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MAIL THIS FORM TO:

SECURITY LIFE INSURANCE COMPANY OF AMERICA

P.O. BOX 1527 LATHAM, NY 12110

TELEPHONE: 1-800-300-9566

	PART 1 - TO BE COMPLETED BY SUBSCRIBE	COMPLETE ALL QUESTIONS #1-15												
₹				3. Sex 4. Patient Birthdate 5. If full time student										
	Se	elf Spouse Child Other	MIF			Sch	nool	City						
שורטו	6. Subscriber Name First Middle Last	7. Subscriber or Social Sec.	Retiree					Subscriber I	Birthdate					
	8. Subscriber or Retiree Address	9. Spouse Birthda	ate	10.	Employer/Unio	n affili	iation - Name	and address						
•	11. City, State, Zip	,												
	Subscriber Retiree If Yes, Family	☐ Subscriber ☐ Retiree If Yes, Family Member Name Social Security					14. Name and address of Family Members' Employer in Item 13							
	5. Any other Dental Benefits for Patient? Yes No If yes, Coverage through Self Spouse Dependent If dependent or spouse, Full Name Give name and address of other coverage above													
•	or other Organization to release any informa benefits payable for this claim to the Plan A purpose of determining benefits payable.	TUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer of the Organization to release any information regarding the dental history, treatment, or enefits payable for this claim to the Plan Administrator or its authorized agent for the urpose of determining benefits payable. **ERTIFICATION - I hereby certify that the foregoing information is true and correct.** 17. AUTHORIZATION TO PAY BENI NAMED DENTIST - I hereby authorized agent for the below named Dentist of the Deservices described below.								orize payment directly to				
ŀ	Signed (Patient or parent, if minor)		Date	Signed (Subscriber)				r) Date						
	Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.								ceals for the p	urpose o	ıf			
	PART II - TO BE COMPLETED BY ATTENDING DENTIST													
-	18. Dentist's Name			occupa or injur	-	No	Yes If yes, of and da	enter brief des tes:	cription					
	19. Mailing Address		27. Is treating auto ac28. Other ac29. Any se	ident?										
	City, State, Zip		covere Plan?	by another										
	20. Dentist Soc. Sec. or T.I.N. 21. Dentist License #	22. Dentist Phone #		30. If Prosthesis, is this initial placement? 32. Is treatment for			replace	ment)	31. Date of prior placement dy commenced, enter					
	23. First Visit date current series 24. Place of treatment	25. Radiographs or models enclosed	' N #		Iontics?	Date ap	opliances place eatment remain	ces placed:						
	Check One:													
	Identify Missing Teeth with "X"	33. Examination and treatment plan - list in order from tooth No. 1 through tooth No. 32 - use chart show												
	FACIAL	Tooth # or Letter Surface (M, O, D, B, L, La, I)	M, O, D, B, (Including X-rays, prophysaxis, materials used, etc.) completed					Procedure Number		=				
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	FACIAL													
ļ	34. Remarks for unusual services													
	hereby certify that the procedures as indicated by date have been completed and the fees indicated are those actually charged the patient regardless of the existence of insurance coverage.								TOTAL FEE CHARGED					

SPECIAL NOTICE

Pre-determination of benefits should be filed when the dentist's estimated charge is \$300 or more. It is to your advantage to know the benefits before you agree to have the work completed.

ATTENTION

This form must be used to report the completion of covered dental services when prior review is not requested.

INSTRUCTIONS TO INSURED

- 1. Fill in Part I Identification section (both patient and employee sections). Show relationship and date of birth.
- 2. Give form to dentist to complete Part II.
- 3. Mail to the Dental Department:

SECURITY LIFE INSURANCE COMPANY OF AMERICA P.O. Box 1527 Latham, NY 12110

4. Any questions concerning your claim should be directed to the Dental Department at the above address or by calling: **1-800-300-9566.**

ELECTRONIC DENTAL CLAIMS PROCESSING IS AVAILABLE THROUGH ENVOY-NEIC HEALTHCARE EDI NETWORK.

OUR ENVOY-NEIC PAYER ID IS 14168.

IF YOU DO NOT CURRENTLY BILL YOUR PATIENT CLAIMS ELECTRONICALLY TODAY, WE ENCOURAGE YOU TO CALL ENVOY-NEIC AT 1-800-366-5716 TO OBTAIN INFORMATION ABOUT THIS COST SAVINGS PROCESS.