

Dental Claim Notice

HOW TO SUBMIT A CLAIM

- A. Fill out every section of the claim form completely.
- B. Include Your Social Security Number.
- C. Attach only original itemized bills (not copies) or ask your dentist to complete the reverse side of this form.
- D. If bills are attached, label them. Make sure the bills include the name, address and telephone number of the doctor.
- E. The doctor must show the cost of each service and the date the service was performed.
- F. If the patient is covered by another group insurance plan which is primary, the claim must be filed under that plan first.
Then you can file a claim under State of Illinois' plan by attaching a copy of the other plan's Explanation of Benefits payments(s) and a copy of the itemized bill(s).
- G. Then send to: Administered By Humana/CompBenefits
P.O. Box 14285, Lexington, KY 40512-4285
Telephone: 1-800-999-1669

claims can be submitted electronically to Payer ID CX021

TO BE COMPLETED BY THE EMPLOYEE

1. Complete for All Claims

Employee's Name _____ Male Female

Employee's Home Address (No. Street) _____

City, State Zip Code _____ Social Security Number _____

Date of Birth (Mo, Day, Yr) _____ Marital Status: Single Married Widowed Divorced Separated

2. Complete for Dependent Claims Only

Dependent's Name (Spouse/Child) _____ Male Female

Relationship to Employee _____ Date of Birth (Mo, Day, Yr) _____

Marital Status: Single Married

Give dependent's address if other than above _____

Claim is for Dependent Child over age 19, indicate Full-time Student _____
if student, give name of school _____

Handicapped

3. Complete for All Claims

Are you, your spouse or child entitled to benefits from any kind of group dental insurance? Yes No

Name of Person with Other Insurance _____ Social Security Number _____

Name of other Employer _____

Name and Address of the insurance carrier providing these benefits _____ Policy number _____

4. Complete for Accidents Only

Work Related Yes No

Date Accident Occured _____

Give a brief description of the accident (include the place where it happened) _____

5. Complete for All Claims

I hereby agree to reimburse State of Illinois for any overpayment made by the Plan.
To all providers of dental care, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators. You are authorized to provide CompBenefits and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on CompBenefits' behalf with information concerning dental care, advice, treatment or supplies provided the Patient, and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for dental benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Signed (Employee) _____ (Date) _____ Signed (Dependent Patient - Not Minor) _____ (Date) _____

6. Complete only if you want payment to go directly to Provider

Authorization to Pay Benefits, I hereby authorize payment directly to the provider of service for the claimed expenses as provided under the State of Illinois Dental Plan. I understand I am financially responsible for charges not covered by this authorization.

Employee's Signature _____ Date _____

