DELTA DENTAL®

www.nedelta.com

Claim Submission Process for Non-Participating Dentists

If you visit a non-participating dentist, you may be requested to bring the attached claim form. Additional claim forms are available by calling Northeast Delta Dental or can be downloaded from **https://www.nedelta.com/patients/resources/**. Payment will be made to you, the Subscriber, unless the state in which the services are rendered requires that assignments of benefits be honored and Northeast Delta Dental receives written notice of an assignment on the claim form before payment for benefits is made. Payment for treatment performed by a non-participating dentist will be limited to the lesser of the dentist's actual submitted charge or Delta Dental's allowance for non-participating dentists in the geographic area in which services are provided. It will be your responsibility to make full payment to the dentist. When there is not sufficient fee information available for a specific dental procedure, Northeast Delta Dental will determine an appropriate payment amount.

If needed, download a claim form, complete and mail to:
Northeast Delta Dental (Maine, New Hampshire & Vermont)
P.O. Box 2002 Concord, NH 03302-2002
Payer ID 02027

Claims must be submitted within one year after dental treatment. For more information or assistance with submitting a dental claim, please call our customer service department at 1-800-832-5700, Monday through Friday, 8 a.m. - 8 p.m. (ET).

We will send you notice regarding the claim within 30 days of receipt unless special circumstances require more time. This notice explains the reason(s) for payment or nonpayment of a claim. If a claim is denied because of incomplete information, the notice will indicate what additional information is needed.

If we need more information we will send you a notice within 15 working days after we receive your claim to let you know.

The following information provides form completion instructions.

GENERAL INSTRUCTIONS

A. The form should be mailed carrier name and address (Item 2).
B. Complete all items unless noted otherwise on the form.
C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
D. All dates must include the four-digit year.
E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate claim form.
F. Gender Codes (Items 6, 14 and 19) – M = Male; F = Female; O = Other/Unknown/Prefer not to Disclose

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).

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; 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

Select the Place of Treatment (Item 38), a HIPAA standard maintained by the Centers for Medicare and Medicaid Services.

PROVIDER SPECIALTY

This code is entered in Item 57a and indicates 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
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

DELTA DENTAL®

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – **OR** – ☐ Request for Predetermination/Preauthorization

CARRIER NAME AND ADDRESS:

2. Northeast Delta Dental (Maine, New Hampshire & Vermont)
P.O. Box 2002
Concord, NH 03302-2002
Payer ID 02027

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, ZIP Code

OTHER COVERAGE

16. Other Dental or Medical Coverage? ☐ No (Skip 17-23) ☐ Yes (Complete 16-23)

PRIMARY SUBSCRIBER INFORMATION

4. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

5. Date of Birth (MM/DD/CCYY) | 6. Gender | 7. Subscriber Identifier (ID#)

8. Plan/Group Number | 9. Employer Name

17. Subscriber Name (Last, First, Middle Initial, Suffix)

18. Date of Birth (MM/DD/CCYY) | 19. Gender | 20. Subscriber Identifier (ID#)

21. Plan/Group Number | 22. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

23. Other Carrier Name, Address, City, State, ZIP Code

PATIENT INFORMATION

10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 11. Student Status ☐ FTS ☐ PTS

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender | 15. 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	30. Description	31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

MISSING TEETH INFORMATION

33. (Place an 'X' on each missing tooth)

Permanent																Primary									
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
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

31a. Other Fee(s)

32. Total Fee

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

35. Remarks

AUTHORIZATIONS

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

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

ANCILLARY CLAIM/TREATMENT INFORMATION

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

39. Number of Enclosures (00 to 99) Radiograph(s) | Oral image(s) | Model(s)

40. Date Last SRP _____/_____/_____

41. Is Treatment for Orthodontics? ☐ No (Skip 42-43) ☐ Yes (Complete 42-43)

42. Date Appliance Placed (MM/DD/CCYY)

43. Months of Treatment Remaining

44. Replacement of Prostheses? ☐ No ☐ Yes (Complete 45)

45. Date Prior Placement (MM/DD/CCYY)

46. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

47. Date of Accident (MM/DD/CCYY)

48. 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)

49. Name, Address, City, State, ZIP Code

50. Corporate Entity NPI (Type 2) | 51. License Number | 52. TIN

53. Phone Number ( ) - | 53a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. 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) Date

55. Individual NPI (Type 1) Locum Tenens Treating Dentist? | 56. License Number

57. Address, City, State, ZIP Code | 57a. Provider Specialty Code

58. Phone Number ( ) - | 59. Treating Provider Specialty