International Emergency 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
Use this box 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.

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

Section C. Dentist Information

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.

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

** Note: a code 99 is likely to be queried.

- 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.

Attach invoice from the dentist to the claim form. Complete the claim form and insert the date the service(s) were performed. Check the box in item 30 if you and the dentist agree this service was an emergency to obtain coverage through this program.

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 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.

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

Submit your claim in the United States to: International Emergency Dental Program
P.O. Box 9304
Minneapolis, MN 55440-9304
E-mail your claim form to: InternationalDentist@decare.mco
Fax your claim form to: Within Ireland 0-94-9362685, Outside of Ireland + 353-94-9362685

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)

<table>
<thead>
<tr>
<th>Service Rendered</th>
<th>Code **</th>
<th>Date of Service (mm/dd/yy)</th>
<th>Tooth #</th>
<th>Surface (mesial/distal/occlusal/lingual/buccal/facial)</th>
<th>Fee (Identify currency, inclusive of tax, if any)</th>
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</tbody>
</table>

** 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.
Claim Form Mailing Instructions

Emergency Claims

Please submit the claim form to the following mailing address or return the completed claim form to your patient for them to mail.

<table>
<thead>
<tr>
<th>Address to Submit Emergency Dental Claims</th>
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</table>
| **By mail:** International Emergency Dental Program  
P.O. Box 9304  
Minneapolis, MN 55440-9304 |
| **By e-mail:** Scan the claim form and e-mail to:  
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