Dental Claim Form

See reverse for instructions

DELTA DENTAL
Delta Dental Plan of New Jersey

1. ☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services
2. ☐ Medicaid Claim Prior Authorization #
☐ Electronic Claim #

3. **Carrier name, address and phone**
Delta Dental Plan of New Jersey
P.O. Box 222
Parsippany, NJ 07054-0222

Claim Inquiries: email: service@deltadentalnj.com
(800) 452-9310

PATIENT

4. Patient Name (Last, First, Middle) ☐ Check here if disabled | 5. Address | 6. City | 7. State

8. Date of Birth (MM/DD/YYYY) / / | 9. Patient ID#/SS# | 10. Sex ☐M ☐F | 11. Phone Number ( ) | 12. Zip Code

13. Relationship to Subscriber/Employee:
☐ Self ☐ Spouse ☐ Child ☐ Other_____

14. If full time student, print school and attach student enrollment documentation (see instructions on reverse).
☐ Full-time Student ☐ Part-time Student

SUBSCRIBER/EMPLOYEE

15. Subs./Emp. ID#/SS# | 16. Employer Name and Address | 17. Group #

18. Subscriber/Employee Name (Last, First, Middle)

19. Address | 20. Phone Number ( )

21. City | 22. State | 23. Zip Code

24. Date of Birth (MM/DD/YYYY) / / | 25. Marital Status ☐ Married ☐ Single ☐ Other | 26. Sex ☐M ☐F

OTHER POLICIES

27. Is Patient covered by another plan for services listed on this form? ☐ No (Skip 28-33) ☐ Yes: ☐ Dental or ☐ Medical | 28. Policy #

29. Other Subscriber's Name (If Different)

30. Date of Birth (MM/DD/YYYY) / / | 31. Sex ☐M ☐F | 32. Program Name

33. Employer Name_____ Address_____

34. Subscriber/Employee Status ☐ Employed ☐ Part-time Status

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 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 to the carrier of any information and documentation relating to this claim and/or any request for pre-treatment estimate without any further authorization in the future.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

35. **LEFT BLANK INTENTIONALLY**

37. **LEFT BLANK INTENTIONALLY**

BILLING DENTIST

38. Name of Billing Dentist or Dental Entity | 39. E-mail | 40. Phone Number ( ) | 41. Fax ( ) | 42. Provider ID # | 43. Dentist Soc. Sec. or T.I.N.

44. Address | 45. Dentist License # / State | 46. First visit date of current series: | 47. Place of treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other

48. City | 49. State | 50. Zip Code | 51. Radiographs or models enclosed? ☐ Yes, How many?_____ ☐ No | 52. Is treatment for orthodontics? ☐ Yes ☐ No If service already commenced: Date appliances placed Total mos. of treatment remaining

53. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No | If no, reason for replacement: | Date of prior placement:

54. Is treatment result of occupational illness or injury? ☐ No ☐ Yes
Brief description and dates_____

55. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither
Brief description and dates_____

56. Diagnosis Code Index

LEFT BLANK INTENTIONALLY

57. Examination and treatment plans - List teeth in order

	Date service completed Mo. Day Year	Tooth	Surface		Procedure Code	Qty	Description	Fee
1.					1.		1.	1.
2.					2.		2.	2.
3.					3.		3.	3.
4.					4.		4.	4.
5.					5.		5.	5.
6.					6.		6.	6.
7.					7.		7.	7.
8.					8.		8.	8.

Admin. Use Only

58. Identify all missing teeth with "X" using the Universal/National System

Permanent									Primary										
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

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

59. Remarks for unusual services

60. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. For pre-treatment estimates, the fees submitted are the actual fees I intend to collect for those procedures.

>
Print Name of Treating Dentist | Signature of Treating Dentist | License Number | Date

61. Address where treatment was performed

62. City | 63. State | 64. Zip Code

8/2001

INFORMATION FOR DENTIST

- This Attending Dentist's Statement is to be used for either a request for payment of completed services or as a request for pre-treatment estimate of benefits. ***
- 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).
- If you are submitting this claim in response to information requested from a prior electronic claim submission, indicate the electronic claim number in the space provided in box 2.
- All appropriate numbered boxes, 1-64, must be completed on this form in order to avoid delays in processing.
- Please check to be sure that the patient has provided all necessary information for items 1-37.
- For DEPENDENT STUDENTS, attach school registrar's certification of current enrollment or copy of paid tuition receipt.
- Refer to the PARTICIPATING DENTIST HANDBOOK for procedure numbers and pre-treatment estimate of benefits instructions.
- If you are unable to list all procedures for the patient on the 8 "procedure" lines on the service report, attach a second FULLY COMPLETED report for the remaining procedures.
- Be sure that the PATIENT HAS SIGNED the Attending Dentist's Statement. The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental 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.
- Be sure to SIGN the Attending Dentist's Statement and include your name or the name of the group practice/corporation responsible for billing. This may differ from the actual treating dentist's name. This is the name that should appear on any payments or correspondence that will be remitted to the billing dentist.
- Be sure to include your social security number or T.I.N. in section 43. These numbers are frequently used as individual provider identification numbers. The Internal Revenue Service requires that either the social security or tax payer identification number of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the social security number if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated. If the billing entity is a group practice, clinic, etc. the entity's T.I.N. should be entered.
- All requests for payment or pre-treatment estimate of benefits must be fully completed on the Attending Dentist's Statement; superbills will not be accepted.
- Mail to:

DELTA DENTAL®
Delta Dental Plan of New Jersey
P.O. Box 222
Parsippany, NJ 07054-0222

Claim Inquiries:
(800) 452-9310
email: service@deltadentalnj.com
www.deltadentalnj.com

- Delta will determine whether the deductible has been satisfied and/or maximum has been reached and calculate the payment accordingly.
- PARTICIPATING DENTISTS will be paid by Delta for services covered under the subscriber's contract, subject to eligibility determination and limits of coverage. **Do not bill your patient until after the Delta payment is made, as it is unlikely that you will always be able to determine in advance precisely what that payment will be.**
- NON-PARTICIPATING DENTISTS—Delta will make payment for services covered by the subscriber's contract directly to the subscriber.
- **Delta shall not be obligated to pay or adjust claims received more than one year after the date of rendition of the service.**

DELTA PARTICIPATING DENTIST RULES

Submission of the Attending Dentist's Statement shall be deemed to constitute an agreement by a participating dentist with the following conditions governing dentist participation in Delta group dental care programs:

1. Obligation of patient for fees for services covered under a Delta group dental care program shall be limited to that amount indicated by Delta as Patient Payment for the services listed.

2. In submitting the Attending Dentist's Statement to Delta, the dentist represents that fees shown thereon are the actual fees charged to and intended to be collected from the patient and do not exceed his/her usual, customary and reasonable fees. **** The dentist's usual fees are subject to verification by inspection of his/her office records upon request by Delta.

3. The dentist will schedule and perform all dental treatment in accordance with applicable standards of the dental profession in his/her community.

4. Delta may periodically check on adequacy of care provided by dentists, and dentists shall cooperate with duly appointed committees or consultants to facilitate such checks.

5. The dentist shall not charge a covered person more than his/her usual fee as filed with Delta, except for procedures performed under unusual or extenuating circumstances, the charges for which shall be subject to the approval of Delta.

6. The dentist shall not be entitled to accept or receive from Delta a fee greater than his/her usual fee, as filed with Delta for the dental services provided. Where payment of the fee is shared by Delta and the covered patient, the total fee as shared shall be no more than the usual fee charged by the dentist as filed with Delta.

*** Pre-treatment estimate of benefits is always recommended for extensive treatment and is only intended to avoid misunderstandings between the patient, dentist, and Delta concerning benefits payable. **A pre-treatment estimate is not a guarantee of benefits. Payment will be determined based upon the patient's eligibility for the services at the time they are completed.**

**** For definition of terms, "usual, customary and reasonable" and other information useful in improving communications among patients, dentists and Delta, please consult the PARTICIPATING DENTIST HANDBOOK, the participation agreement, the Bylaws of Delta, and the applicable Rules and Regulations.