

Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services Request for Predetermination/Preauthorization
 EPSDT/ Title XIX

2. Predetermination/Preauthorization Number



INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender

- M F

15. Policyholder/Subscriber ID (SSN or ID#)

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender

- M F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person Named in #5

- Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above

- Self Spouse Dependent Child Other

19. Student Status

- FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender

- M F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee |
|----|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|-----------------|---------|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

MISSING TEETH INFORMATION

| 34. (Place an 'X' on each missing tooth) | Permanent | | | | | | | | | | | | | | | | Primary | | | | | | | | | | 32. Other Fee(s) | 33. Total Fee | | | | | |
|--|-----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---------|---|---|---|---|---|---|---|---|---|------------------|---------------|--|--|--|--|--|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | A | B | C | D | E | F | G | H | I | J | | | | | | | |
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | T | S | R | Q | P | O | N | M | L | K | | | | | | | |
| 35. Remarks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____ Date
Patient / Guardian signature

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Date
Subscriber signature

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number () -

52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment

- Provider's Office Hospital ECF Other

39. Number of Enclosures (00 to 99)

- Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?

- No (Skip 41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis?

- No Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from

- Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____ Date
Signed (Treating Dentist)

54. NPI

55. License Number

56. Address, City, State, Zip Code

56A. Provider Specialty Code

57. Phone Number () -

58. Additional Provider ID

HOW TO FILE A CLAIM

1. Complete boxes 1 – 23.
2. Please make sure box 15 contains your member number as it appears on your ID card. **Do not use your social security number in this box.**
3. Be sure to sign the authorization to release information in box 36.
4. Ask your dentist to complete boxes 24 – 58, or attach an original itemized billing from the dentist on his/her letterhead or approved ADA claim form that includes all information requested in boxes 24-58.
5. Attach all related Explanation of Benefits statements for other coverage if applicable.
6. Send completed claim form to:

Dental Claims Administrator
PO Box 69436
Harrisburg, PA 17106-9436

NOTE: Subscriber submitted claim forms must be submitted within 180 days of the date of service. Claims which cannot be identified due to incomplete subscriber information will be returned.

HOW TO REACH US

Phone: • Members - (888) 223-4999
 • Providers - (888) 224-5213

Write: Dental Customer Service
 PO Box 69437
 Harrisburg, PA 17106-9437