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

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 (if applicable)	7. Name of Employer (if applicable)	

DENTAL PROVIDER INFORMATION		
8. Dentist Name		9. Phone Number
10. Address, City, State, Zip Code		
11. NPI Number	12. License Number	13. Tax ID Number

ACCIDENT INFORMATION

NOTE: If the requested service(s) is related to an accidental injury, supporting documentation is required to process your claim

14. Are these services related to:

☐ Work Accident ☐ Auto Accident ☐ Other Accident Date of Accident _____ If auto accident related, what state did the accident occur in _____

DO YOU HAVE OTHER INSURANCE?

If yes, complete the below (lines 15 - 18) and include a copy of the Explanation of Benefits (EOB) from your primary insurance (NOTE: not applicable for Tier One members)

15. Name of Other Dental Insurance	16. Policy Number	17. Group Number
18. Address, City, State, Zip Code		

DENTAL SERVICES RECEIVED

	19. Date of Service (MM/DD/YYYY)	20. Area of Oral Cavity	21. Tooth Number(s) or Letters(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							

Fraud Warning Notices

State law requires us to notify you of the following:

AL, AK, AR, DE, GA, HI, ID, IL, IN, IA, KS, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NC, ND, OH, OK, OR, PA, SC, SD, TX, UT, VT, VA, WA, WV, WI, WY: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

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.

CONNECTICUT: 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 ($5,000) and the stated value of the claim for each such violation.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal penalties.

MASSACHUSETTS: 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 ($5,000) and the stated value of the claim for each such violation.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil and criminal penalties.

PUERTO RICO: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized

for each violation with a fine no less than five thousand ($5,000) dollars or more than ten thousand ($10,000) dollars, or imprisonment for a fixed term of three (3) years or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if extenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be subject to criminal penalties.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW YORK: 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.

<table>
<tr><th colspan="2">ACKNOWLEDGEMENT OF SERVICES AND PAYMENT
(Signatures are required as proof that services noted above have been rendered and paid in full)</th></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>26. Member/Authorized Representative Signature</td><td>27. Date</td></tr>
<tr><td colspan="2">Dental Provider/Practice Acknowledgement: I acknowledge that the service(s) noted above have been rendered and that I have authority on behalf of the Dental Provider/Practice to provide and verify the accuracy of the above information. In addition, I acknowledge that box 25 reflects the full and accurate payment made by the member less any discounts/adjustments., I verify that the information supplied in this Reimbursement Form is true and correct to the best of my knowledge, and I understand that any falsifications or omissions made when providing this information may subject me to administrative, civil, or criminal liability.</td></tr>
<tr><td>28. Dental Provider or Dental Office Representative Signature</td><td>29. Date</td></tr>
<tr><td colspan="2">29a. PRINT Name and/or Title</td></tr>
</table>

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.

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