TruAssure INSURANCE COMPANY

Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

TruAssure Insurance Co.
P.O. Box 4495
Lisle, IL 60532
Payer ID: ILDTA

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY | 22. Gender | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. 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 prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Date Last SRP ____/____/____

41. Is Treatment for Orthodontics? ☐ No (Skip 42-43) ☐ Yes (Complete 42-43)

42. Date Appliance Placed (MM/DD/CCYY)

43. Months of Treatment Remaining | 44. Replacement of Prostheses ☐ No ☐ Yes (Complete 45) | 45. Date Prior Placement (MM/DD/CCYY)

46. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

47. Date of Accident (MM/DD/CCYY) | 48. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

49. Name, Address, City, State, Zip Code

50. NPI | 51. License Number | 52. SSN or TIN

53. Phone Number ( ) - | 53a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X_____
Signed (Treating Dentist) Date

55. NPI
Locum Tenens Treating Dentist? | 56. License Number

57. Address, City, State, Zip Code | 57a. Provider Specialty Code

58. Phone Number ( ) - | 59. Additional Provider ID