DELTA DENTAL

Form for international claims

TYPE OF TRANSACTION

1. ☐ STATEMENT OF ACT ☐ PREDETERMINATION REQUEST

MAIL CLAIMS TO: **DELTA DENTAL OF COLORADO**
P.O. BOX 173803
DENVER, CO 80217-3803

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 CODE:

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 CODE:

12. DATE OF BIRTH

13. GENDER ☐ M ☐ F

14. SUBSCRIBER/ POLICYHOLDER 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

SUBSCRIBER INFORMATION

	22. DATE OF SERVICE MM/DD/YYY	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							

29. TOTAL FEE CHARGED

30. PLACE **X** ON MISSING TOOTH NUMBERS

MISSING TEETH	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

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. WHERE PERMITTED BY LAW, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.

PATIENT/GUARDIAN 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 (#40 – #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)		
39. NAME, ADDRESS, CITY, STATE, ZIP CODE: **DENTIST FOREIGN** **DELTA DENTAL OF COLORADO** **P.O. BOX 173803** **DENVER, CO 80217-3803**		
40. NPI	41. LICENSE NUMBER **9993333AB**	42. SSN OR TIN **9993333AB**
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 JUDGMENT. SIGNED (TREATING DENTIST) DATE		
45. NPI	46. LICENSE NUMBER **9993333AB**	47. SSN OR TIN **9993333AB**
48. ADDRESS, CITY, STATE, ZIP CODE (IF DIFFERENT THAN #33) **P.O. BOX 173803 DENVER, CO 80217-3803**		
49. PHONE NUMBER	50. ADDITIONAL DENTIST ID	51. SPECIALTY CODE

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 AND INQUIRIES TO	TELEPHONE ELIGIBILITY AND BENEFIT INFORMATION	WEBSITE
DELTA DENTAL OF COLORADO P.O. BOX 173803 DENVER, CO 80217-3803	1-800-610-0201	deltadentalco.com

INSTRUCTIONS FOR COMPLETING THE 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.
- If being completed on a typewriter, make sure the 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 er (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.

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