Group Employee Benefits
Dental Claim

Regular Mail:
Equitable
Employee Benefits Group
P.O. Box 2107
Grapevine, TX 76099-2107

Express Mail:
Equitable
Employee Benefits Group
8500 Freeport Pkwy 4th Floor
Irving, TX 75063

EQUITABLE

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America*

For Assistance
Call (866) 274-9887
Fax (469) 417-1973

INSTRUCTIONS

NOTE: Incomplete claim forms will be returned to you for missing information. This will delay the processing of the claim. For faster, easier submission of claims, the provider may contact the claim processing center for information regarding electronic claim submission.

TO THE EMPLOYEE – USE BLACK INK ONLY

1. Complete Section 1 blocks 1-21 in full.
2. Complete Section 1 blocks 15-19 only if other dental coverage exists.
3. If you wish to have your benefits for this claim paid directly to your dentist, sign block 20.
   If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan, it is suggested you file for Predetermination of Benefits.
4. Be certain to sign the authorization to release information in box 21.

TO THE DENTIST – USE BLACK INK ONLY

1. COMPLETE SERVICES – Check the box noted “STATEMENT OF SERVIES RENDERED” and complete blocks 1-17. When entering the treatment plan on the form, please indicate a separate fee for each individual service rendered.
2. PREDETERMINATION OF BENEFITS – If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the employee’s Dental Plan (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked “PRE-TREATMENT ESTIMATE”, and complete blocks 1-17.
   NOTE” PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.
3. If the employee indicates that benefits should be paid directly to the dentist, these benefits will be sent directly to you with a copy of the transaction to the employee.
   X-rays taken for metal restorations and crowns should be submitted with treatment plan. They may also be requested for other services. X-rays will be reviewed by practicing Dentists and returned promptly.

TO EMPLOYEE & DENTIST

Send the completed benefits request and bill to the address listed above.

1. TO BE COMPLETED BY EMPLOYEE

1. Employer's Name	2. Group Policy Number

3. Employee's Name	4. Employee's Date of Birth

5. ☐ Active ☐ Retired Date of Retirement:_____	6. Employee's Address	7. Employee's Telephone

8. Patient's Name	9. Patient's Date of Birth	10. Relationship to Employee
		☐ Self ☐ Spouse ☐ Child ☐ Other

11. Patient's Address (if different from employee)	12. Patient's Gender
	☐ Male ☐ Female

13. Is claim related to an accident? ☐ No ☐ Yes If Yes, date _____ time _____ ☐ am ☐ pm	14. Is claim related to employment? ☐ No ☐ Yes

15. Are any family members' expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes

16. If Yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:

17. Member's ID Number	18. Member's Name	19. Member's Date of Birth

20. I Authorize payment directly to the below-named dentist

Employee Signature_____ Date ____/___/_____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to Equitable* a complete copy of, and to communicate telephonically or electronically with Equitable's representatives about, any and all of the following personal, private, or privileged information, records, or documents relative to:

Insured's Name (Please Print)	Date of Birth	Last 4 Digits of SSN

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by Equitable (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefit s and/or leave request and/or request for accommodation. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to Equitable.

I UNDERSTAND that once My Information has been disclosed to Equitable as permitted under this Authorization, it may be re-disclosed by Equitable as permitted by law or my further authorization. I authorize Equitable to use or disclose My Information (i) to my employer for a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures Equitable may make, unless Equitable has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to Equitable. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing Equitable to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory complaints, or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

21.Signature of Insured or Authorized Representative	Date (Valid for 2 years)	Relationship to Insured (if applicable)

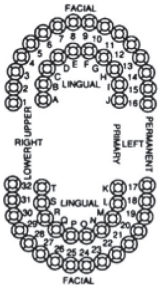
TO BE COMPLETED BY DENTIST – USE BLACK INK ONLY

1. This is a request for:
☐ Pre-Treatment Estimate Predetermination/Preauthorization Number ☐ Statement of Services Rendered

2. Dentist's Name & Address (include ZIP Code)	3. National Provider Identifier	
	4. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.	
	5. First Visit Date Current Series	6. Place of Treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other
		7. Radiographs or models enclosed? ☐ No ☐ Yes How many?

Is treatment result of:	No	Yes	If Yes, enter brief description and dates.
8. occupational illness or injury?			
9. auto accident?			
10. other accident?			
11. Are any services covered by another			
12. If prosthesis, is this initial placement?			If No, date of prior placement and reason for replacement.
13. Is treatment for orthodontics?			Date appliance placed: Initial Appliance Fee: No. of months of treatment: Monthly Fee: Mos. of treatment remaining: Total Case Fee:

14. To expedite claim handling, identify all missing teeth with "X"



15. Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. Use charting system shown.

Tooth # or Letter	If Previously Extracted, Give Date	Surface	Description of Service (x-rays, prophylaxis, materials used, etc.)	Date Service Performed MM	DD	YYYY	Procedure Number	Fee

16. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.
Dentist's Signature Date

17. National Provider Identification
Total Charge $
Amount paid $
Balance due $

State Fraud Warnings

New York Fraud Warning:
"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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

NY STATE RESIDENTS READ AND SIGN ONLY: I have read and understood the New York State Fraud Warning.

Signature:_____ _____

Employee's Signature **Current Date (mm/dd/yyyy)**

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties, including fines and confinement in prison.
Alaska and New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided under state law.
Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
California: For your protection, California law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
Delaware, Florida, Idaho, Indiana, and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia, Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or any other person. Penalties may include imprisonment, fines or a denial of insurance benefits.
Kentucky and Pennsylvania: Any person who knowingly and with the 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 may be subject to criminal and civil penalties.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oregon and All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.
Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum two (2) years.