

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate **or** statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
  2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.
  - 3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.
  - 8-11, 16. Patient name address, city, state, and zip code: Include the patient's legal name.
  12. Patient date of birth: Necessary to determine eligibility.
  13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
  14. Sex: Necessary for identification purposes and for statistical analysis.
  15. Patient phone number: Necessary if questions arise that require immediate attention.
  17. Relationship to subscriber/employee: Relationship between the insured person and the patient may affect the patient's eligibility, as well as level of benefits available.
  18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
  19. Subscriber/Employee ID # or Social Security number: This information refers to the insured person and is not necessarily the patient. The Social Security number (SSN) is commonly used for computer and manual processing of claims.
  20. Employer name: Self explanatory.
  21. Group number: Refers to the master contract policy number assigned to the employer group.
  - 22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.
  31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
  32. Policy #: Refers to master contract policy number assigned to the employer group.
  - 33-35. Other subscriber's information: Refers to employee with policy number in box #32.
  36. Plan/Program name: Necessary to identify national programs such as TRICARE.
  37. Employer/School: Refers to person in box #33. Necessary for eligibility requirements and COB.
  38. Subscriber/Employer status: Refers to person in box #22. May be necessary for eligibility and COB.
  39. 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.
  40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
  41. Employee/subscriber block: Necessary when 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.
  - 42-43,46,50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
  44. Provider ID #: Necessary when carriers assign unique numbers to providers that differ from the Social Security number or the tax payer identification number (T.I.N.).
  45. Dentist's Social Security number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security or T.I.N. 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 or the entity T.I.N. when the billing entity is a group practice or clinic.
  47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
  48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
  49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
  53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
  54. Is treatment for orthodontics? Necessary to determine the prorated benefit.
  55. If prosthesis is for a crown, bridge or denture, is this initial placement? Determines eligibility and liability.
  56. Is treatment result of occupational illness or injury? Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
  57. Is treatment result of auto accident? Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
  58. Diagnosis Code Index: When reporting the diagnoses for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnoses code(s) in spaces 1-8, as necessary. The submitter should record the 5-digit diagnosis codes on line 1 through 8. In box 59, the numbers 1-8 would be entered under the diagnosis index # column.
  59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnoses as necessary for each procedure code. When a patient has more than one diagnoses per procedure, separate index number with comma.
  60. Identify all missing teeth with "x".
  61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
  62. Dentist's signature block: The treating dentist's signature and license number. Dentists should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
  - 63-66. Address where treatment was performed: Necessary if the treatment was performed at a different location than indicated in boxes #46,50-52.
- 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.

# Dental Claim Form

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1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Specialty (see backside)	3. Carrier Name
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT	Prior Authorization #	4. Carrier Address
		5. City
		6. State
		7. Zip

<b>PATIENT</b>	8. Patient Name (Last, First, Middle)			9. Address			10. City			11. State			
	12. Date of Birth (MM/DD/YYYY) / /		13. Patient ID #			14. Sex <input type="checkbox"/> M <input type="checkbox"/> F		15. Phone Number ( )			16. Zip Code		
	17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						18. Employer/School Name _____ Address _____						

<b>SUBSCRIBER / EMPLOYEE</b>	19. Subs./Emp. ID#/SSN#		20. Employer Name			21. Group #			31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical			32. Policy #					
	22. Subscriber/Employee Name (Last, First, Middle)											33. Other Subscriber's Name					
	23. Address					24. Phone Number ( )				34. Date of Birth (MM/DD/YYYY) / /		35. Sex <input type="checkbox"/> M <input type="checkbox"/> F		36. Plan/Program Name			
	25. City			26. State		27. Zip Code				37. Employer/School Name _____ Address _____							
	28. Date of Birth (MM/DD/YYYY) / /			29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other			30. Sex <input type="checkbox"/> M <input type="checkbox"/> F			38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student							
	39. 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 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.  X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)									40. Employer/School Name _____ Address _____					41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.  X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)		

<b>BILLING DENTIST</b>	42. Name of Billing Dentist or Dental Entity				43. Phone Number ( )			44. Provider ID #		45. Dentist Soc. Sec. or T.I.N.					
	46. Address				47. Dentist License #			48. First visit date of current series:		49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other					
	50. City		51. State		52. Zip Code			53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No			54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced:				
	55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No							If no, reason for replacement: _____			Date of prior placement: _____		Date appliances placed _____		Total mos. of treatment remaining _____
	56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____				57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____										

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____																											
59. Examination and treatment plans - List teeth in order																											
Date (MM/DD/YYYY)	Tooth		Surface		Diagnosis Index #		Procedure Code		Qty	Description		Fee	Admin. Use Only														
60. Identify all missing teeth with "X"																											
Permanent						Primary						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	Payment by other plan	
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	Max. Allowable	
61. Remarks for unusual services												Deductible															
												Carrier %															
												Carrier pays															
												Patient pays															

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.  X _____ Signed (Treating Dentist) License # _____ Date (MM/DD/YYYY) _____			63. Address where treatment was performed		
64. City		65. State		66. Zip Code	