EPIC SPECIALTY BENEFITS

Dental Claim Form

The EPIC Life Insurance Company
P.O. Box 8430
Madison, WI 53708
Fax: (608) 327-6307

Instructions: To submit a claim, fill out the Dental Claim Form below and attach a copy of your billing statement from your dental provider, or have your dentist complete sections 3 through 5. Fax or mail the completed form along with any supporting documentation.

1. Policyholder Information

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

Identification Number _____Employer Name _____ Group Number _____

If I obtain services from a participating dentist (an in-network dentist), I understand that payment of the dental benefits will be sent to the named dentist or dental entity.

Signature of Policyholder_____Date_____

2. Patient Information

Last Name _____ First Name _____ Middle Initial _____

Relationship to Policyholder _____ Date of Birth _____ ☐ Student

I have been informed of the treatment plan and associated fees. I agree to be responsible for 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.

Signature of Patient _____Date_____

3. Ancillary Information

** Sections 3, 4, and 5 should be filled out by the dentist who performed the service.**

Place of Treatment: ☐ Provider's Office ☐ Hospital

ECF Number of enclosures (0 to 99): Radiograph(s) _____ Oral Image(s) _____ Model(s) _____ Charting _____

Protheses is Placed: ☐ Initial Placement ☐ Prior Placement ☐ Prior Placement Date _____

Treatment resulting from: ☐ Occupational Injury/Illness ☐ Auto Accident ☐ Other Accident | Accident Date: _____

Accident State: _____ Treatment for Orthodontics: ☐ Yes ☐ No | Placed Date: _____ Months Remaining: _____

4. Provider Information

Provider Last Name _____ First Name _____ Middle Initial _____

Provider Address _____ City _____ County _____ State _____ Zip _____

Taxonomy Code _____ Provider NPI# (Type 1) _____ License #/Other ID _____

Provider NPI# (Type 1) _____ License #/Other ID _____ Phone Number _____

Provider Billing Name _____ Provider Billing SSN/TIN# _____

Provider Billing Address _____ City _____ County _____ State _____ Zip _____

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

Signature of Provider _____Date_____

5. Services

Check Missing Tooth Number(s):

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T												

Procedure Date	Oral Cavity	Tooth Letter	Tooth Surface	Diagnostic Codes	Procedure Code	Treatment	Fee
Remarks:							Total Fee: