

MEMBER DENTAL CLAIM FORM

Please submit claim to:
Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

HEADER INFORMATION		INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX		3. Company/Plan Name, Address, City, State, Zip Code	
2. Predetermination/Preauthorization Number		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
OTHER COVERAGE (Mark applicable box and complete 5-11. If none, leave blank.)		PATIENT INFORMATION	
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (if both, complete 5-11 for dental only.)		13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#)	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		16. Plan/Group Number 17. Employer Name	
6. Date of Birth (MM/DD/CCYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#)		18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other 19. Reserve For Future Use	
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		21. Date of Birth (MM/DD/CCYY) 22. Gender <input type="checkbox"/> M <input type="checkbox"/> 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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee	
1										
2										
3										
4										
5										

33. Missing Teeth Information (Place an "X" on each missing tooth.)																34. Diagnosis Code List Qualifier <input type="checkbox"/> <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)				31a. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____					
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A") B _____ D _____		32. Total Fee			

35. Remarks

AUTHORIZATIONS		ANCILLARY CLAIM/TREATMENT INFORMATION	
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		38. Place of Treatment _____ (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N) <input type="checkbox"/> (Use "Place of Service Codes for Professional Claims")	
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		40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)	
		42. Months of Treatment Remaining: 43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)	
		45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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.)			TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
48. Name, Address, City, State, Zip Code			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 _____ Signed (Treating Dentist) Date		
49. NPI	50. License Number	51. SSN or TIN	54. NPI	55. License Number	
52. Additional Provider ID			56. Address, City, State, Zip Code		56a. Provider Specialty Code
52a. Phone Number () -		57. Phone Number () -		58. Additional Provider ID	

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

CA: For your protection California law requires that the following appear on the form: Any person who knowingly presents a false claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

DC & RI: 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.

FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

IN & OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LA: 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.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

TN & WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.