# Dental Claim Form

# CWA Local 1180

1. ☐ Dentist's pretreatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☐ EPSDT — Prior Authorization #
3. Carrier Name: CWA Local 1180 Scheduled Dental Benefit Plan
4. Carrier Address: 1040 Avenue of the Americas 24th Floor
5. City: New York — 6. State: NY — 7. Zip: 10018

## PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State

12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Gender ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code

17. Relationship to Subscriber/Employee ☐ Self ☐ Spouse ☐ Child ☐ Other _____

18. Employer/School Name _____ Address _____

## SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #

22. Subscriber/Employee Name (Last, First, Middle)

23. Address | 24. Phone Number ( )

25. City | 26. State | 27. Zip Code

28. Date of Birth (MM/DD/YYYY) / /

29. Marital Status ☐ Married ☐ Single ☐ Other

30. Gender ☐M ☐F

39. 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 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 under applicable law, I authorize release of any information relating to this claim.

X _____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

## OTHER POLICIES

31. Is patient covered by another plan ☐ No (Skip 32–37) ☐ Yes: ☐ Dental or ☐ Medical | 32. Policy #

33. Other Subscriber's Name

34. Date of Birth (MM/DD/YYYY) / / | 35. Gender ☐M ☐F | 36. Plan/Program Name

37. Employer/School Name _____ Address _____

38. Subscriber/Employee Status ☐ Employed ☐ Part-time Status ☐ Full-time Student ☐ Part-time Student

40. Employer/School Name _____ Address _____

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity,

X _____
Signed (Employee/Subscriber) Date (MM/DD/YYYY)

## BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.

46. Address | 47. Dental License # | 48. First visit date of current series: | 49. Places of treatment ☐Office ☐Hosp. ☐ECF ☐Other

50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many? _____ ☐No | 54. Is treatment for orthodontics? ☐ Yes ☐ No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____

55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐ Yes ☐ No — If no, reason for replacement: _____ Date of prior placement: _____

56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes Brief description and dates _____

57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither Brief description and dates _____

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

| Date (MM/DD/YYYY) | Tooth | Surface | Diagnosis Index # | Procedure Code | Qty | Description | Fee | Admin. Use Only |
|---|---|---|---|---|---|---|---|---|
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60. Identify all missing teeth with "X"

| Permanent | | | | | | | | | Primary | | | | | | | | | | Total Fee | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | Payment by other plan | |
| 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 | Max. Allowable | |

61. Remarks for unusual services

Deductible
Carrier %
Carrier pays
Patient pays

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed

64. City | 65. State | 66. Zip Code

Form DCF 118

Questions tel. 1 212-505-5050

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate or statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.

3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.

8-11, 16. Patient name, address, city, state, and zip code: Include the patient's legal name.

12. Patient date of birth: Necessary to determine eligibility.
13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
14. Gender: Necessary for identification purposes and for statistical analysis.
15. Patient phone number: Necessary if questions arise that require immediate attention.
17. Relationship to subscriber/employee: Relationship between the insured person and the patient may affect the patient's eligibility, as well as level of benefits available.
18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
19. Subscriber/Employee ID # or Social Security number: This information refers to the insured person and is not necessarily the patient. The Social Security number (SSN) is commonly used for computer and manual processing of claims.
20. Employer name: Self explanatory.
21. Group number: Refers to the master contract policy number assigned to the employer group.

22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.

31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
32. Policy #: Refers to master contract policy number assigned to the employer group.

33-35. Other subscriber's information: Refers to employee with policy number in box #32.

36. Plan/Program name: Necessary to identify national programs such as TRICARE.
37. Employer/School: Refers to person in box #32. Necessary for eligibility requirements and COB.
38. Subscriber/Employer status: Refers to person in box #32. May be necessary for eligibility and COB.
39. Patient signature block: The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
41. Employer/subscriber block: Necessary when the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.

42-43, 46, 50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.

44. Provider ID #: Necessary when carriers assign unique numbers to providers that differ from the Social Security number or the tax payer identification number (T.I.N.).
45. Dentist's Social Security number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security or T.I.N. of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated or the entity T.I.N. when the billing entity is a group practice or clinic.
47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
54. Is treatment for orthodontics? Necessary to determine the prorated benefit.
55. If prosthesis is for a crown, bridge or denture, is this the initial placement? Determines eligibility and liability.
56. Is treatment result of occupational illness or injury? Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
57. Is treatment result of auto accident? Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
58. Diagnosis Code Index: When reporting the diagnoses for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnosis code(s) in spaces 1-8 as necessary. The submitter should record the 5-digit diagnosis codes on line 1 through 8. In box #59, the numbers 1-8 would be entered under the diagnosis index # column.
59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnoses as necessary for each procedure code. When a patient has more than one diagnoses per procedure, separate index number with comma.
60. Identify all missing teeth with "x".
61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
62. Dentist's signature block: The treating dentist's signature and license number. Dentists should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.

63-66. Address where treatment was performed: Necessary if the treatment was performed at a different location than indicated in boxes #46, 50-52.

For administrative use only. Area where carrier calculates benefits.