#### ADA Dental Claim Form Insured and/or Administered by Connecticut General Life Insurance Compa **HEADER INFORMATION** 1. Type of Transaction (Mark all applicable boxes) CIGNA Dental Statement of Actual Services Request for Predetermination/Preauthorization EPSDT/ Title XIX POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 2. Predetermination/Preauthorization Number 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION 3. Company/Plan Name, Address, City, State, Zip Code **CIGNA Dental** P.O. Box 188037 Chattanooga, TN 37422-8037 14. Gender 13. Date of Birth (MM/DD/CCYY) 15. Policyholder/Subscriber ID (SSN or ID#) M F OTHER COVERAGE 16. Plan/Group Number 17. Employer Name 3332268 **Carroll County Public Schools** Yes (Complete 5-11) 4. Other Dental or Medical Coverage? No (Skip 5-11) PATIENT INFORMATION 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) 18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status FTS 6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#) Spouse Dependent Child PTS M F 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 9. Plan/Group Number 10. Patient's Relationship to Person Named in #5 Spouse Dependent 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code 21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist) Πм RECORD OF SERVICES PROVIDED 24 Procedure Date 27. Tooth Number(s) or Letter(s) 28 Tooth 29 Procedure Tooth (MM/DD/CCYY) Surface 31. Fee Code 30. Description Cavity Systen MISSING TEETH INFORMATION 32 Other Е Fee(s) 2 3 8 9 10 11 12 13 14 15 16 В С D G Н 34. (Place an 'X' on each missing tooth) 32 25 | 24 21 17 Т Р 0 33.Total Fee 31 30 29 28 27 26 23 22 20 19 18 S R Q Ν M L

35. Remarks **AUTHORIZATIONS ANCILLARY CLAIM/TREATMENT INFORMATION** 39. Number of Enclosures (00 to 99) 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 38. Place of Treatment Radiograph(s) Oral Image(s) 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 Provider's Office Hospital ECF Other 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY) information to carry out payment activities in connection with this claim No. (Skip 41-42) Yes (Complete 41-42) 42. Months of Treatment Remaining 44. Date Prior Placement (MM/DD/CCYY) Patient/Guardian signature 43. Replacement of Prosthesis? Date No Yes (Complete 44) 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named 45. Treatment Resulting from dentist or dental entity Occupational illness/injury Auto accident Other accident Subscriber signature 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State Date BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting TREATING DENTIST AND TREATMENT LOCATION INFORMATION claim on behalf of the patient or insured/subscriber) 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. 48. Name, Address, City, State, Zip Code Date 54. NPI 55. License Number 56A. Provider Specialty Code 56. Address, City, State, Zip Code 49. NPI 50. License Number 51. SSN or TIN 52A. Additional Provider ID Phone Number ( 58. Additional Provider ID



American Dental Association www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

#### **GENERAL INSTRUCTIONS**

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
- C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
- D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

## COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

### NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: www.ada.org/goto/npi

#### ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

# **PROVIDER SPECIALTY CODES**

56A <u>Provider Specialty Code</u>: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist  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

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

**Caution:** Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

# IMPORTANT CLAIM NOTICE

**Alaska Residents:** A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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

The authorization shall remain in effect for the term of your coverage. You or your designated representative is entitled to receive a copy of this claim form.

**California Residents:** For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Residents:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** 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 of the third degree.

**Kentucky Residents:** 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.

**Maryland Residents:** Any person who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota Residents:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

**New York Residents:** 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 \$5000 and the stated value of the claim for each such violation.

**Oregon Residents:** Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

**Pennsylvania Residents:** 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.

**Tennessee Residents:** 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.

**Texas Residents:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Virginia Residents:** Any person who, with 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 state law.

CIGNA Dental refers to CIGNA Dental Health, Inc., and its operating subsidiaries as well as its affiliated companies Connecticut General Life Insurance Company and CIGNA HealthCare of Connecticut, Inc.