

# CLAIM FOR DENTAL, VISION, AND HEARING EXPENSE BENEFITS

**Submit x-rays with:**

- treatments involving gold restoration, crowns, root canals, or bridgework
- X-RAYS MAY BE REQUESTED FOR OTHER SERVICES

Any person who knowingly and with intent to injure, defraud, or deceive any insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

MAIL TO:  
 CLAIMS DEPARTMENT  
 P.O. BOX 925309  
 HOUSTON, TX 77292-2728

**PART 1**

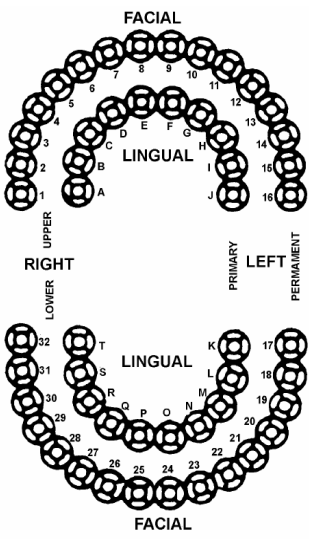
1. Patient Name		2. Relationship to Employee Self   Spouse   Child   Other				3. Sex M   F		4. Patient Birthday MO   Day   Year			5. If full time student School   City	
6. Employee First   Middle   Last			7. Employee Social Security No.			8. Group number if known						
9. Employee Mailing Address								City, State			Zip	
10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim. Patient's Signature (Parent if minor).												

**PART 2**

11. Dentist Name First   Middle   Last												
12. Mailing Address								City, State			Zip	

**TO BE COMPLETED BY DENTIST**

13. Dentist Soc. Sec. or ITIN		14. Dentist License No.		15. Dentist Phone No.		16. First Visit Date Current Series		17. Place of Treatment Office   Hosp.   ECF   Other			18. Radiographs or Models Enclosed?		No	Yes	How Many?
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19. Dentist - Check One <input type="checkbox"/> Pretreatment Estimate <input type="checkbox"/> Statement of Actual Services  	32. Examination and treatment Plan - List in order from tooth number 1 through tooth number 32 Use chart system shown										For Home Office Only			
	Tooth No. or Ltr.	Surface	Description of Services (including X-rays, Prophyaxis Materials Used, etc.)	Date Service Performed			Procedure Code	Fee	For Home Office Only					
Mo.				Day	Yr.	<input type="checkbox"/> Schedule			<input type="checkbox"/> Other					

Dental Unit Use		Total Fee Actually Charged	Deductible	
Employee Eligible Date _____				These benefits will, subject to Policy provisions, be payable if the described procedures are performed while the patient is insured with ManhattanLife Assurance Company of America
Employee Effective Date _____				
Termination Date _____				
Verified By _____				
Date _____				

**Part 3**

**TO BE COMPLETED BY DENTIST**

I hereby certify that the services listed above have been performed on the above named patient on the dates indicated													
Dentist Signature _____								Date _____		Patient pays		Insurance will pay	



## DENTAL, VISION, HEARING CLAIM FORM

### Claimant's Proof of Loss

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Social Security No: \_\_\_\_\_ Telephone No: \_\_\_\_\_

#### THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/OTOLOGIST

- Name of Examiner: \_\_\_\_\_ License No: \_\_\_\_\_
- Date of Most Recent Hearing Aid Test: \_\_\_\_\_
- Date of Prescription for Hearing Aid: \_\_\_\_\_
- In my professional opinion, a hearing aid  is required  is not required
- Hearing Loss (%) Left Ear \_\_\_\_\_ % Right Ear \_\_\_\_\_ %

#### THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

- Hearing Aid Center: \_\_\_\_\_ License No: \_\_\_\_\_
- Hearing Aid Type or Mode: \_\_\_\_\_
- Cost of Hearing Aid Appliance \$ \_\_\_\_\_

#### DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE BELOW)

Date(s) of Service MM DD YY	Place of Service	Type of Service	Modifier	Procedures, Services, or Supplies CPT or HCPCS Code	Diagnosis Code	Charges	Or Units	Leave Blank

Federal Tax I.D. Number SSN <input type="checkbox"/> EIN <input type="checkbox"/>	Patient's Account No.	Accept Assignment? <input type="checkbox"/> YES <input type="checkbox"/> NO	Total Charges \$	Amount Paid \$	Balance Due \$
Signature of Physician or Supplier Including Degrees or Credentials	Name and Address of Facility Where Services Were Rendered (if other than home or office)		Physician's, Supplier's Billing Name, Address, Zip Code and Phone #		
Signed _____			PIN # _____		
Date _____			GRP # _____		

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

**WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## How to File a Claim for Your Dental, Vision and Hearing Policy

### Vision

#### Purchases and Vision Exams at a Retail Store

Most vision care (Exams, eyeglasses, frames, lenses, and contacts) are purchased at retail location, such as Lenscrafters, Costco, Walmart and independent retailers. Most of these locations require you to pay at the cash register, requiring you to file the claim yourself.

#### Purchases made from an online store

Sometimes vision care (eyeglasses, frames, lenses, and contacts) are purchased from online stores, such as 1800contacts.com, coastal.com or lens.com. If you purchase online you will need to print out the itemized paid receipt provided by the retailer and submit with your completed claim form.

#### Claim Filing

We accept the HCFA 1500 (Health Care Financial Administration) standardized health insurance claim form or the Vision Claim Form at [www.manhattanlife.com](http://www.manhattanlife.com)

Your policy will consider charges for basic eye exams, refractions, eyeglasses and contact lenses.

In the information section of the form, you or your physician must fill in the following information.

- Insured's full name and address
- Insured's ID Number
- The name and date of birth of the insured receiving the vision services.

#### If your vision care provider files the claim for you

Many ophthalmologist and optometrists will file the claim on your behalf. Many may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Insurance ID card to your vision care provider.

### Hearing

#### Claim Filing

We accept the HCFA 1500 (Health Care Financial Administration) Standardized health insurance claim form or the Hearing Claim at [www.manhattanlife.com](http://www.manhattanlife.com)

Your policy will considered charges for hearing exams due to hearing loss and the cost of hearing aids.

In the information section of the form, you or your physician must fill in the following information.

- Insured full name and address
- Insured's policy number
- The name and date of birth of the insured receiving the hearing services.

#### If your hearing care provider files the claim for you

Many audiologists and otologist will file the claim on your behalf. Many may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Insurance ID card to your hearing care provider.

#### Attachment of Supporting Documentation for Vision and Hearing Claims

You should substantiate your claim expenses by attaching itemized bills and receipts, which contain the following information.

- Insured's full name and address
- Insured's ID number
- Provider's name and address
- Dates that care or treatment was provided
- Physician's and/or Retailer's Tax ID Number
- Dates that hearing aids and/or glasses/contacts were purchased
- ICD diagnosis codes
- CPT/HCPCS procedure codes
- Description of each treatment
- Charge for each service.

## Dental

### Claim Filing

A dental insurance claim form is submitted to request payment for services rendered or to file for per-authorization of services to be performed. We accept the ADA's (American Dental Association) standardized dental insurance claim form.

In the information section of the form, you or the dentist must fill in the following information.

- Insured's full name and address
- Insured's ID Number
- The name and date of birth of the insured receiving the dental services.

### Attachment of Supporting Documentation

You should substantiate your dental insurance claim expenses by attaching itemized bills and receipts, which contain the following information.

- Insured's full name and address
- Insured's ID number
- Provider's name and address
- Dates that dental care or treatment was provided
- Dentist's Tax ID Number
- Dates that services or treatment were received
- Tooth surface(s) and tooth number(s), arch, quadrant
- ADA procedure codes
- Description of each treatment
- Charge for each service

### If your Dental Care Provider Files the Claim for You

Many dental offices will file the claim on your behalf. Some may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Insurance ID card to your dental care provider.

**All claims be submitted to ManhattanLife Assurance Company of America by mail or fax.**

**ManhattanLife Assurance Company of America**

**Worksite Division**

**P.O. Box 924408**

**Houston, Texas 77292-4408**

**Fax: 713-583-0677**

[www.manhattanlife.com](http://www.manhattanlife.com)