Dental Claim Form

(603) 223-1234
(800) 832-5700
Delta Dental Plan of Maine
Delta Dental Plan of New Hampshire
Delta Dental Plan of Vermont

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

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

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

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

NORTHEAST DELTA DENTAL
ONE DELTA DRIVE
PO BOX 2002
CONCORD, NH 03302-2002

OTHER COVERAGE

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

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Subscriber Identifier
9. Plan/Group Number	10. Patient's Relationship to Other Insured (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

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

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Subscriber Identifier
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) ☐ 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)	
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	33. Total Fee	

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.

X _____
Patient/Guardian signature Date

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 _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ 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 (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

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

47. Auto Accident State

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 (Billing Entity)	50. License Number	51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. Treatment completed – payment requested. I hereby certify that I have completed the procedures as indicated by date of service. I request payment in accordance with Plan rules and regulations.

X _____
Signed (Treating Dentist) Date

54. NPI (Treating Dentist)	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty

PLEASE SEE REVERSE SIDE FOR DEFINITION OF INCURRED DATES (DATE OF SERVICE).
IMPORTANT: ALTHOUGH THE INCURRED DATE IS USED FOR DETERMINING LIABILITY, A SERVICE MUST NEVER BE BILLED UNTIL COMPLETED. **(ADS 07/15)**

GENERAL INSTRUCTIONS

A. The form is designed so that the Primary Payer's (primary insurance company) name and address (Item 3) are visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the comprehensive instructions that completion is not required.
D. When a name and address field is required the full name of an individual or a business, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to a secondary payer, complete the form in its entirety and attach the primary payers Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

ITEMS OF NOTE

39. Number of Enclosures (00 to 99): This item is completed whether or not radiographs, oral images, or study models are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore no possible attachments are missing.
When supplementary material is sent with the claim, the number of each type is entered in the appropriate box, using two digits. If less than 10, use 0 in the first position. 'Oral Images' include digital radiographic images and photographs and are reported by the number of images.
43. Replacement of Prosthesis?: This Item applies to Crowns and all Fixed or Removable Prostheses (e.g. bridges and dentures). Please review the following three situations in order to determine how to complete this Item.
    a) If the claim does not involve a prosthetic restoration check "NO" and proceed to Item 45.
    b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, check "NO" and proceed to Item 45.
    c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, check the "YES" field and complete section 44.
53. Certification: Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed procedures indicated by date for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form. Dentists should be aware that they have an ethical and legal obligation to refund fees for services that are paid in advance but are not completed.

PROVIDER TAXONOMY CODES

58. Treating Provider Specialty: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist / A dentist is a person qualified by a doctorate in dental surgery (DDS) or dental medicine (DMD) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice / Many dentists are general practitioners who handle a wide variety of dental needs.	1223G000IX
Dental Specialty / Other dentists practice in one of the nine specialty areas recognized by the American Dental Association.	Various (see following list)
Dental Public Health	1223D000IX
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X
Dental provider taxonomy codes listed above are a subset of the full code set that is posted at **http://www.wpc-edi.com/codes/codes.asp**	

DATE OF INCURRED LIABILITY

The Date of Incurred Liability refers to the date a service is subject to the applicable Deductible, Co-insurance Percentage, Maximum benefit, and limitations. The total cost of the service is applied to the Coverage Period during which the service is completed, irrespective of the Coverage Period in which the service is started.

PLEASE NOTE

Northeast Delta Dental's date of incurred liability for multiple visit procedures is as follows:

A. Restorative Crowns and Onlays — Total cost for crowns and onlays shall be incurred on the date that the crown or onlay is cemented.
B. Fixed Partial Dentures (abutment crowns and pontics) — The total cost for fixed partial dentures shall be incurred on the date that the said appliance is cemented.
C. Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the said appliance is delivered to the patient.
D. Endodontics — Total cost for endodontic treatment shall be incurred when the canal is filled to completion.
E. Implant Body — Total cost for the implant body, including healing cap, shall be incurred on the date of surgical placement.
F. Implant Prosthetics — Total cost for the prosthetic portion of an implant shall be incurred on the date that the said appliance is cemented or delivered to the patient.
G. Orthodontics — Total cost for the orthodontic treatment shall be incurred on the date the initial bands, or a segment thereof, or a device, is placed in the patient's mouth.

COMPLETION OF TREATMENT

Northeast Delta Dental does not make payment for incomplete treatment unless terminated due to death of patient. To qualify as a covered service, a service must be completed and, if applicable, "delivered" to the patient.

FRAUD NOTICE

MAINE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH RSA 638:20.