Claim submission made easy

When visiting a provider where you are responsible for payment of services at the time of service, use this claim form to request reimbursement for authorized services according to your plan document. Send your completed form and itemized receipts that indicate the services provided and the amount charged for each service. Services must be paid in full to receive reimbursement. Claims can be submitted to: **Interactive Medical Systems, PO Box 1349, Wake Forest, NC 27588.**

How to file your dental claim

1. Complete the member and patient information on the top of the claim form.
2. Provide a copy of the dentist's Statement of Treatment or a detailed receipt of services that includes:
    - Date each service was performed
    - Tooth Number(s) or Letter(s), if applicable
    - Tooth Surface, if applicable
    - CDT Procedure Code
    - Description
    - Fee for each service

    If the Statement of Treatment or similar document you receive from your dentist is missing any of the information listed in Step 2, please enter it on the claim form (#13).
3. Sign and submit the claim.

What happens next?

Each time IMS processes a claim submitted by you or your healthcare provider, we explain how we processed it in the form of an Explanation of Benefits (EOB). If you have not received your EOB within 30 days from submission of your Dental Claim form, please call IMS at 800-426-8739 for confirmation that your claim was received. Please call IMS with any questions at 800-426-8739 Option 2 for Member.

MEMBER DENTAL CLAIM FORM

1. Member Name	2. Member ID # (from ID card)	3. Member Group # (from ID card)
4. Member Address		5. Phone Number
6. Patient Name		7. Patient Date of Birth
8. Is Patient Covered for Dental Care by Another Plan _____ No _____ Yes - If yes, please complete box 9		
9. Name of Other Carrier/Plan _____ Cardholder Name _____ Relationship to Member _____ Self _____Spouse _____ Child _____Other		
10. Is Treatment Related to Orthodontics? _____ No _____ Yes If Yes, Date Appliance Placed _____ Months of Treatment Remaining _____		
11. Check if Treatment Resulting from _____ Auto Accident _____ Job Related _____ Other Accident _____		
12. Is Treatment Replacement of Prosthesis? _____ No _____ Yes If yes, Date of Prior Placement _____		

13. Complete this section if the Dental Statement of Treatment does not include this information.

	Date of Service	Area of Oral Cavity	Tooth No. or Letter	Tooth Surface	CDT Procedure Code	Description	Fee
1							
2							
3							
4							
5							
6							
7							
							Total Fee Charged

Treating Dentist Name	Dentist Address	Phone Number
Tin or SS#	License Number	

By signing below you are authorizing the release of any information to Interactive Medical Systems (IMS) and certifying the information provided in support of this claim is complete and correct. If the patient is a minor, a parent must sign the statement. Other authorized representatives include caretaker, guardian or other individual as appropriate under state law and the circumstances of the case. By signing the statement, the patient (or parent or other authorized representative), consents to the use and disclosure of information relating to the services provided by the health care professional for the purpose of treatment, payment or health care operation, including submission of a claim for benefits to a provider or administrator of dental benefits.

Signature of Member _____ Date Signed _____

Don't forget to include a copy of the dentist's statement of treatment.