

MEMBER DENTAL CLAIM FORM

| HEADER INFORMATION | | | | | | | | | | Please submit claim to: Dental Claims P.O. Box 69421 Harrisburg, PA 17106-9421 | | | | | | | | | | | | | |
|--|--|-------------------------|--|------------------|--|----------------------------------|--|-------------------|--|---|--|--------------------|--|-----------|--|-----------------|--|--|--|-------------------|--|--|--|
| 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 | | | | | | | | | | POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | | | | | | | | | | | | | |
| 2. Predetermination/Preauthorization Number | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Company/Plan Name, Address, City, State, Zip Code | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER COVERAGE (Mark applicable box and complete 5-11. If none, leave blank.) | | | | | | | | | | 13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#) | | | | | | | | | | | | | |
| 4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (if both, complete 5-11 for dental only.) | | | | | | | | | | 16. Plan/Group Number 17. Employer Name | | | | | | | | | | | | | |
| 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) | | | | | | | | | | PATIENT INFORMATION | | | | | | | | | | | | | |
| 6. Date of Birth (MM/DD/CCYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) | | | | | | | | | | 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. Reserve For Future Use | | | | | | | | | | | | | |
| 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 | | | | | | | | | | 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | | | | | | | | | | | | | |
| 11. Other Insurance Company/Dental Benefit Plan Name, 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 | | 29a. Diag. Pointer | | 29b. Qty. | | 30. Description | | | | 31. Fee | | | |
| 1 | | | | | | | | | | | | | | | | | | | | | | | |
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| 5 | | | | | | | | | | | | | | | | | | | | | | | |
| 33. Missing Teeth Information (Place an "X" on each missing tooth.) | | | | | | | | | | 34. Diagnosis Code List Qualifier <input type="checkbox"/> <input type="checkbox"/> (ICD-9 = B; 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 | | | | | | | | | | ANCILLARY CLAIM/TREATMENT INFORMATION | | | | | | | | | | | | | |
| 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 | | | | | | | | | | 38. Place of Treatment _____ (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N) <input type="checkbox"/> (Use "Place of Service Codes for Professional Claims") | | | | | | | | | | | | | |
| | | | | | | | | | | 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: <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) | | | | | | | | | | | | | |
| | | | | | | | | | | 43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) | | | | | | | | | | | | | |
| | | | | | | | | | | 44. Date of Prior Placement (MM/DD/CCYY) | | | | | | | | | | | | | |
| 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 | | | | | | | | | | 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.) | | | | | | | | | | TREATING DENTIST AND TREATMENT LOCATION INFORMATION | | | | | | | | | | | | | |
| 48. Name, Address, City, State, Zip Code | | | | | | | | | | 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 | | | | | | | | | | | | | |
| 49. NPI 50. License Number 51. SSN or TIN | | | | | | | | | | 54. NPI 55. License Number | | | | | | | | | | | | | |
| 52. Additional Provider ID 52a. Phone Number () - | | | | | | | | | | 56. Address, City, State, Zip Code 56a. Provider Specialty Code | | | | | | | | | | | | | |
| 57. Phone Number () - | | | | | | | | | | 58. Additional Provider ID | | | | | | | | | | | | | |

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

CA: For your protection California law requires that the following appear on the form: Any person who knowingly presents a false claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

DC & RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

IN & OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

TN & WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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| English | ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711). |
| Español (Spanish) | ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711). |
| 繁體中文 (Chinese) | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。 |
| Tiếng Việt (Vietnamese) | CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711). |
| 한국어 (Korean) | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오. |
| Tagalog (Tagalog - Filipino) | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711). |
| Русский (Russian) | ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711). |
| العربية (Arabic) | يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711) |
| Kreyòl Ayisyen (French Creole) | ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711). |
| Français (French) | ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711). |
| Polski (Polish) | UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711). |
| Português (Portuguese) | ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711). |
| Italiano (Italian) | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711). |
| Deutsch (German) | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711). |
| 日本語 (Japanese) | 注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366（TTY: 711）まで、お電話にてご連絡ください。 |
| فارسی (Farsi) | توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید. |