Dental Claim Form

See reverse for instructions

1.	2.	3. Carrier name and address
☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Provider ID #	☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #	

PATIENT COVERAGE INFORMATION

4. Patient name first m.i. last	5. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____	6. Sex m f	7. Patient birthdate MM DD YYYY	8. If full time student school city
9. Employee/subscriber name and mailing address	10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate MM DD YYYY	12. Employer (company) name and address	13. Group number
14. Is patient covered by another dental plan yes no If yes, complete 15-a. Is patient covered by a medical plan? yes no	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employer(s)	
17-a. Employee/subscriber name (if different from patient's)	17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate MM DD YYYY	18. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other _____	

19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim.**

› _____ _____
Signed (Patient* – see reverse) Date

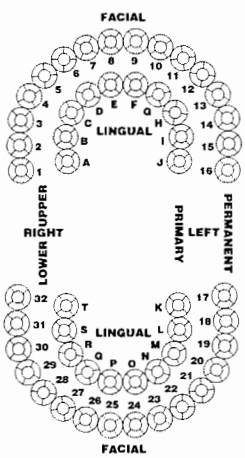
20. **I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**

› _____ _____
Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity			30. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates	
22. Address where payment should be remitted			31. Is treatment result of auto accident?				
23. City, State, Zip			32. Other accident?				
24. Dentist Soc. Sec. or T.I.N.	25. Dentist license no.	26. Dentist phone no.	33. If prosthesis, is this initial placement?			(If no, reason for replacement)	34. Date of prior placement
27. First visit date current series	28. Place of treatment Office Hosp. ECF Other	29. Radiographs or models enclosed? No Yes How many?	35. Is treatment for orthodontics?			If service already commenced enter: Date appliances placed	Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

38. Remarks for unusual services

39. **I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.**

› _____
Signed (Treating Dentist) License Number Date

40. Address where treatment was performed

City State Zip

41. **Total Fee Charged**	
42. **Payment by other plan**	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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The following is an item-by-item description of the questions appearing on the new form. All questions in the Billing Dentist Section should be answered as completely as possible to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries. Special completion and mailing instructions, which may vary from company to company, will be printed on the form and will not be addressed here.

1. **Dentist's pretreatment estimate or statement of actual services:** By checking the appropriate box, the form may be processed more quickly and with less chance of error. **Provider identification number:** Some third-party payers use an I.D. number that is different from the T.I.N. or license number.
2. **Medicaid claim, EPSDT, prior authorization number, patient I.D. number:** Include appropriate information for government funded benefit programs as necessary.
3. **Carrier name and address:** The name and address of the carrier where the claim is to be sent. On carrier-supplied claim forms, this information ordinarily will be preprinted at the top of the form.
4. **Patient name:** This should be completed in full for proper identification purposes.
5. **Relationship to employee:** Employee here refers to the insured person and his or her relationship to the patient. This relationship sometimes affects the patient's eligibility, as well as level of benefits available.
6. **Sex:** This is requested for identification purposes and for statistical analysis.
7. **Patient birthdate:** Very important for determination of eligibility.
8. **If full-time student:** Eligibility of the dependent patient may be affected if the patient is over a certain age (specified in the benefits policy) and is still a full-time student.
9. **Employee/subscriber name and address:** Refers to the insured person and is not necessarily the patient.
10. **Employee/subscriber dental plan I.D. number:** If you do not know your dental plan ID # contact your dental plan. Your social security number (SSN) is commonly used for computer and manual processing of claims, but some carriers use an identification number that is different from the SSN.
11. **Employee/subscriber birthday:** Very important for determination of coordination of benefits.
12. **Employer (company) name and address:** Refers to employer of person in #8.
13. **Group number:** Refers to master contract policy number assigned to the employer group.
14. **Is patient covered by another dental plan? or Is patient covered by a medical plan?:** This is to determine multiple coverage. The information contained in items 14-18 is very important in order to determine which other carriers, if any, have primary liability for treatment provided.

15a. **Name and address of carrier(s):** Refers to carrier(s) in #14.

15b. **Group number:** Refers to #14.

16. **Name and address of other employer(s):** Refers to employer offering plan in #14.

17a. **Employee/subscriber name (if different from patient's):** Refers to employee from #16.

17b. **Employee/subscriber dental plan I.D. number:** Refers to Employee in #17a. If you do not know your dental plan ID # contact your dental plan. Your social security number (SSN) is commonly used for computer and manual processing of claims, but some carriers use an identification number that is different from the SSN.

17c. **Employee/subscriber birthdate:** Refers to employee in #17a. Necessary for coordination of benefits.

18. **Relationship to patient:** Refers to employee in 17a.

*19. **Patient signature block:** The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.

20. **Employee/subscriber block:** This block must be completed if the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
21. **Name of Billing Dentist, or Dental Entity:** The individual dentist's name or the name of the group practice/corporation responsible for billing. This may differ from the actual treating dentist's name. This is the name that should appear on any payments or correspondence that will be remitted to the billing dentist.
22. **Address where payment should be remitted:** Self explanatory.
23. **City, state, zip:** Self explanatory.
24. **Dentist's social security number or T.I.N.:** Refers to dentist or dental entity in #21. These numbers are frequently used as individual provider identification numbers. The Internal Revenue Service requires that either the social security or tax payer identification number of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated. If the billing entity is a group practice, clinic, etc., the entity's T.I.N. should be entered.
25. **Dentist's license number:** Frequently used as a means of provider identification. This should be the license number of the billing dentist. This may differ from that of the treating dentist, which appears in the Dentist's signature block at the bottom of the form.
26. **Dentist's phone number:** Self explanatory. Include area code also.
27. **First visit date current series:** Important to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
28. **Place of treatment:** Depending on where treatment is rendered, medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
29. **Radiographs or models enclosed**: Indicates whether diagnostic materials were submitted. Assists in return of proper number of materials to dentist.
30. **Is treatment result of occupational illness or injury?:** Refers to possible application of Workers Compensation, which would alter coverage available and carrier involved. Important for coordination of benefits and accurate claims processing.
31. **Is treatment result of auto accident?**: Will affect reimbursement in no-fault auto cases. Indicates whether another party's insurance may be responsible. Also important for coordination of benefits.
32. **Other accident?:** Similar to #30 and #31.
33. **If prosthesis, is this initial placement?:** Most dental contracts have specific limitations on replacement of dentures, partials, crowns, and bridges. This is used to determine eligibility and liability.
34. **Date of prior placement?:** Contracts specify time limitations concerning the replacement of prosthetic devices.
35. **Is treatment for orthodontics?**: When orthodontics are covered, dates and months of treatment remaining will affect the prorated monthly reimbursement made to the dentist.
36. **Identify missing teeth with "x"**: Self explanatory.
37. **Examination and treatment plan:** Self explanatory. Use the American Dental Association's Current Dental Terminology (CDT-2) for appropriate procedure codes.
38. **Remarks for unusual services**: Use to indicate any information which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, utilize unused portion of #37, or attach a separate sheet.
39. **Dentist's signature block:** The treating dentist's signature and license number.
40. **Address where treatment was performed:** Complete this section if the treatment was performed at a different location than indicated in #22 and #23.
41. **Total fee charged:** Sum of the fees for each procedure reported.
42. **Payment by other plan:** If known, indicate the dollar amount paid by other benefit plan(s).

For administrative use only: Area where carrier calculates benefits.

Payment itemization: The spaces under "payment by other plan" will be completed by the carrier and may vary from carrier to carrier.