Colonial Voluntary Benefits

Dental Claim Office
P.O. Box 80139
Baton Rouge, LA 70898-0139
Phone: (888) 400-9304 or (225) 400-9304

Dental Claim Form

Return completed form via fax **(855) 400-9307**, email **DentalClaims@ColonialLife.com**, or mail to the address above.

PART 1 - To be completed by member

The following information is required with your DETAILED RECEIPT for reimbursement:

Subscriber Information

1. Subscriber social security number or member ID:		2. Subscriber name (Last name, First name, MI):	
3. Subscriber's address:		City: State:	Zip code:
4. Subscriber birth date: _____ / _____ / _____ MM DD YY	5. Subscriber policy/Group number:	6. Subscriber's company name (if group policy):	
7. Email Address		8. Telephone/contact number: (_____) _____	

Patient Information

9. Patient name (Last name, First name, MI):		10. Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	11. Patient birth date: _____ / _____ / _____ MM DD YY
12. Is patient a full-time student? ☐ Yes ☐ No **If yes**, please provide proof.		13. Is patient covered by another dental plan? ☐ Yes ☐ No	
If #13 is YES, please complete below:			
14. Policy number:		15. Name and address of insurance carrier:	
16. Name of insured:	17. Relationship: ☐ Spouse ☐ Child	18. Insured's social security number:	19. Date of birth: _____ / _____ / _____ MM DD YY
20. Name and address of employer (if applicable):			

Patient's or authorized person's signature:

I hereby authorize payment direct to the below named dentist of the insurance benefits otherwise payable to me.

Signature (insured person)(if signed here, signature also needed below) : _____ **Date**: _____

I have reviewed the treatment plan, and I authorize release of any information relating to this claim. I understand I am responsible for all costs of dental treatment. I certify these statements to be true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony. All work covered on this form has been completed.

Signature (Patient, or parent if minor) : _____ **Date**: _____

PART 2 - To be completed by attending dentist (Attach copy of statement of services or pretreatment estimate.)

Dentist Information

21. Dentist name:	22. Dentist telephone: (_____) _____	23. Email address:	
24. Dentist's mailing address:	City:	State:	Zip code:
25. Is treatment result of occupational illness or injury? ☐ Yes ☐ No	26. Is treatment result of an auto accident? ☐ Yes ☐ No		
27. Other accident? ☐ Yes ☐ No	28. If prosthesis, is this initial placement? ☐ Yes ☐ No		

NOTE: Missing or inaccurate information on claim forms will cause delays in claim processing. Copy of detailed receipt must be included.

Dental plans are underwritten by The Paul Revere Life Insurance Company, Worcester, MA and administered by Starmount Life Insurance Company.