

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

Or email claim form to: MemberClaims@nedelta.com

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			



		1								
HEADER INFORMATION		_	CARRIER NAME AND ADDRESS: 2. Northeast Delta Dental (Maine, New Hampshire & Vermont)							
Type of Transaction (Check all applicable boxes) Statement of Actual Services - OR - Request for Predetermination/Preauthorization			P.O. Box 2002							
			Concord, NH 03302-2002							
PRIMARY PAYER INFORMATION			Payer ID 02027							
3. Name, Address, City, State, ZIP Code	ОТІ	OTHER COVERAGE								
			4							
PRIMARY SUBSCRIBER INFORMATION			16. Other Dental or Medical Coverage? No (Skip 17-23) Yes (Complete 16-23)							
4. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code										
			17. Subscriber Name (Last, First, Middle Initial, Suffix)							
	17. 3	subscriber Name (Las	t, First, Middle i	iriitiai, Suriix)						
5. Date of Birth (MM/DD/CCYY) 6. Gender 7. Subscriber Identifier (ID#)										
			18. Date of Birth (MM/DD/CCYY) 19. Gender 20. Subscriber Identifier (ID#)							
8. Plan/Group Number 9. Employer Name			16. Date of Birth (MM/DD/CC11) 19. Gender 20. Subscriber identifier (ID#)							
	21.	21 Plan / Croup Number 22 Palationahin to Primary Cut with a Charles								
PATIENT INFORMATION	21.1	21. Plan/Group Number 22. Relationship to Primary Subscriber (Check applicable box) Self Spouse Dependent Other								
10. Relationship to Primary Subscriber (Check applicable box)										
Self Spouse Dependent Child Other	FTS PTS	23. (23. Other Carrier Name, Address, City, State, ZIP Code							
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZI	P Code									
17 D (D) II										
13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Patient ID/Acc	ount # (Assigned by Dentist	t)								
RECORD OF SERVICES PROVIDED			1							
24. Procedure Date 25. Area 26. 27. Tooth Numb				70 Danauin	5		71 5.			
(MM/DD/CCYY) of Oral Tooth or Letter(s) Cavity System) Surface Cod	ie			30. Descript	LION	31. Fee			
1										
2							İ			
	- - - 									
3										
4										
5										
6										
7										
8										
	- - - 						 			
9										
10			<u> </u>							
MISSING TEETH INFORMATION	Permanent			Primar		31a. Other				
33. (Place an 'X' on each missing tooth) $\begin{vmatrix} 1 & 2 & 3 & 4 & 5 & 6 \\ \hline 32 & 31 & 30 & 29 & 28 & 27 \end{vmatrix}$	7 8 9 10 11 12 26 25 24 23 22 21			C D E F		J Fee(s)				
32 31 30 23 20 27		20 1.	3 10 17 1 3	K Q I	, 14 14 6	32. Total Fee				
34. Diagnosis Code List Qualifier (ICD-9 = B, ICD-10 = AB)	34a. Diagnosis Code(s) (Primary diagnosis in "A	") A _	B	3	c	D				
35. Remarks										
AUTHORIZATIONS		ANI	CILLARY CLAIM/T	DEATMENT	INFORMATIO	NI .				
36. I have been informed of the treatment plan and associated fee	_	Place of Treatment (C			Iumber of Enclosures (00 to	99)			
for all charges for dental services and materials not paid by my de prohibited by law, or the treating dentist or dental practice has a d		Provider's Office			adiograph(s) Oral image(
my plan prohibiting all or a portion of such charges. To the extent	permitted by law, I consent		Data Last CDD 41	1 I. T						
to your use and disclosure of my protected health information to a in connection with this claim.	40.	40. Date Last SRP 41. Is Treatment for Orthodontics? No (Skip 42-43) Yes (Complete 42-43)								
x	42 [42. Date Appliance Placed 43. Months of Treatment 44. Replacement of Prostheses?								
Patient/Guardian signature		42. Date Appliance Placed 43. Months of Treatment 44. Replacement of Prostneses? Remaining No Yes (Complete 45)								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me,			45. Date Prior Placement 46. Treatment Resulting from (Check applicable box)							
directly to the below named dentist or dental entity.			(MM/DD/CCYY) Occupational illness/injury Auto accident Other accident							
XSubscriber signature Date			47. Date of Accident (MM/DD/CCYY) 48. Auto Accident State							
-			TREATING DENTIST AND TREATMENT LOCATION INFORMATION							
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)			I hereby certify that t	he procedures	as indicated by	date are in progress (fo				
40 Name Address City Chats 710 Code			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) Legum Topogo Tracking Population 56. License Number								
		-	um Tenens Treating D		573	Provider Specialty Cod	le .			
57. Address, City, State, ZIP Code 57a. Provider Specialty Code										
50. Corporate Entity NPI (Type 2) 51. License Number	52. TIN	I								
53. Phone Number () -	53a. Additional Provider ID) 5Ω	Phone Number ()	- 59 T	reating Provider				
SoSile Humber ()	SSG. AGGINGHAI FIOVIGENT	50.	. Hone Mullipel (,		pecialty				