INSTRUCTIONS FOR FILING DENTAL CLAIMS

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION.
AFLAC DOES NOT REQUIRE PRECERTIFICATIONS AND WILL NOT COMPLETE THE FORM FOR PRECERTIFICATION.

1. All claims must be submitted on a typed ADA claim form; a copy is on the back of these instructions. Your dentist may prefer to file your claims electronically.

2. Only dental claims may be filed with this claim form. If you need to file a claim under another Aflac policy, please submit the appropriate claim form.

3. Please ask your dentist's office to complete the entire form. Blank fields will cause the form to be returned and the claim processing to be delayed. We must have the following information:

- The policyholder's dental policy number (Please leave the Group Field blank).
- The policyholder's complete name as it is printed on the Dental Plan ID card.
- The patient's full name, sex, date of birth and relationship to the insured.
- The treatment date, tooth or surface, oral cavity and if initial placement, ADA code and charge for each procedure.
- The patient's Social Security number. (This will speed up claim processing.)

4. If the patient is a full-time student and over age 19, please indicate this on the form.

5. If you are filing for the initial benefit under the Orthodontic Rider or a cosmetic rider benefit, there is a two-year waiting period before benefits are payable under these riders.

6. Your dentist may submit the claim electronically. Make sure that Aflac's payer number (58066) is included on each claim submitted.

Submit the typed claim form directly to Aflac at:
Aflac Worldwide Headquarters
Attention: Claims Department
1932 Wynnton Road
Columbus, GA 31999-7254
Fax: 1-877-44-AFLAC (1-877-442-3522) Attn: Dental Claims

If you have any questions, please call our toll-free number 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com.

1.	Dentist's pre-treatment estimate Dentist's statement of actual services	Specialty (see backside)	3. Carrier Name **Aflac**
2.	Medicaid Claim EPSDT	Prior Authorization #	4. Carrier Address **1932 Wynnton Road**
			5. City **Columbus** 6. State **GA** 7. Zip **31999**

PATIENT

8. Patient Name (Last, First, MIddle)	9. Address	10. City	11. State
12. Date of Birth (MM/DD/YYYY) _____/_____/_____	13. Patient ID # / SSN #	14. Sex M F	15. Phone Number ( )	16. Zip Code
17. Relationship to Subscriber / Employee: Self Spouse Child Other _____		18. Employer / School Name: _____ Address: _____	

SUBSCRIBER / EMPLOYEE

19. Subs. SSN #	20. Employer Name	21. Policy #
22. Subscriber/Employee Name (Last, First, Middle)		
23. Address	24. Phone Number ( )	
25. City	26. State	27. Zip Code
28. Date of Birth (MM/DD/YYYY) _____/_____/_____	29. Marital Status Married Single Other	30. Sex M F

39. 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 the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

X _____
Signed (Patient/Guardian) Date: (MM/DD/YYYY)

OTHER POLICIES

31. Is patient covered by another plan No (Skip 32-37) Yes Dental or Medical	32. Policy #
33. Other Subscriber's Name	
34. Date of Birth (MM/DD/YYYY) _____/_____/_____	35. Sex M F	36. Plan/Program Name
37. Employer / School Name: _____ Address _____	
38. Subscriber/Employee Status Employed Part-time Status Full-time Student Part-time Student	
40. Employer/School Name _____ Address _____	
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X _____ Signed (Employee/ Subscriber) Date (MM/DD/YYYY)	

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity	43. Phone Number ( )	44. Provider ID #	45. Dentist Soc. Sec. or T.I.N.
46. Address	47. Dentist License #	48. First visit date of current series:	49. Place of treatment Office Hosp. ECF Other
50. City / 51. State / 52. Zip Code	53. Radiographs or models enclosed? Yes, How many?_____ No	54. Is treatment for orthodontics? Yes No If service already commenced:
55. If prosthesis (crown, bridge, dentures), is this initial placement? Yes No If no, reason for replacement: _____ Date of prior placement: _____		Date appliances placed _____ Total months of treatment remaining: _____
56. Is treatment result of occupational illness or injury? No Yes Brief description and dates:		57. Is treatment result of: Auto Accident? Other Accident? Neither Brief description and dates:

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans. List teeth in order.

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with X

Permanent				Primary	
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	Payment by other plan	
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	T S R Q P	O N M L K	Max. allowable	

Total Fee	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services:

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed.

64. City	65. State	66. Zip Code

Policy #: | | | | | | | | |

AU

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

_____ _____

Signature Date Printed Name

Individual/Guardian/Personal Representative

_____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Policy #: | | | | | | | | |

AU

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I agree that a copy of this authorization is as valid as the original.

_____ _____

Signature Date Printed Name

Individual/Guardian/Personal Representative

_____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

RETAIN THIS COPY FOR YOUR RECORDS