

Send Completed Forms to: Healthplex, Inc. Attention: Claims Dept.

PO Box 9255

Uniondale, NY 11553-9255

1. Type of Transaction (Mark all applicable boxes)	Providers Call – (888) 468-2183 Press Option 1 for IVR or Option 3 www.healthplex.com			
Statement of Actual Services Request for Predetermination/Preauthorization  EPSDT/Title XIX	ALL INFORMATION MUST	ALL INFORMATION MUST BE PRINTED		
2. Predetermination/Preauthorization Number	POLICYHOLDER/MEMBER		surance Company Name	d in #3)
	12. Policyholder/Member Nam			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	<b>†</b>			
3. Company/Plan Name, Address, City, State, Zip Code	1			
	13. Date of Birth (MM/DD/YYY)	·	Policyholder/Member ID	(SSN or ID#)
		M F D		
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)	16. Plan/Group Number	17. Employer Name/G	roup Name	
4. Dental? Medical? (If both complete 5-11 for dental only)  5. Name of Policyholder/Member in #4 (Last, First, Middle Initial, Suffix)	DATIENT INCODMATION			
7. Name of Folleyholder/Member III #4 (East, First, Middle IIIIda, Samx)	PATIENT INFORMATION  18. Relationship to Policyholde	er/Member in #12 Above	19 Reserved	For Future Use
6. Date of Birth (MM/DD/YYYY) 7. Gender 8. Policyholder/Member ID (SSN or ID#)	Self Spouse			rorruture ost
M F D	20. Name (Last, First, Middle In			
9. Plan/Group Number 10. Patient's Relationship to Person named in #5				
Self Spouse Dependent Other	er			
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code				
	21. Date of Birth (MM/DD/YYY)	Y) 22. Gender 23. P	Patient ID/Account # (Assig	ned by Dentist
DECORD OF CERVICES PROVIDED. TO BE COMPLETED BY DENTICE				
RECORD OF SERVICES PROVIDED - TO BE COMPLETED BY DENTIST           24.         25.         26.         27.         28.         29.         29a.	29b.	30.		31. Fee
	ic Quantity	Description		Fee
(MM/DD/YYYY) Oral Cavity System or Letter(s) Surface Code Pointer  1				
2				
3				
4				
5				
6				
7				
8				
9				
10.				
1 2 2 4 5 6 7 9 9 10 11 12 12 14 15 16		= BB; ICD-10 = AB)	31a. Other Fee(s)	
34a. Diagnosis 1 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagno		C D	32. Total Fee	
35. Remarks	В		_	
D. Reiliai ka				
	NCILLARY CLAIM TREATMEN	T INFORMATION		
charges for dental services and materials not paid by my dental benefit plan, unless prohibited by	Place of Treatment (e.g $11 = 0$	Office; 22 = O/P Hospital)	39. Enclosures?	
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	(Use "Place of Service Codes for Prof	fessional Claims")	No Yes	
understand that benefits will automatically be assigned to my dentist if he of she is a fleatinglex	s Treatment for Orthodontics?		41. Date Appliance Placed (I	MM/DD/YYYY)
Participating Provider.	No (Skip <b>41-42</b> ) Yes (Compl	lete <b>41-42)</b>		
	Months of Treatment 43.F	Replacement of Prosthesis	44. Date of Prior Placement (	(MM/DD/YYYY)
Signed (Patient or Member/Guardian)  Date		No Yes (Complete 44)		
to the below named dentist or dental entity, if allowed under my group guidelines. I understand that	Treatment Resulting from (check applic	cable box)		
	Occupational Illness/Injury	Auto Accident Oth	ner Accident	
	Date of Accident (MM/DD/YYYY)		47. Auto Accident State	
Signed (Member/Guardian)  BILLING DENTIST OR DENTAL ENTITY  TRI	REATING DENTIST AND TREATMEN	T LOCATION INFORMATIO	N	
	hereby certify that the procedure(s) a visits) or have been completed and that for those procedures.			equire multiple ntend to collect
l x				
	Signed (Treating Dentist)		Date	
54. N	NPI 55. L	icense Number		
49. NPI# 50. License Number 51. SSN or TIN 56. <i>I</i>	Address, City, State, Zip Code		56a. Specialty Provide	r Code
52 Phone Number 52A Additional Provider ID 57.1	Phone Number	E0 V44	ditional Provider ID	

# GOES HERE

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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

## **GENERAL INSTRUCTIONS**

- A. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- B. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- C. All dates must include the four-digit year.
- D. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

## **COORDINATION OF BENEFITS (COB)**

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

#### DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a - Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 - Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a - Diagnosis Code(s) / A, B, C, D (up to four with the primary adjacent to the letter "A")

#### PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, A HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office 12 = Home 21 = Inpatient Hospital 22 = Outpatient Hospital 31 = Skilled Nursing Facility 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website\_POS\_database.pdf"

## **PROVIDER SPECIALTY**

This code is entered in Item 56a and indicated the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code	
<b>Dentist</b> 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	

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

SEND CLAIM TO: Healthplex, Inc. Attention: Claims Dept. PO Box 9255 Uniondale, NY 11553-9255 Fax: 516-542-2614

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