CarePartners of Connecticut Medicare Advantage HMO and PPO Member Dental Claim Form

(please complete one form per provider)

CarePartners of Connecticut MEDICARE ADVANTAGE

INSTRUCTIONS

1. You may need your dental provider to assist and supply information in completing this form, including the procedure code(s). Please also refer to the Member Claim Form Help Sheet for additional information.
2. To request reimbursement for dental services provided, please submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed claim form.
   b. Proof of services rendered.
   c. Proof of payment for the services being requested for reimbursement.
3. Reimbursement will be sent to the member at the address CarePartners of Connecticut has on record. If you believe your address is different than the address of record, please call Member Services at 1-888-341-1507 (TTY: 711).
4. Retain a copy of all receipts and documentation for your records.

MEMBER INFORMATION

Member ID #	Date of Birth (MM/DD/YYYY)

Member's Last Name	First Name	Middle Initial

CLAIM INFORMATION

Dental Provider Name	Setting where treatment was received	Telephone Number	Tax ID Number or National Provider Identifier (NPI)

Address of Dental Provider	Were services received outside of the U.S.? ☐ No, proceed to the next section ☐ Yes, answer the following questions: In what country was the patient seen? In what language was the bill written? In what currency was the bill paid?

Date(s) of Service	Procedure Codes for each service provided (if known)	Procedure Descriptions (e.g., office visit, dental cleaning, dental X-rays)	Tooth Number (if known)	Amount Paid
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
/ /				$
			Total amount paid	$

Attach another sheet if more services are reported.

Member or Personal Representative signature is required.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be canceled and I may be subject to criminal and/or civil penalties for false healthcare claims. I also understand that CarePartners of Connecticut may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name	Signature	Date

[redacted]

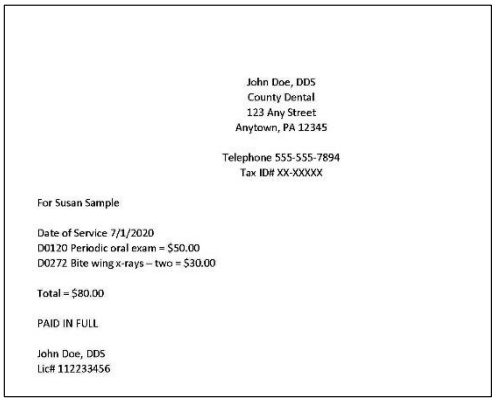
Please submit this form and all documentation to:

Dental Claims Processing Center
PO Box 211424
Eagan, MN 55121

MEMBER CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Member's ID #	Client ID #, found on the front of the ID card.
Member's Name	Last and First Names and Middle Initial of member who received services.
Member's Date of Birth	Date of birth: MM/DD/YYYY
Provider's Name, Address, Telephone Number, Tax ID number, or National Provider Identifier (NPI)	A dental provider includes, but is not limited to, general dentist, periodontist, and oral surgeon.
In what setting did the patient receive treatment?	Most dental services are received in an office.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code (if known) and detailed description (e.g., office visit, dental cleaning, dental X-ray).
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the canceled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider on the provider's letterhead with authorized signature indicating payment was made; a receipt for purchased items with the provider's name and address preprinted on the receipt with items listed and amount paid.

PROOF OF SERVICE AND PROOF OF PAYMENT EXAMPLES



John Doe, DDS
County Dental
123 Any Street
Anytown, PA 12345

Telephone 555-555-7894
Tax ID# XX-XXXXX

For Susan Sample

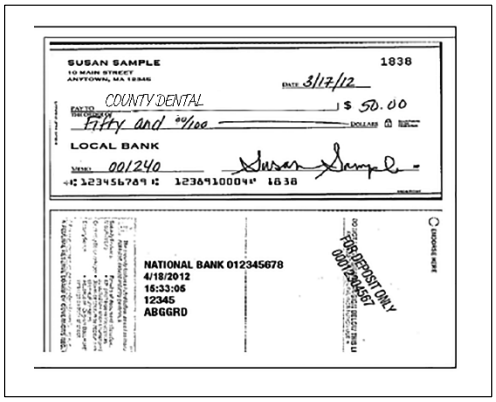
Date of Service 7/1/2020
D0120 Periodic oral exam = $50.00
D0272 Bite wing x-rays – two = $30.00

Total = $80.00

PAID IN FULL

John Doe, DDS
Lic# 112233456

This example demonstrates both proof of payment and proof of service.



SUSAN SAMPLE
10 MAIN STREET
ANYTOWN, MA 12345

1838

DATE 3/17/12

PAY TO THE ORDER OF COUNTY DENTAL $ 50.00

Fifty and 00/100 DOLLARS

LOCAL BANK

MEMO 001240 Susan Sample

⑆123456789⑆ 123691000⑈ 1838

NATIONAL BANK 012345678
4/18/2012
16:33:06
12345
ABGGRD

FOR DEPOSIT ONLY
0001234567

This example demonstrates proof of payment.