



Dental Administration
 PO Box 2050
 Winston-Salem, NC 27102

Documentation of Other Coverage

Action Required by Subscriber: Complete all information requested below, sign and date this form and return it to ACS at the address shown above. A completed Other Insurance Coverage form must be submitted upon request.

IMPORTANT: Failure to provide all requested information will delay the processing of your claims.

Subscriber Name:	Subscriber Id	Subscriber's Day Time Telephone Number
Claimant Name	Group Id Number	Group Name
Is the Claimant listed above covered under any other Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "NO" Please Sign and date at the bottom of the form and return it to ACS at the address shown above.		
If "YES" Please Provide the following Information:		
Name of Other Carrier:		Policy Number:
Subscriber Name:	Relation to Claimant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	
Effective Date of Coverage: / /	Term Date of Coverage: / /	
Subscriber Certification: I HEREBY CERTIFY THAT THE ABOVE INFOAMTION IS TRUE AND CORRECT. I ALSO UNDERSTAND THAT THE PRIVACY STANDARDS FO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT REGULATIONS AUTHORIZE A COVERED ENTITY/HEALTH CARE PROVIDER TO RELEASE PROTECTED HEALTH INFORMATION TO ACS BENEFIT SERVICES, INC. FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS PURPOSES.		
Subscriber Signature: _____		Date: _____
For ACS Use Only: Other Coverage is: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary Date: / /		