DENTCARE DELIVERY SYSTEM, INC.

☐ **DENTIST'S PRE-TREATMENT ESTIMATE**
☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

NOTE: ALL INFORMATION MUST BE PRINTED
TREATMENT OVER $250 MUST BE PREAUTHORIZED

Send Completed Forms to: DENTCARE DELIVERY SYSTEM, INC.
333 Earle Ovington Blvd.,Suite #300, Uniondale, NY 11553-3608
Providers Call - (888) 468-2183 Press Option 1 for IVR or Option 3
Members Call - (800) 468-0600
www.dentcaredeliverysystems.org

1. Patient Name	2. Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	3. Sex: M ☐ F ☐	4. Group #	5. Patient Date of Birth	6. Fulltime Student: Yes ☐ No ☐
7. Subscriber Name: First / Middle / Last			8. Subscriber Social Security # / ID #		9. Subscriber Date of Birth
10. Subscriber Mailing Address		City,		State,	Zip

11. Are Other Family Members Employed? Yes ☐ No ☐ Employee Name / Employee ID #	12. Date of Birth	13. Name and Address of Employer in Item 11
14. Is Patient Covered by Another Dental Plan? Yes ☐ No ☐ If No, Skip #15	15. Dental Plan Name / Policy # / Name and Address of Carrier	

16. I certify that I have read and understand the eligibility requirements for this program as described in the plan and that the patient for whom the claim is made is eligible for benefits. I further certify that neither I nor any of my dependents is covered by any other enrollment in a group dental insurance program, except as noted. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed (Patient or Guardian) _____ Date _____

To Be Completed By Dentist

	17. Procedure Date (MM/DD/YY)	18. Area of Oral Cavity	19. Tooth #(s) / Letter(s)	20. Tooth Surface	21. Procedure Code	22. Description	23. Fee	24. Administrative
1								
2								
3								
4								
5								
6								
7								
8								
9								
10.								

25. 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	26. Other fee(s)		
	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			
28. **Remarks**					27. Total Fee		

AUTHORIZATIONS

29. I have been informed of the treatment plans 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. I understand that benefits will automatically be assigned to my dentist if he or she is a Healthplex PPO Provider.

X _____
Patient/Guardian signature Date

30. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity, if allowed under my group guidelines. I understand that benefits will automatically be assigned to my dentist if he or she is a Healthplex PPO Provider.

X _____
Subscriber signature Date

ANCILLARY CLAIM TREATMENT INFORMATION

31. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

32. Number of Enclosures
Radiographs(s) [ ] Oral Image(s) [ ] Model(s) [ ]

33. Is Treatment for Orthodontics?
☐ No (Skip **34-35**) ☐ Yes (Complete **34-35)**

36. Replacement of Prosthesis?
☐ No ☐ Yes (Complete 37)

34. Date Appliance Placed (MM/DD/YY) 35. Months of Treatment Remaining

37. Date Prior Placement (MM/DD/YY)

38. Treatment Resulting from (Check applicable box)
☐ Occupational Illness/injury ☐ Auto Accident ☐ Other accident

39. Date of Accident (MM/DD/YY) 40. Auto Accident State

41. **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

Name, Address, City, State, Zip Code

42. Provider ID | 42A. NPI # | 43. License Number

44. SSN or TIN | 45. Phone Number

46. **TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

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

X _____
Signed (Treating Dentist) Date

47. Provider ID | 47A. NPI# | 48. License Number

49. Address, City, State, Zip Code

50. Phone Number | 51. Treating Provider Specialty

IMPORTANT:

"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."

PLEASE REVIEW BEFORE SUBMITTING CLAIMS

INSTRUCTIONS FOR MEMBERS:

1. Complete items 1 through 15 in full to assure positive and prompt payment. Please print or type.
2. The member must sign and date the claim.
3. If total charges for the planned course of treatment can reasonably be expected to be $250 or more, the form must be completed and submitted prior to the commencement of the course of treatment for a pre-determination of benefits. Healthplex will notify you of the benefits payable.
4. If total charges for the planned course of treatment will be less than $250, the claim form should be completed when treatment is completed.
5. Dental coverage is subject to specific limitations and exclusions. Please refer to your insurance booklet and certificate for a description of covered services, limitations, and exclusions.
6. THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT.

INSTRUCTIONS FOR DENTIST:

1. Predetermination required for $250 or more, x-rays must be attached.
2. Please only submit **Duplicate** x-rays. X-rays will **NOT** be returned unless a self-addressed **STAMPED** envelope is included with the claim.
3. You can submit x-rays electronically by using NEA at http://www.nea-fast.com.
4. Generally, x-rays will not be required pre-operatively when the treatment plan involves only the use of Amalgam, Plastic, Silicate or Composite Restorations.
5. Diagnostic x-rays should be submitted for all other treatment. A pre-operative and post-operative x-ray is required where endodontic treatment has been rendered.

REMARKS FOR UNUSUAL SERVICES:

_____

_____

_____

MAIL COMPLETED FORM TO:

DENTCARE
DELIVERY SYSTEMS, INC.

333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

Members Only Call Customer Service - 800-468-0600
Providers Only Call Provider Hot Line - 888-468-2183 Press Option 1 for IVR or Press Option 3

www.healthplex.com
Email: Info@healthplex.com