

Dental Claim Form

Mail Completed Form to:
NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

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 ☐ U 8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 ☐ U 15. Policyholder/Subscriber ID (Assigned by Plan)

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 ☐ U 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.)												34. Diagnosis Code List Qualifier ☐ ☐ (ICD-10 = AB)										31a. Other Fee(s)																							
1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		34a. Diagnosis Code(s) A _____ C _____													
32		31		30		29		28		27		26		25		24		23		22		21		20		19		18		17		(Primary diagnosis in "A") B _____ D _____										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

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

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)

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

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

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

53a. Locum Tenens Treating Dentist? ☐

54. NPI 55. License Number

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

57. Phone Number () - 58. Additional Provider ID