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 you and your dental provider as proof of services and payment received.
- Completed forms are to be mailed to:

AFLAC Claims
PO BOX 45
Milwaukee, WI 53201

Important Information: 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 material fact commits a fraudulent insurance act, which is a crime and may result in criminal and/or civil penalties.

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	7. Name of Employer (if applicable)	
8. Are you covered by another dental plan? Yes/No – **If yes, complete the following below**		
9. Name of Other Dental Insurance	10. Policy Number	11. Group Number
12. Address, City, State, Zip Code		

DENTAL PROVIDER INFORMATION		
13. Dentist Name	14.Phone Number	
15. Address, City, State, Zip Code		
16. NPI Number	17. License Number	18. Tax ID Number

DENTAL SERVICES RECEIVED

	19. Date of Service (MM/DD/YYYY)	20. Area of Oral Cavity	21.Tooth Number(s) or Letter(s)	22.Tooth Surface	23.Procedure Code	24.Description	25.Amount Paid
1							
2							
3							
4							
5							
6							
7							
8							
9							

ACKNOWLEDGEMENT OF SERVICES AND PAYMENT (Signatures are required as proof that services noted above have been rendered and paid in full)	
Member Acknowledgement: I acknowledge that I received the dental services noted above, and have paid my dental provider in full.	
26. Member/Authorized Representative Signature	*27. Date*
Dental Provider Acknowledgement: I acknowledge that the services noted above have been rendered and paid in full by the member.	
28. Dental Provider Signature	*29. Date*

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.