Dental Claim Reimbursement Request

Instructions for Completing this Form and Submitting Your Claim

Your Health Plan and LIBERTY Dental Plan are dedicated to prompt and accurate payment of claims to our plan participants. Following these instructions and completing the claim form in its entirety will help us process your claim in a timely manner. Claims submitted without complete documentation cannot be processed and will be returned to you.

Who should complete this form?

Health Plan members who have paid for dental expenses out-of-pocket and are requesting reimbursement.

If someone other than the member is submitting the request, please include the required Appointment of Representative (AOR), Power of Attorney (POA), or Durable Power of Attorney (DPA) form. The AOR form can be found at: **CMS.gov/Medicare/CMS-Forms/CMS- Forms/Downloads/CMS1696.pdf**

Submit the required documentation.

Submit a separate reimbursement request for each bill. Include itemized receipts showing your proof of payment and original bills from providers. Keep copies for your records. Cash register receipts, canceled checks, money orders, credit card vouchers, or personal lists of services or bills stating only "balance forward" are not acceptable as substitutes for original bills.

To ensure prompt processing of your claim, bills submitted must include the following (contact your provider to obtain any additional information):

- The name and address of the provider (on letterhead) of the service or supply (e.g., dental provider), including the Tax ID and NPI numbers
- The patient's full name and LIBERTY Dental plan member identification number
- CDT Code(s) for the type of service provided (e.g., exam, cleaning)
- Place of service (e.g., office)
- Date and charge for each service or supply provided

If another insurance carrier has made payment on this service, an explanation of benefits from that carrier must be submitted with the claim.

How to submit your completed claim.

Submit your completed claim and all documentation to LIBERTY by:

- **Mail** to CLAIMS SUBMISSION, LIBERTY Dental Plan Attn: Claims, P.O. BOX 401086 Las Vegas, NV 89140
- **Email to nevadaclaims@libertydentalplan.com**
- **Fax** to **888-401-1129**

Questions? We're here to help!
Call LIBERTY Dental Plan's Member Services with the phone number on the back of your ID card.

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LIBERTY DENTAL PLAN

Section 1: Patient and Subscriber Information *(please print)*

Patient Name *(first, middle initial, last)*	**Patient** Date of Birth	LIBERTY Dental ID No.

Subscriber Name *(first, middle initial, last)*	Phone No. ( )

Subscriber Street Address	City	State	Zip Code

Group Name	**Group** No. *(if applicable)*

Section 2: Provider and Billing Information *(contact your provider for the following)*

Provider Name	Phone No. ( )	Date of Service

Provider Street Address	City	State	Zip Code

Tax ID No.	NPI No.

Type of Service Performed ☐ **Dental** Total Reimbursement Requested ▶ $

Are you covered under another insurance plan that provides coverage for the type of service being submitted? ☐ **Yes** ☐ **No**

If ***Yes***, provide the following information about that insurance:

Insurance Company Name	**Policyholder** Name

Policy or ID No.	Other Carrier Phone No. ( )	Policy/Other Carrier Effective Date

Insurance Company Street Address	City	State	Zip Code

Section 3: Certification and Authorization to Release

By signing below, I certify that the above statements are correct. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an application 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 be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber's Signature *Date*