

જો તમે કે તમે મદદ કરી રહ્યાં હો તેમને Florida Combined Life plans વિશે પૂછો હોય, તો તમને મદદ અને તમારી ભાષામાં માહિતી કોઈ ખર્ચ વગર મેળવવાનો અધિકાર છે. દુભાષિયા માટે આ નંબર પર ફોન કરો, 1-888-223-4892.

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Florida Combined Life plans

คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-223-4892

1557 Non-Discrimination

Florida Combined Life Insurance Company, Inc. (FCL) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FCL does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

FCL.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact 1-888-223-4892

If you believe that FCL has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
Email civilrightscordinator@fclife.com.

You can file a grievance in person or by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW.,
Room 509F, HHH Building, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

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

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

M F

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

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

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

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

M F

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status

Self Spouse Dependent Child Other FTS PTS

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

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

M F

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
																	T	S	R	Q	P	O	N	M	L	K		

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. 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.

X _____ Date
 Patient / Guardian signature

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 _____ Date
 Subscriber signature

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

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

52. Phone Number () - 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 39. Number of Enclosures (00 to 99)

Provider's Office Hospital ECF Other Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)

No (Skip 41-42) Yes (Complete 41-42)

42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)

No Yes (Complete 44)

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 _____ Date
 Signed (Treating Dentist)

54. NPI 55. License Number

56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number () - 58. Additional Provider ID

How to File a Claim

1. Complete boxes 1 – 23.
2. Please ensure box 15 contains your member number as it appears on your ID card.
3. Be sure to sign the authorization to release information in box 36.
4. If you wish to have your benefits paid directly to your dentist, sign box 37.
5. Ask your dentist to complete boxes 24 – 58, or attach an original itemized billing from the dentist on his/her letterhead or approved ADA claim form that includes all information requested in boxes 24 – 58.
6. Attach all related Explanation of Benefits statements for other coverage if applicable.
7. Please keep copies of your bills prior to sending the originals with this claim. Services that are denied for payment will be noted on your Explanation of Benefits. No bills are returned to you even if they are denied for payment.
8. Send completed claim form to:

Florida Combined Life
Dental Claims Department
P.O. Box 1047
Elk Grove Village, IL 60009-1047

NOTE: Subscriber submitted claim forms should be submitted within 90 days of the date of service. Claims which cannot be identified due to incomplete subscriber information will be returned.

How to Reach Us

Phone: 888-223-4892
Monday - Friday, 8:00 am - 8:00 pm EST

FRAUD NOTICE: 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.