Colonial Life

Dental Claim Office
P.O. Box 80139
Baton Rouge, LA 70898-0139
Phone: (888) 400-9304 or (225) 400-9304

Dental Claim Form

Return completed form via fax **(855) 400-9307**, email **DentalClaims@ColonialLife.com**, or mail to the address above.

PART 1 - To be completed by member

The following information is required with your DETAILED RECEIPT for reimbursement:

Subscriber Information

1. Subscriber social security number or member ID:		2. Subscriber name (Last name, First name, MI):	
3. Subscriber's address:		City: State:	Zip code:
4. Subscriber birth date: _____ / _____ / _____ MM DD YY	5. Subscriber policy/Group number:	6. Subscriber's company name (if group policy):	
7. Email Address		8. Telephone/contact number: (_____) _____	

Patient Information

9. Patient name (Last name, First name, MI):		10. Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	11. Patient birth date: _____ / _____ / _____ MM DD YY
12. Is patient a full-time student? ☐ Yes ☐ No **If yes**, please provide proof.		13. Is patient covered by another dental plan? ☐ Yes ☐ No	
If #13 is YES, please complete below:			
14. Policy number:		15. Name and address of insurance carrier:	
16. Name of insured:	17. Relationship: ☐ Spouse ☐ Child	18. Insured's social security number:	19. Date of birth: _____ / _____ / _____ MM DD YY
20. Name and address of employer (if applicable):			

Patient's or authorized person's signature:

I hereby authorize payment direct to the below named dentist of the insurance benefits otherwise payable to me.

Signature (insured person)(if signed here, signature also needed below) : _____ **Date**: _____

I have reviewed the treatment plan, and I authorize release of any information relating to this claim. I understand I am responsible for all costs of dental treatment. I certify these statements to be true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony. All work covered on this form has been completed.

Signature (Patient, or parent if minor) : _____ **Date**: _____

PART 2 - To be completed by attending dentist (Attach copy of statement of services or pretreatment estimate.)

Dentist Information

21. Dentist name:	22. Dentist telephone: (_____) _____	23. Email address:	
24. Dentist's mailing address:	City:	State:	Zip code:
25. Is treatment result of occupational illness or injury? ☐ Yes ☐ No	26. Is treatment result of an auto accident? ☐ Yes ☐ No		
27. Other accident? ☐ Yes ☐ No	28. If prosthesis, is this initial placement? ☐ Yes ☐ No		

NOTE: Missing or inaccurate information on claim forms will cause delays in claim processing. Copy of detailed receipt must be included.