International Emergency and Expatriate Dental Program Claim Form and Instructions for Members

How to Complete the Claim Form

The dental claim form is designed to capture the information that is essential for an accurate payment. Please complete this form in English to ensure prompt payment. All claims should either be printed or typed to ensure accuracy and ease of administration. You may submit this claim in local or U.S. currency. If a claim is submitted with a non-U.S. currency, the currency submitted will be translated to U.S. currency as of the date of service using the website www.OANDA.com/converter/classic as the source.

Section A. General Information

Item 1.) Use this box only if you are a member who resides in the United States, was traveling abroad and received emergency dental care while outside of the United States.

Item 2.) Use this box only if you are a member who is enrolled in the Expatriate Dental Program, lives outside of the United States and received any dental care, including emergency care.

Section B. Employee and Patient Information

The employee and/or patient should complete the information in this section. This will ensure that the information is accurate for proper dental plan eligibility determination.

Follow the complete instructions for each numbered item in this section.

Print or type the following information:

Item 1.) The name of the country where services are given

Item 2.) The name of the employer providing the dental benefit coverage

Item 3.) The name of the patient receiving the services identified on this claim

Item 4.) The U.S. Identification Number of the patient receiving services

Item 5.) The date of birth, in month-day-year format, for the patient receiving services

Item 6.) The local Identification Number of the patient receiving services

Item 7.) Place a checkmark in this box if the patient is a full-time student

Item 8.) The name of the employee who is employed by the employer providing the dental benefits coverage

Item 9.) The U.S. Identification Number of the employee identified in Item 8

Item 10.) The date of birth, in month-day-year format, for the employee identified in Item 8

Item 11.) The local Identification Number of the employee identified in Item 8

Item 12.) The reason treatment is being performed (for example to diagnose, provide preventive care, emergency treatment, restoration)

Item 13 – 17.) The mailing address of the employee including street, city, state/province, country and postal/ZIP code

Item 18.) The home telephone number of the employee identified in Item 8

Item 19.) The work telephone number of the employee identified in Item 8

Item 20.) The facsimile number of the employee identified in Item 8, if available

Item 21.) The e-mail address of the employee identified in Item 8, if available

Section C. Dentist Information

The dentist or dental office personnel should complete this section. If the dentist is not willing to complete this section, the member may complete and attach a copy of the billing statement from the dentist.

Follow the complete instructions for each numbered item in this section.

Print or type the following information:

Item 22.) The dentist's complete name and title

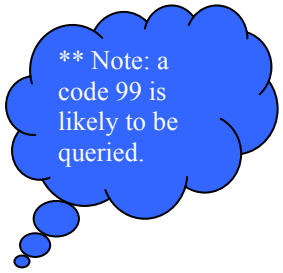
Item 23 – 27.) The mailing address of the dentist's surgery or practice. This includes street, city, state/province, country and postal code/ZIP code

Item 28.) The telephone number of the dentist's surgery or practice, including country and city code

Section D. Description of Services, Item 29.

- Print the name of the service in the space provided for "Service Rendered." List only one service per line on the claim form. This section is for non-emergency dental care services.
- Depending on the service provided, please use the following codes in the space provided for "Code." Place the two-digit code in the space provided under the heading "Code." List only one code per line.

Service Type	Code
Preventive Service	19
Diagnostic Service or Examination	09
Restorative Service (amalgams)	28
Major Restorative Service (crowns, inlays, onlays)	29
Endodontic	39
Periodontics	49
Prosthodontics, removable	58
Maxillofacial Prosthetics	59
Implant Services	60
Prosthodontics	69
Simple Extractions	78
Oral Surgery	79
Orthodontics	88
Miscellaneous	99 **



- Identify the date the service was rendered and place the date in the space provided by listing the month, day and year.
- List the tooth number in the space provided for "Tooth Number." Use the tooth numbering system of the country where services are provided.
- List the tooth surface in the space provided. Tooth surfaces to be used when describing posterior teeth are mesial, distal, occlusal, lingual, or buccal. Tooth surfaces to be used when describing anterior teeth are mesial, distal, occlusal, lingual, or facial. You may place more than one surface per line and abbreviate the surface name by using the first letter of the surface.
- List the fee or the charge to the patient for each dental care service provided in local currency or U.S. dollars. Please indicate the currency type in the space allocated on the claim for "Fee."

Section E. Emergency Services, Item 30.

Check the "Yes" or "No" box if dental services were obtained while traveling outside of the United States. If "Yes" is checked and the dental service(s) were performed to treat a dental emergency, attach the invoice from the dentist to the claim form. Complete the claim form and insert the date the service(s) were performed.

Patient's Signature

In the space provided, the patient or guardian (if the patient is a minor) should sign the bottom of the claim form. If this form is submitted via e-mail, the signature is deemed authorized and present if the patient's name is typed in the space provided.

Dentist's Signature

The dentist should sign the claim form in the space provided. If either the dentist or the member submits this form via e-mail, the signature is deemed present if the dentist's name is typed in the space provided. If you are submitting the claim electronically, you must have the dentist's permission to place his/her name in the signature space. If you do not have his/her authorization, leave this space blank.

SECTION A. Please mail, e-mail or fax completed Claim Form with itemized bills and receipts. All Claims must be in English. Fees may be submitted in either local or U.S. currency.

1.) ☐ I live in the U.S., traveled abroad and this claim is for an emergency. Complete all applicable boxes except number 29.

If you checked # 1, the address to submit your claim in the United States is:

Mail: International Emergency Dental Program
P.O. Box 29
Minneapolis, MN 55440-0029

By e-mail: Scan the claim form and e-mail to:
InternationalDentist@decare.com

2.) ☐ I live outside of the U.S. and am submitting a claim for dental services under the Expatriate Dental Program. Complete all applicable boxes.

If you checked # 2, the address to submit your claim internationally is:

DeCare International
Industrial Estate
Claremorris
Mayo, Ireland

Phone: 0-94-9372257 (in Ireland)
Phone: + 353-94-9372257 (outside Ireland)
Facsimile: 0-94-9362685 (in Ireland)
Facsimile: + 353-94-9362685 (outside Ireland)

+ Dial your country's outbound calling code (for example, Switzerland is 00) plus 353-94-9372257

Please print or type on this Claim Form.
Complete Sections A, B, C and Signature line. Complete a Separate Claim Form for each Family Member.

SECTION B. EMPLOYEE AND PATIENT INFORMATION

1.) Country where services were rendered_____

2.) Employer_____

3.) Patient's Name_____

4.) Identification Number:

5.) Patient's Date of Birth_____
(month) (day) (year)

6.) Local Identification Number:

7.) If patient is a full-time student, check this box ☐

8.) Employee's Name:_____

9.) Identification Number:

10.) Employee's Date of Birth_____
(month) (day) (year)

11.) Local Identification Number:

12.) Reason for treatment _____

Employee's Mailing Address

13.)_____ (Street)

14.) _____ (City)

15.) _____ (State/Province)

16.) _____ (Country)

17.)_____ (Postal Code/Zip Code)

Please provide the Employee's telephone and facsimile numbers, with country and city codes.

18.)_____ (Home Number)

19.)_____ (Work Number)

20.)_____ (Fax Number)

21.)_____ (E-mail Address)

SECTION C. DENTIST INFORMATION.

22.)_____ (Dentist Name)

23.)_____ (Surgery/Practice Street)

24.)_____ (City)

25.)_____ (State/Province)

26.)_____ (Country)

27.)_____ (Postal Code/Zip Code)

28.) +_____ (Telephone Number - Include country and city code)

29.) SECTION D. DESCRIPTION OF SERVICES (Please retain X-rays and keep records, including Clinical Narrative for future reference)

Service Rendered	Code **		Date of Service (mm/dd/yy)	Tooth #	Surface (mesial/distal/occlusal/ lingual/buccal/facial)	Fee (Identify currency) (Inclusive of tax, if any)
		00				
		00				
		00				
		00				
		00				
	** Note 99 in this area is likely to be queried.					

SECTION E.

30.) Emergency Services ☐ Yes ☐ No

For emergency claim, attach invoice from dentist and insert date of service here _____ (Date)

PATIENT'S SIGNATURE AND RELEASE: (Parent or Guardian, if claim is for a minor). I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine benefits payable.

31.) ***PATIENT'S SIGNATURE:***_____ ***DATE:***_____

32.) ***DENTIST'S SIGNATURE:***_____ ***DATE:***_____

Electronic dispatch of this form will be deemed to be a signature.

DeCare Dental™

Claim Form Mailing Instructions

Emergency Claims

If your patient lives in the United States, traveled abroad, received emergency dental services and you are completing the invoice/claim for them and are mailing it on their behalf, please submit the claim form to the following mailing address or return the completed claim form to your patient for them to mail.

Address to Submit Emergency Dental Claims

By mail: International Emergency Dental Program
P.O. Box 29
Minneapolis, MN 55440-0029

By e-mail: Scan the claim form and e-mail to:
InternationalDentist@decare.com

By facsimile: US Facsimile: 1-651-994-5172

Expatriate Dental Program Claims

If your patient is a member of the Expatriate Dental Program and received dental care while living and working abroad, and you are completing the invoice/claim for them and are mailing it on their behalf, please submit the claim form to the following mailing address:

Address to Submit Expatriate Dental Claims

DeCare International
Industrial Estate
Claremorris
Mayo
Ireland

Facsimile: within Ireland 0-94-9362685
Outside of Ireland + 353-94-9362685

E-mail address: InternationalDentist@decare.com

DeCare Dental International Telephone Numbers and Instructions For Dental Claims Inquiry or Questions

When calling within Ireland: 0-94-9372257

When calling outside of Ireland: Contact your international operator and Request: + 353-94-9372257

Hours for Claim query: 0830 – 1700 GMT
Monday through Friday

Facsimile: within Ireland 0-94-9362685
Outside of Ireland + 353-94-9362685