

**MANAGEMENT BENEFITS FUND**  
DENTAL CLAIM FORM



Send Completed Forms to:  
**Healthplex, Inc.**  
PO Box 211672  
Eagan, MN 55121

See reverse side for additional information

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)

- ☐ Statement of Actual Services    ☐ Request for Predetermination/Preauthorization  
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both complete 5-11 for dental only)

5. Name of Policyholder/Member in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YYYY)    7. Gender    8. Policyholder/Member ID (SSN or ID#)  
M ☐ F ☐

9. Plan/Group Number    10. Patient's Relationship to Person named in #5  
☐ Self    ☐ Spouse    ☐ Dependent    ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**ALL INFORMATION MUST BE PRINTED**

**POLICYHOLDER/MEMBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Member Name (Last, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YYYY)    14. Gender    15. Policyholder/Member ID (SSN or ID#)  
M ☐ F ☐

16. Plan/Group Number  
**GG-453**    17. Employer Name/Group Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Member in #12 Above    19. Reserved For Future Use  
☐ Self    ☐ Spouse    ☐ Dependent Child    ☐ Other

20. Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code

21. Date of Birth (MM/DD/YYYY)    22. Gender    23. Patient ID/Account # (Assigned by Dentist)  
M ☐ F ☐

**RECORD OF SERVICES PROVIDED - TO BE COMPLETED BY DENTIST**

	24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diagnostic Pointer	29b. Quantity	30. Description	31. Fee	
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
33. Missing Teeth Information (Place an "X" on each missing tooth)						34. Diagnosis Code List Qualifier				31a. Other Fee(s)	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16						34a. Diagnosis Codes				32. Total Fee	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17						A _____ C _____ B _____ D _____ (Primary diagnosis in "A")					

35. Remarks

**AUTHORIZATIONS**

36. 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 Participating Provider.

X

Signed (Patient or Member/Guardian) \_\_\_\_\_ 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, if allowed under my group guidelines. I understand that benefits will automatically be assigned to my dentist if he or she is a Healthplex Participating Provider.

X

Signed (Member/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

**BILLING DENTIST OR DENTAL ENTITY**

(Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/member)

48. Name, Address, City, State, Zip Code

49. NPI#    50. License Number    51. SSN or TIN

52. Phone Number    52A. Additional Provider ID

**ANCILLARY CLAIM TREATMENT INFORMATION**

38. Place of Treatment ☐ (e.g 11 = Office; 22 = O/P Hospital)    39. Enclosures?  
(Use "Place of Service Codes for Professional Claims")  
No ☐ Yes ☐

40. Is Treatment for Orthodontics?  
☐ No (Skip 41-42)    ☐ Yes (Complete 41-42)    41. Date Appliance Placed (MM/DD/YYYY)

42. Months of Treatment    43. Replacement of Prosthesis  
☐ No    ☐ Yes (Complete 44)    44. Date of Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from (check applicable box)  
☐ Occupational Illness/Injury    ☐ Auto Accident    ☐ Other Accident

46. Date of Accident (MM/DD/YYYY)    47. Auto Accident State

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. 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 submitted are the actual fees I have charged and intend to collect for those procedures.

X \_\_\_\_\_  
Signed (Treating Dentist) \_\_\_\_\_ Date \_\_\_\_\_

54. NPI    55. License Number

56. Address, City, State, Zip Code    56a. Specialty Provider Code

57. Phone Number    58. Additional Provider ID



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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

#### GENERAL INSTRUCTIONS

- A. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- B. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- C. All dates must include the four-digit year.
- D. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

#### 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). There are additional detailed completion instructions in the CDT manual.

#### 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-CM; 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

Enter the 2-digit Place of Service Code for Professional Claims, A HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office    12 = Home    21 = Inpatient Hospital    22 = Outpatient Hospital    31 = Skilled Nursing Facility    32 = Nursing Facility

The full list is available online at "[www.cms.gov/PhysicianFeeSched/Downloads/Website\\_POS\\_database.pdf](http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf)"

#### PROVIDER SPECIALTY

This code is entered in Item 56a and indicated 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
<b>Dentist</b> 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
<b>General Practice</b>	1223G0001X
<b>Dental Specialty</b> (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

Provider taxonomy codes listed above are a subset of the full code set that is posted at "[www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy)"

E-mail inquiries to [info@healthplex.com](mailto:info@healthplex.com)  
For additional information visit [healthplex.com](http://healthplex.com)

Dedicated Customer Service Line for Management Benefits Fund Members: 1-888-468-5179  
Provider Hotline: 1-888-468-2183 (Press Option 1 for IVR or Option 3)