IF YOU HAVE A COLONIAL LIFE DENTAL POLICY, USE THE FOLLOWING FORM.

1. Please ask your dentist's office to complete the attached form.

2. Submit the claim form to:

Mail: Colonial Life
PO Box 30507
Salt Lake City, UT 84130
Fax: 1-855-855-1575, Attn: Dental Claims

Please note**:** Dental policy claims are sent to HealthPlanServices for processing. In addition, dentist may submit the claim electronically

To check the status of your dental policy claim:
Phone: 877-477-4065, Web: HPSClaimServices.com

To see the full list of Dental benefits, please visit:
http://www.coloniallife.com/dentalbenefits

Only dental policy claims may be filed with this claim form. If you are submitting a claim under your Accident policy with Colonial Life, see Accident claim form. If you are submitting a vision rider claim, see the vision claim form

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Colonial Life
PO Box 30507

Salt Lake City UT ZIP 84130-0507

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
	☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Other Insurance Company Name
Address
City ST ZIP

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Policyholder Name
Address 1
Address 2
City ST ZIP

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number	17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Patient Name
Address 1
Address 2
City ST ZIP

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee 0

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Dentist Name
Address 1
Address 2
City ST ZIP

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number	52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from

☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number

56. Address, City, State, Zip Code	56a. Provider Specialty Code
Address City ST ZIP	

57. Phone Number	58. Additional Provider ID