DELTA DENTAL

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION

1. ☐ STATEMENT OF ACTUAL SERVICES ☐ PREDETERMINATION REQUEST

MAIL CLAIMS TO DELTA DENTAL
240 VENTURE CIRCLE
NASHVILLE, TN 37228

OTHER COVERAGE

2. OTHER DENTAL OR MEDICAL COVERAGE? ☐ NO IF NO, SKIP TO #11 ☐ YES
3. AMOUNT OF PRIMARY PAYMENT $
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP
5. DATE OF BIRTH
6. GENDER ☐ M ☐ F
7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)
8. PLAN/GROUP NUMBER
9. RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME

SUBSCRIBER INFORMATION

11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP
12. DATE OF BIRTH
13. GENDER ☐ M ☐ F
14. SUBSCRIBER ID (SSN OR ID#)
15. PLAN/GROUP NUMBER
16. EMPLOYER NAME

PATIENT INFORMATION

17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)
18. RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
19. DATE OF BIRTH
20. GENDER ☐ M ☐ F
21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS ☐ FULL TIME STUDENT ☐ TOTALLY & PERM DISABLED ☐ IRS DEPENDENT ☐ SPONSORED DEPENDENT

DENTAL SERVICES

	22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH	PERMANENT															PRIMARY										29. TOTAL FEE CHARGED
30. PLACE X ON MISSING TOOTH NUMBERS	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	

REMARKS

31.

AUTHORIZATIONS

32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.

PATIENT/GUARDIAN SIGNATURE DATE

33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.

SUBSCRIBER SIGNATURE DATE

ADDITIONAL CLAIM INFORMATION

34. PLACE OF TREATMENT ☐ DENTAL OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER
35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____
36. IS TREATMENT RELATED TO ORTHODONTICS? ☐ NO ☐ YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____
37. TREATMENT RESULTING FROM: ☐ OCCUPATIONAL ILLNESS/INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT
38. REPLACEMENT OF PROSTHESIS? ☐ YES DATE PRIOR PLACEMENT _____ ☐ NO

BILLING DENTIST/DENTAL ENTITY (IF APPLICABLE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)

39. NAME, ADDRESS, CITY, STATE, ZIP
40. NPI
41. LICENSE NUMBER
42. TIN
43. PHONE NUMBER ( )

TREATING DENTIST AND LOCATION

44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO PREDETERMINE THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGEMENT.

X _____
SIGNED (TREATING DENTIST) DATE

45. NPI
46. LICENSE NUMBER
47. TIN
48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)
49. PHONE NUMBER ( )
50. ADDITIONAL DENTIST ID
51. SPECIALTY CODE

For the fastest processing, submit claims electronically through our **Dental Office Toolkit!**
It's free, easy, and available to all dentists. Check our Web site for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- Clearly type, hand write, or use a computer printer to enter information.
- Use all upper-case (capital) letters, if possible.
- Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.
- Keep information within the correct field.
- Make sure the typewriter or printer ribbon is dark and the print can be easily read.
- Cover mistakes with line tape and print or type over—do not use liquid correction fluid.
- Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter $0 unless the primary carrier's determination of payment was $0. DO NOT ATTACH the primary carrier's voucher.
- Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- Hand or machine print
- When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).
- Use current ADA CDT procedure codes.
- Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.
- Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.
- Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO	WEB SITE
Delta Dental 240 Venture Circle Nashville, TN 37228	(800) 223-3104 (615) 255-3175	www.deltadentaltn.com