus in all states but New York. In New York, plans are underwritten by American Family Life Assurance Company of New York. Individual plans are underwritten by Tier One Insurance Company. In California, Tier One does business as Tier One Life Insurance Company.