ADA American Dental Association® Dental Claim Form

Health & DC 37 Security Plan

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

DC 37 HEALTH & SECURITY PLAN
125 BARCLAY ST., NY., N.Y. 10007-2179
(212) 815-1234

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

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#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

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 ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

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

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ 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										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee $

35. Remarks

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.

X _____
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.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of 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

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

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52a. Additional Provider ID

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.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID

A FAILURE TO COMPLY WITH THESE INSTRUCTIONS COULD RESULT IN A DELAY OF YOUR CLAIM BEING PROCESSED OR A REJECTION OF THIS CLAIM

Important Notes

Pre-authorization is mandatory before beginning treatment for prosthetics (dentures and bridgework), single crowns, extensive gum treatment, TMJ therapy, root canal therapy or orthodontics. **YOU MUST SUBMIT A PRE-AUTHORIZATION PLAN FOR THE ABOVE LISTED SERVICES OR YOUR CLAIM WILL BE REJECTED.** The Plan's office reviews the pre-authorization plan, then notifies you and your dentist if the intended work is covered and for how much. **PLAN COVERAGE FOR ANY WORK PERFORMED BY YOUR DENTIST ASSUMES THAT YOU ARE ELIGIBLE FOR BENEFITS WHEN THE WORK IS PERFORMED,** and takes into consideration the Plan's rules and regulations regarding yearly maximums and frequency limitations for certain procedures. Payment will be made only if you are eligible at the time the service is performed. Crown and bridgework should not be started until you and your dentist receive notification about the pre-authorization plan.

The maximum benefit is $1,700 per calendar year and is based on the Plan's fee schedule. In all circumstances, Plan rules regarding restrictions, limitations, and annual dollar limit will apply.

Instructions for filing a request for pre-authorization or claim for completed services:

Member:

- Complete all information in the Policy Holder/Subscriber section including boxes #4 -23.
- Member, patient or guardian of minor child should complete box #36 by providing the date and either signature or indicating "signature on file."
- Member must complete box #37 to authorize payment to dentist.

Dentist:

- Complete all information in the dentist section including your social security number or tax I.D. number and complete address.
- In the treatment area, list all procedures and fees separately. Include all information such as tooth number and quadrant codes, dollar amounts for each procedure, and the **total dollar amount in box #32**. Only CDT codes will be accepted in column #29.
- All necessary mounted x-rays should be submitted along with a request for pre-authorization or claims for completed services.

TO EXPEDITE CLAIMS PROCESSING, submit claims or requests for pre-authorization **ELECTRONICALLY** via Secure EDI at https://www.secureedi.com/securetrack/home.aspx. Submit all paper claims or requests for pre-authorization to the DC 37 Health and Security Plan, 125 Barclay Street, New York, N.Y. 10007. All correspondence to the Plan office should include the member's name, social security number or PID # (personal identification number). **The member must file a claim for completed services within 30 days after the completion of work. Claims for orthodontic services may be submitted monthly, but no later than quarterly.**

FALLO DE CUMPLIR CON LAS INSTRUCCIONES PUEDE RETRAZAR EL PROCESO DE SU RECLAMO O QUE EL PAGO SEA RECHAZADO.

Notas importantes

Es obligatorio tener una autorización previa antes de empezar el tratamiento de prótesis (dentaduras y trabajo de puente), coronas solas, tratamiento extensivo de encías, terapia TMJ, terapia de raíces u ortodoncia. **DEBE PRESENTAR UN PLAN DE PREAUTORIZACIÓN PARA LOS SERVICIOS ARRIBA MENCIONADOS. SI NO, SE LE RECHAZARÁ SU RECLAMO.** La oficina del Plan revisa el plan de preautorización y después le notifica a usted y a su dentista si el trabajo que se busca hacer está cubierto y cuánto dinero cubre. **PLAN CUBRE TRABAJOS HECHOS POR SU DENTISTA ASUMIENDO QUE USTED TIENE DERECHO A RECIBIR PRESTACIONES CUANDO SE REALIZA EL TRABAJO**, y tomando en cuenta las reglas y regulaciones del Plan sobre cantidades máximas permitidas cada año y frecuencia permitida para ciertos procedimientos. El pago se efectuará sólo si usted es elegible en el momento en que el servicio se lleva a cabo. Antes de empezar el tratamiento para dentaduras y trabajo de puentes el dentista y el miembro deben recibir un plan de preautorización. **El máximo de prestaciones permitidas es $1,700.00 por cada año, del calendario, con base en el programa de cuotas del Plan. En cada circunstancia se aplicarán las reglas del Plan respecto a restricciones, límites, y límites de dólares anuales.**

Instrucciones para llenar una solicitud de preautorización o de reclamo para servicios ya hechos.

El miembro:

- Complete toda la informacion en la parte sobre la seccion "policy holder/subscriber," incluyendo cajas #4-23
- El miembro, paciente o encargado de un nino menor debe completar caja # 36 poniendo la fecha y firma o indicando "firma en archivo."
- Miembro tiene que completar caja # 37 para autorizar pago al dentista.

El dentista:

- Complete toda la información en la parte sobre el dentista, incluyendo su número de seguro social, o de identificación de contribuyente de impuestos, y su dirección completa.
- En la parte sobre el tratamiento, haga una lista de todos los procedimientos y cuotas separado. Incluya toda la información como el número del diente y cuadrante códigos, cantidades de dinero para cada procedimiento y la cantidad total en dólares en caja # 32. Se aceptarán solamente códigos de CDT (terminologia corriente dental) en columna #29.
- Todas las radiografías montadas necesarias deben presentarse junto con una solicitud de preautorización o de reclamos por servicios ya hechos.

PARA ACELERAR PROCESAMIENTO DE LOS RECLAMOS, SUBMITE LOS RECLAMOS O SOLICITUDES DE PREAUTORIZACION **ELECTRONICAMENTE** via Secure EDI a https://www.secureedi.com/securetrack/home.aspx. Sumita todos los reclamos o solicitudes de preautorizacion en papel a DC37 Health and Security Plan 125 Barclay Street, New York, N.Y. 10007. Todas la correspondencia recibidas al plan debe de incluiré el nombre del miembro y el numero de seguro social o PID # (numero de identificación personal). **El Miembro debe presentar un reclamo por servicios ya hechos en un plazo de 30 días después de terminar el trabajo. Los reclamos por servicios de ortodoncia deben presentarse mensualmente, a más tardar trimestralmente.**