



HEALTH PLAN OF NEW YORK

Healthplex/HIP
P.O. Box 249
Hempstead, NY 11551-0249

HEADER INFORMATION		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX		
2. Predetermination/Preauthorization Number		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		
3. Company/Plan Name, Address, City, State, Zip Code		
OTHER COVERAGE		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> 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	30. Description				31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

MISSING TEETH INFORMATION										Permanent										Primary										32. Other Fee(s)						
34. (Place an 'X' on each missing tooth)										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	33. 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 <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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



Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a #10 window envelope. Please fold the form using the ‘tick-marks’ printed in the margin.
- B. In the upper right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
- C. All items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
- D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer’s Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the “Remarks” field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Identifier): This is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA’s Web site: www.ada.org/goto/npi.

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider’s NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as ‘Dentist’ may be used instead of any other dental practitioner code.

Category / Description Code	Code
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.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA’s Web site at:
www.ada.org/goto/dentalcode