DELTA DENTAL®

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION

1. ☐ STATEMENT OF ACTUAL SERVICES ☐ PREDETERMINATION REQUEST

MAIL CLAIMS TO **DELTA DENTAL OF NEW MEXICO**
2500 LOUISIANA BLVD. NE, SUITE 600
ALBUQUERQUE, NEW MEXICO 87110

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

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

12. DATE OF BIRTH
13. GENDER ☐ M ☐ F
14. SUBSCRIBER 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

DENTAL SERVICES

	22. DATE OF SERVICE MM/DD/CCYY	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							

MISSING TEETH	PERMANENT																PRIMARY										29. TOTAL FEE CHARGED
30. PLACE **X** ON MISSING TOOTH NUMBERS	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.

SUBSCRIBER 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
40. TYPE 2 NPI
41. LICENSE NUMBER
42. SSN OR TIN
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 JUDGEMENT.

X _____
SIGNED (TREATING DENTIST) DATE

45. TYPE 1 NPI
46. LICENSE NUMBER
47. SSN OR TIN
48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #33)
49. PHONE NUMBER ( )
50. ADDITIONAL DENTIST ID
51. SPECIALTY CODE

For the fastest processing, submit claims electronically through our **Dental Office Toolkit**! It's free, easy, and available to all dentists. Check our Web site at www.deltadentalnm.com for more information.

INSTRUCTIONS FOR COMPLETING THE CLAIM

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- Enter the subscriber's and patient's names in this order: last, first, middle initial.
- If the patient has dental coverage through another carrier(s):
  - Complete fields #2 through #10 in the "Other Coverage" section.
  - 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
  - Attach the primary carrier's voucher.

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 (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.

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 FOR ELIGIBILITY AND BENEFIT INFORMATION	WEB SITE
Delta Dental of New Mexico 2500 Louisiana Blvd. NE, Suite 600 Albuquerque, New Mexico 87110	505-855-7111 877-395-9420 (Toll Free)	www.deltadentalnm.com