Section 20
Dental

Dental Program Overview

ADA Claim Form
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CDPHP Dental Programs Overview

CDPHP considers the oral hygiene of its members an important part of their overall health. The health plan strives to provide members with options for cost-effective access to medically necessary, quality dental care. A variety of partnerships and contracts makes this possible.

Our dental program includes the following:

1) Delta Dental

CDPHP has entered into a co-marketing agreement with Delta Dental of New York to offer the high quality dental plans and services that have made the Delta Dental system the nation’s largest dental benefits provider. Delta Dental programs are marketed alongside our medical plans, giving members access to the largest network of participating dentists in the U.S. Delta Dental may be reached at 1-800-471-7091, ext. 4916, for information about participation.

2) Delta Dental (Medicaid–Select Plan and HARP and Child Health Plus Only)

CDPHP has transitioned the management of our Select Plan, HARP, and Child Health Plus dental programs to Delta Dental, effective July 1, 2018.

3) CDPHP and Unified Products

CDPHP continues to have direct dental business not managed by either of the above-named companies. The health plan is also responsible for those dental services that are covered under the medical benefit for all lines of business. This includes treatment of accidental injury to natural teeth and congenital anomalies.

To request fee schedules or other information about the CDPHP dental program, please call the CDPHP provider services department at 1-800-926-7526.

Revised June 2018
# AOA Dental Claim Form

## HEADER INFORMATION

1. **Type of Transaction (Mark all applicable boxes)**
   - Statement of Actual Services
   - Request for Predetermination/Preauthorization

2. **EPSDT/Title XIX**

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. **Company/Plan Name, Address, City, State, Zip Code**

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

5. **Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)**

6. **Date of Birth (MM/DD/CCYY)**

7. **Gender**
   - M
   - F

8. **Policyholder/Subscriber ID (SSN or ID#)**

## OTHER COVERAGE

9. **Plan/Group Number**

10. **Patient’s Relationship to Person Named in #5**
    - Self
    - Spouse
    - Dependent Child
    - Other

11. **Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**

## RECORD OF SERVICES PROVIDED

<table>
<thead>
<tr>
<th>Procedure Date (MM/DD/CCYY)</th>
<th>Area of Oral Cavity</th>
<th>Tooth System</th>
<th>Tooth Number(s) or Letter(s)</th>
<th>Tooth Surface</th>
<th>Procedure Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

## MISSING TEETH INFORMATION

<table>
<thead>
<tr>
<th>Tooth</th>
<th>Permanent</th>
<th>Primary</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

## 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.

### 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.

### Subscriber signature

**Date**

## 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**

52. **Phone Number ( ) – **

53. **SSA Additional Provider ID**

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

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

13. **Date of Birth (MM/DD/CCYY)**

14. **Gender**

15. **Policyholder/Subscriber ID (SSN or ID#)**

16. **Plan/Group Number**

17. **Employer Name**

## PATIENT INFORMATION

18. **Relationship to Policyholder/Subscriber in #12 Above**

19. **Student Status**
   - Self
   - Spouse
   - Dependent Child
   - Other

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

21. **Date of Birth (MM/DD/CCYY)**

22. **Gender**

23. **Patient ID/Account # (Assigned by Dentist)**

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. **Place of Treatment**
   - Provider’s Office
   - Hospital
   - ECF
   - Other

39. **Number of Enclosures (00 to 99)**

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**
   - Occupational illness/injury
   - Auto accident
   - Other accident

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

47. **Auto Accident State**

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

### Signed (Treating Dentist)

**Date**

## ACKNOWLEDGMENTS

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J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)
General Instructions:

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the left and right margins. The upper-right blank space is provided for insertion of the third-party payer's claim or control number.

a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow.
b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20 and 48).
c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53).
d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the third-party payer.

Data Element Specific Instructions

1. EPSDT / Title XIX -- Mark box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21.
2. Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
3. Leave blank if no other coverage.
4. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
5. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
6. Subscriber's or employer group's Plan or Policy Number. May also be known as the Certificate Number. [Not the subscriber's identification number.]
7. Complete only if the patient is not the Primary Subscriber. (i.e., "Self" not checked in Item 18)
8. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
9. Enter if dentist's office assigns a unique number to identify the patient that is not the same as the Subscriber Identifier number assigned by the payer (e.g., Chart #).
10. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.
12. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen (-) to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
13. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B = Buccal; D = Distal; F = Facial; L = Lingual; M = Mesial; O = Occlusal.
14. Use appropriate dental procedure code from current version of Code on Dental Procedures and Nomenclature.
15. Dentist's full fee for the dental procedure reported.
16. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
17. Total of all fees listed on the claim form.
18. Report missing teeth on each claim submission.
19. Use "Remarks" space for additional information such as 'reports' for 9999 codes or multiple supersumeritary teeth.
20. Patient Signature: The patient is defined as an individual who has established a professional relationship with the 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.
21. Subscriber Signature: Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
22. ECF is the acronym for Extended Care Facility (e.g., nursing home).
23. Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.
24. 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.
25. Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim.
26. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
27. The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied only if the provider accepts payment directly from the third-party payer.
28. When the payment is being accepted directly report the: 1) SSN if the billing dentist is unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
29. The treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
30. Use address, including city, state and zip code, where treatment performed by treating (rendering) dentist.
31. Enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers Taxonomy' code list. The current list is posted at: http://www.wpc-edl.com/codes/codes.asp. The available taxonomy codes, as of the first printing of this claim form, follow printed in boldface.

122300000X Dentist -- A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.

Many dentists are general practitioners who handle a wide variety of dental needs.

1223G0001X General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

1223D0001X Dental Public Health
1223D0200X Endodontics
1223P0010X Oral & Maxillofacial Pathology
1223D0080X Oral and Maxillofacial Radiology
1223S0112X Oral & Maxillofacial Surgery
1223X0400X Orthodontics

1223P0221X Pediatric Dentistry
1223P0300X Periodontics
1223P0700X Prosthodontics

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