

PO Box 2006
Concord, NH 03302-2006
(800) 253-1358

Dependent Verification Request

To: _____ Group: _____
Date: _____
Subscriber ID: _____

We are in receipt of a claim for your dependent noted below. In order to determine coverage for your dependent, and to ensure timely processing of the claim, we would appreciate your completing this form and promptly returning it. If you are unable to respond within 21 days, we will assume the coverage for this dependent should be canceled and the claim(s) denied.

Dependent's Name: _____ Birth Date: _____

- 1. Is the dependent a student in an accredited school, college, or university?** Yes No

If yes:

Name of the School: _____

Current school year: _____ to _____

If no:

Is the dependent incapacitated? Yes No

- 2. If the dependent is incapacitated, we must receive written verification from the attending physician on his/her letterhead, which must include the following information:**

- A) Type of disability
- B) Prognosis – permanent or temporary
- C) If temporarily disable, an estimate as to the length of time of the disability

Upon the return of this form to our office, the claim will be processed promptly, and our records will be changed to reflect the dependent's status as verified by you and/or the attending physician. Students will be updated for the current school year. Please remember to notify your employer if coverage for this dependent has changed.

If you have any questions, please feel free to contact our Customer Service department at 800-253-1358.

I hereby affirm that, to the best of my knowledge and belief, the information provided in this document is true and accurate.

SUBSCRIBER'S SIGNATURE _____ Date _____

Subscriber's daytime telephone number: _____

**This form is to be completed by the subscriber and returned to New England Dental Administrators, LLC.
A copy was forwarded to the rendering provider for informational purposes.**