**Dental Claim Form** (603) 223-1234 HEADER INFORMATION 🛆 DELTA DENTAL' (800) 832-5700 1. Type of Transaction (Check all applicable boxes) Delta Dental Plan of Maine Delta Dental Plan of New Hampshire Statement of Actual Services Request for Predetermination/Preauthorization Delta Dental Plan of Vermont EPSDT/Title XIX 2. Predetermination/Preauthorization Number PRIMARY INSURED INFORMATION 12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code PRIMARY PAYER INFORMATION 3. Name, Address, City, State, Zip Code NORTHEAST DELTA DENTAL ONE DELTA DRIVE PO BOX 2002 14. Gender 13. Date of Birth (MM/DD/CCYY) 15. Subscriber Identifier (SSN or ID#) CONCORD, NH 03302-2002 ∏м ∏ ғ OTHER COVERAGE 16. Plan/Group Number 17. Employer Name 4. Other Dental or Medical Coverage? Yes (Complete 5-11) No (Skip 5-11) PATIENT INFORMATION 5. Other Insured's Name (Last, First, Middle Initial, Suffix) 18. Relationship to Primary Insured (Check applicable box) 19. Student Status 7. Gender 8. Subscriber Identifier (SSN or ID#) Spouse Dependent Child Other FTS PTS 6. Date of Birth (MM/DD/CCYY) Пм ∏ F 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 10. Patient's Relationship to Other Insured (Check applicable box) 9. Plan/Group Number Self Spouse Dependent Other 11. Other Carrier Name, Address, City, State, Zip Code 22. Gender 21. Date of Birth (MM/DD/CCYY) 23. Patient ID/Account # (Assigned by Dentist) ¬м [ RECORD OF SERVICES PROVIDED 5. Area 26 27. Tooth Number(s) 28. Tooth 29. Procedure 24. Procedure Date Tooth of Oral 30. Description 31. Fee (MM/DD/CCYY) or Letter(s) Surface MISSING TEETH INFORMATION Permanent Primary 32. Other Fee(s) 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 В С D Е F G Н 34. (Place an 'X' on each missing tooth) 31 29 28 27 26 25 24 23 22 21 20 19 18 17 S R Q Р 0 Ν М 33.Total Fee 35. Remarks **AUTHORIZATIONS** ANCILLARY CLAIM/TREATMENT INFORMATION 39. Number of Enclosures (00 to 99)
Radiograph(s) Oral Image(s) Mod 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 38. Place of Treatment (Check applicable box) 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 Provider's Office Hospital ECF 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. 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY) No (Skip 41-42) Yes (Complete 41-42) 42. Months of Treatment Remaining 44. Date Prior Placement (MM/DD/CCYY) Patient/Guardian signature 43. Replacement of Prosthesis? No Yes (Complete 44) 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named 45. Treatment Resulting from (Check applicable box) Occupational illness/injury Auto accident Other accident Subscriber signature 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 TREATING DENTIST AND TREATMENT LOCATION INFORMATION claim on behalf of the patient or insured/subscriber) 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. 48, Name, Address, City, State, Zip Code

Signed (Treating Dentist) Date 54. NPI (Treating Dentist 55. License Number 56. Address, City, State, Zip Code 50. License Number 51. SSN or TIN 58. Treating Provider Specialty 57. Phone Number ( 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 12/06)

49. NPI (Billing Entity)

52. Phone Number (

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 6 of the ADA Publication titled CDT-2007/2008. Key extracts from that section of CDT-2007/2008 follow:

## 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

A service shall be deemed to have been incurred and the total cost for that service subject to applicable deductible, co-payment percentage, maximum benefit, and limitations shall be applied to the contract year during which the service was incurred, irrespective of the contract year during which the service is completed, according to the following:

## PLEASE NOTE

Although the "Procedure Date" column should indicate the date treatment was initiated (in accordance with Northeast Delta Dental's definition of "Date of Incurred Liability"), payment should never be requested until the procedure is completed.

- A. Restorative Crowns. Total cost for crowns and jackets shall be incurred on the date that the tooth is prepared to receive said appliance.
- B. Fixed Bridge (Abutment Crowns and Pontics). Total cost for fixed bridges shall be incurred on the date that the first tooth is prepared to receive said appliance.
- C. Removable Bridgework (Removable Dentures). Total cost for removable bridgework (dentures) shall be incurred on the date that the final impressions are taken for said appliance.
- D. Endodontics. Total cost for endodontic treatment shall be incurred when the pulp chamber of the tooth is opened for the root canal.
- E. Implants. Total cost for an allowance toward a prosthesis used in conjunction with an implant shall be incurred on the date that the impression is taken for said prosthesis.

# 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.