CHAPTER 22

HEALTH BENEFIT PLANS

Authority

N.J.S.A. 17:1–8.1, 17:1–15e and P.L. 1999, c.339.

Source and Effective Date

R.2000 d.452, effective November 6, 2000.
See: 32 N.J.R. 2860(a), 32 N.J.R. 4014(a).

Executive Order No. 66(1978) Expiration Date

Chapter 22, Health Benefit Plans, expires on November 6, 2005.

Chapter Historical Note

Chapter 22, Health Benefit Plans, was adopted as R.2000 d.452, effective November 6, 2000. See: Source and Effective Date.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

Authority

N.J.S.A. 17:1–8.1, 17:1–15c, 17:29B–1 et seq., 17B:30–13.1, 26:2J–15b and 17B:30–23 et seq.

Source and Effective Date

R.2001 d.13, effective January 2, 2001.
See: 32 N.J.R. 1985(a), 33 N.J.R. 105(a).

11:22–1.1 Purpose and scope

(a) This chapter implements N.J.S.A. 17B:30–26 through 34, which sets standards for the payment of claims relating to health benefit plans and dental plans.

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, dental service corporation and dental plan organization that issues health benefit plans or dental plans in this State and to any agent, employee or other representative of such entity that processes claims for such entity.

11:22–1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"ADR" means alternate dispute resolution.

"Agent" means any entity, including a subsidiary of a carrier, or an organized delivery system as defined by N.J.S.A. 17:48H–1 with which a carrier has contracted to perform claims processing or claims payment services.

"Capitation payment" means a periodic payment to a health care provider for his services under the terms of a contract between the provider and a carrier, under which the provider agrees to perform the health care services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Claim" means a request by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services or supplies or dental services or supplies covered under a health benefits plan or dental plan issued by a carrier.

"Clean claim" means:

1. The claim is for a service or supply covered by the health benefits plan or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;

3. The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;

4. The carrier does not reasonably believe that the claim has been submitted fraudulently; and

5. The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits or dental plan.

"Covered service or supply" means a service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provides services or supplies.

"Dental plan" means a benefits plan which pays dental expense benefits or provides dental services and supplies and is delivered or issued for delivery in this State by or through any carrier in this State.

"Department" means the Department of Banking and Insurance.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits or provides hospital and medical services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by Federal law. For the purposes of this chapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A–1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" or "provider" means an individual or entity which, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professional licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

11:22–1.3 Acknowledgment of receipt of claims

(a) A carrier or its agent shall acknowledge receipt of a claim by the same means it was received upon request from a health care provider or covered person either:

1. If submitted by electronic means, no later than two working days following receipt of a claim submitted by electronic means. The acknowledgement of receipt of an electronic claim shall go to the entity from which the carrier received the claim; or

2. If submitted by written notice, no later than 15 working days following receipt of a claim submitted by other than electronic means. Written claims are considered received based on the U.S. mail postmark date.

(b) The carrier or its agent shall provide written notice to the provider and the covered person within 30 days of receipt of the claim if the carrier disputes or denies a claim, in full or in part. The notice shall comply with the requirements of N.J.A.C. 11:22–1.6. If only a portion of a claim is disputed or denied, the carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22–1.5.

11:22–1.4 Claim submission requirements

A carrier or its agent shall notify its participating health care providers at least annually, and shall make available to covered persons on request, a listing of the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims. Carriers or their agents may change the required information and documentation as long as participating health care providers are given at least 30 days prior notice of the change in the requirements. Carriers or their agents shall also supply participating health care providers with a street address where claim submissions can be delivered by hand or registered/certified mail.

11:22–1.5 Prompt payment of claims

(a) A carrier and its agent shall remit payment of clean claims pursuant to the following time frames:

1. Thirty calendar days after receipt of the claim where the claim is submitted by electronic means or the time established for the Federal Medicare program by 42 U.S.C. § 1395u(c)2(B), whichever is earlier; or

(b) The plan referred to in (a) shall provide for full implementation of a system for the use of those electronic transaction and code sets referred to therein no later than October 16, 2002.

(c) In accordance with N.J.A.C. 11:22–1.3, payers receiving an electronically filed claim shall individually acknowledge receipt of each claim by responding with a 277 acknowledgement described in (a)7 above. Nothing in this section shall prevent payers from also using any other responses including, but not limited to, the 997 Functional Acknowledgement of batch transfers in addition to providing a 277 acknowledgement.

(d) In the event a provider's system is unable to receive a 277 acknowledgement, the payer shall establish a mutually agreeable alternative means of acknowledgement with the provider.

11:22–3.8 Use of clearinghouses in electronic transactions

(a) When computing the number of days for purposes of acknowledging an electronic claim and/or any other health care transactions required by this subchapter, the following shall apply:

1. When the provider chooses to use a clearinghouse for the transmission of claims to a payer, notice delivered by the payer to the clearinghouse shall constitute notice to the provider.

2. When a payer uses a clearinghouse for the receipt of any electronic transactions required by this subchapter, notice sent by the payer through the clearinghouse shall not constitute notice to a provider until it is delivered to the provider by the clearinghouse, or is available for pickup from the provider's mailbox at the clearinghouse.

3. When a payer and provider use the same clearinghouse for the transmission and receipt of health care transactions, notice that is sent by one party to the clearinghouse shall also constitute notice to the other party.

11:22–3.9 Information protection practices

All information and materials coming into the possession of health benefits payers, health care providers and their agents and vendors for the administration of the health care transactions described in this subchapter are subject to and shall comply with practices and requirements established in N.J.S.A. 17:23A–1 et seq., the Insurance Information Practices Act.

11:22–3.10 Fraud prevention and detection

(a) All payers shall deploy as part of any system for the electronic receipt and transmission of claims an anti-fraud program, resident system and/or software that is approved by the Department's Division of Anti-Fraud Compliance.

(b) The anti-fraud system described in (a) above shall be capable, at a minimum, of the following activities:

1. Screening all claims, pre-payment and/or post-payment, for data patterns associated with fraudulent activity;

2. Responding to audit specific inquiries to facilitate fraud investigations;

3. Identifying phantom vendors, employees, patients and providers;

4. Identifying inappropriate or inconsistent charges; and

5. Scanning provider claims for unnecessary and repetitive charges.

(c) The anti-fraud efforts described in this section shall be made a part of and incorporated into a payer's fraud prevention and detection plan when required pursuant to N.J.A.C. 11:16–6, as applicable.

(d) Those payers not required to have a fraud prevention and detection plan under N.J.A.C. 11:16–6 shall file a description of the system required by this section with:

New Jersey Department of Banking and Insurance
Division of Anti-Fraud Compliance
Attn: HINT/HIPAA–Fraud Prevention and Detection Plans
PO Box 324
20 West State Street
Trenton, NJ 08625–0324

(e) Payers shall comply with the requirements of N.J.S.A. 17:33A–1 et. seq. regarding the obligation to report suspected fraud to the New Jersey Office of Insurance Fraud Prosecutor.

11:22–3.11 Penalties

Failure to comply with this subchapter may result in the imposition of penalties as authorized by law, including suspension or revocation of the payer's authority to do business in the State of New Jersey.

APPENDIX
EXHIBIT 1

[Carrier Logo][1] **Enrollment/Change Request** **[Carrier Name][2]**

[Employer][3] Group Information - To Be Completed by [Employer]

Group Name	[Group Number	Class Code][4]

A. Type of Activity - To Be Completed by [Employer] *Refer to instructions on back before completing this form. Print clearly.*

1. Enrollment
☐ New [Enrollee/Subscriber][5]
Effective Date ___/___/___
Date of Hire ___/___/___

2. Change - *Check all that apply.* (Date of Event / Reason)
☐ Add Spouse ___/___/___ ____
☐ Add Dependent Child ___/___/___ ____
☐ Name Change ___/___/___ ____
☐ Change Plan ___/___/___ ____
☐ Other ___/___/___ ____
☐ [Add/Change Office ID Numbers: Primary / Ob/Gyn / Dentist][6]

3. Remove or Terminate - *Check all that apply.* (Effective Date / Reason)
☐ Remove Spouse* ___/___/___ ____
☐ Remove Dependent Child* ___/___/___ ____
☐ [Employee] Withdrawal/Termination ___/___/___
NOTE: [Employee] must be enrolled for spouse/dependent(s) to have coverage.
* Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State - *Not all options are available. Contact [Employer] for available options.*
Coverage For: ☐ [Employee] ☐ Dependents
Length of Continuation: ☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos
Date of Loss of Coverage: ___/___/___
Date of Qualifying Event: ___/___/___
[Billing: ☐ Home ☐ Group][7]

B. [Employee] Information - Complete Sections [B - H].[8]

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
[Employer] Name			Work Telephone ( )
Work Address		City, State	ZIP Code

C. Plan Option - Your selection must be offered by your [employer].
Check One:
[Indicate Plan Names/Copays/Deductibles][9]

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. [Attach proof if full-time college student.][10]

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage Yes	[Other Rx Drug Coverage][11] Yes	[Primary Office ID Number][12]	[Current Patient][13] Yes	[Ob/Gyn Office ID Number][14] (If applicable)	[Current Patient] Yes	[Dentist Office ID Number][15] (If applicable)	[Current Patient] Yes
[Employee]			☐ ☐	/ /		☐	☐		☐		☐		☐
Spouse			☐ ☐	/ /		☐	☐		☐		☐		☐
Child			☐ ☐	/ /		☐	☐		☐		☐		☐
Child			☐ ☐	/ /		☐	☐		☐		☐		☐
Child			☐ ☐	/ /		☐	☐		☐		☐		☐

[E. Pre-Existing Conditions Statement][16]
[NOTE: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes ☐ No ☐ 1. During the past [6][17] months, have you or any dependent covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.
- ☐ a. Alcoholism or Drug Abuse
- ☐ b. Arthritis
- ☐ c. Blood Disorder
- ☐ d. Back or Neck Disorder, Injury or Pain
- ☐ e. Cancer or Tumors
- ☐ f. Diabetes
- ☐ g. Gastro or Intestinal Disorder
- ☐ h. Heart Disorder or Condition or Chest Pain
- ☐ i. High Blood Pressure
- ☐ k. Kidney or Liver Disorder
- ☐ l. Lung or Respiratory Disorder
- ☐ m. Mental or Nervous Disorder
- ☐ n. Paralysis, Stroke or Epilepsy

Yes ☐ No ☐ 2. During the past [6] months, have you or any dependent to be covered:
- a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?
- b. been advised to have treatment or surgery or testing that has not been done?
- c. been admitted to a hospital or other health care facility as an inpatient?
- d. taken prescribed medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.]

[F]. Other Insurance
Is your Spouse Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse's employer.
If "Yes" to Other Health Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.
[If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.]

[G]. Dependent Information
Does any dependent listed in Section D live at a different address than the [Employee]? ☐ Yes ☐ No
If "Yes," who and what address?
Explain the circumstances.
If any dependent's last name differs from yours, explain the circumstances.

[H]. [Employee] Signature *If you have questions concerning the benefits and services provided by or excluded under this [Agreement][18], contact a [Member Services][19] representative at [phone number][20] before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the [employee] copy of this application.

[Employee] Signature - *Required* X
Date ___/___/___ E-Mail Address

[I]. [Employer] Verification - To Be Completed by [Employer]
[Employer] Signature - *Required* X
Title Date ___/___/___

[[Employee] copy may be used as a temporary ID card for 30 days from the effective date if authorized by [employer]. Coverage must be verified with [Carrier Name] prior to visiting a specialist or admission to a hospital.][21]

MBNL (9-02)

NJ - HINT
[Internal Carrier Form Number][22]

Instructions

[Employer]

- Complete the **[Employer] Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting application.
- Complete **Section [I] - [Employer] Verification** in the lower right corner of the form.
  - [Employer] must complete this section for all new enrollments, coverage changes and terminations.
  - [Employer] must sign and date the application in order for it to be processed.

[Employee] - Complete Sections [B - H].

Section B - [Employee] Information:
Complete **all** information in order for your application to be processed.

Section C - Plan Option:
- [Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay and/or Individual Deductible Amount (if applicable).]
- Select only an option offered by your [employer].

Section D - Individuals Covered:
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- [If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).]
- If you or your dependent(s) have other Health [or Rx drug] coverage, check off the "Yes" box(es) and complete Section [F] - Other Insurance.
- [From the appropriate provider directory, locate the **[6-digit]** [23] office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.] [12, 14, 15]
- [If you are a current patient, please check the "Current Patient" box.]

[Section [E] - Pre-Existing Conditions Statement:
Complete this section for all new enrollments. **Exception**: For Small Employer Group coverage, this section must be completed only by persons enrolling for coverage in a group of 2 - 5 [employees], and to late entrants.]

Section [F] - Other Insurance:
Complete this section for all new enrollments or coverage changes.

Section [G] - Dependent Information:
Complete this section for all new enrollments or coverage changes.

Section [H] - [Employee] Signature:
- Complete this section for all new enrollments, coverage changes and terminations.
- [Employee] must sign and date the application in order for it to be processed.

Section [I] - [Employer] Verification:
- [Employer] must complete this section for all new enrollments, coverage changes and terminations.
- [Employer] must sign and date the application in order for it to be processed.

Conditions of Enrollment

[Applicant] Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to [Carrier Name], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [Carrier Name] has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of this authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a [Carrier Name] [plan or group policy], coverage is provided by [Carrier Name] in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by [Carrier Name].
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

MBNL

Explanation of Brackets

{Information identified in this format is offered only to explain reasons for textual changes made (usually because some element of required data for the 834 electronic enrollment form was not present on the written form). This text should be deleted before publication of this form.}

1. Replace bracketed text with carrier's logo.
2. Replace bracketed text "carrier name" with carrier's full name throughout document.
3. If the carrier refers to the "Employer" using another term such as "Planholder" or "Contractholder" or some similar term, replace the term "Employer" with such other term throughout document.
4. If the carrier refers to "Group Number/Class Code" using another term such as "Policy Number," "Control Number" or some similar term, replace the term "Group Number/Class Code" with such other term.
5. If the carrier refers to the "Enrollee/Subscriber" using another term such as "Member" or "Applicant" or some similar term, replace the term "Enrollee/Subscriber" with such other term throughout document.
6. Omit "Add/Change Office ID Number" options if the carrier does not offer such options.
7. The continuation Billing options should be omitted if the carrier does not offer such options.
8. Renumber Sections B–H accordingly if "Section E. Pre-Existing Conditions" is being omitted.
9. Insert carrier plan options and deductibles, coinsurance or copayment options.
10. If the carrier does not want the proof of full-time student status provided with the enrollment form, omit the direction to attach proof.
11. Omit "Rx Drug" section and corresponding question in Section F if carrier does not require.
12. Omit "Primary Office ID Number" section if the plan does not require the selection of a Primary Care Physician.
13. Omit "Current Patient" section if the carrier does not require.
14. Omit "Ob/Gyn Office ID Number" section if the plan does not require the selection of an Ob/Gyn Physician.
15. Omit "Dentist Office ID Number" section if the plan does not require the selection of a Dentist.
16. The text "and pre-existing conditions statement" should be omitted if the carrier does not elect to include the pre-existing conditions statement text as part of the standard enrollment form. Renumber succeeding sections.
17. Carrier's pre-existing condition period. For plans other than small employer plans, insert the pre-existing conditions periods that are contained in non-small employer plans. For small employer plans, the periods are six months and six months (technically 180 days).
18. If the carrier refers to the "Agreement" using another term such as "Plan," "Contract," "Policy," or some similar term, replace the term "Agreement" with such other term throughout document.
19. If the carrier refers to the "Member Services" using another term such as "Claim Office" or "Customer Service" or some similar term, replace the term "Member Services" with such other term.
20. Insert carrier's phone number.
21. Carrier should insert the procedure to be followed to allow the applicant to secure coverage before the actual ID card is issued.
22. Available for carriers that use an internal number in addition to the identifying form number.
23. Identify the number in the manner appropriate to the director.

EXHIBIT 2

New Jersey Department of Banking and Insurance
ATTN: HINT Status Reports
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

HINT Operational Status Report

1. This is the:
   (Indicate one):
   [ ] First Report due on _____.
   [ ] Interim Report due on _____.
   [ ] Final Report due on _____.
2. The current status of the implementation of HINT electronic filing reports for health care benefit payment systems is:
   _____
   _____
   _____
   _____
   _____
3. If compliance is not yet achieved, indicate when the requirements of N.J.A.C. 11:22–3 will be accomplished:
   _____
   _____
   _____
   _____
   _____
4. What specific obstacles have been identified that may cause the filer NOT to comply with the timetable set forth in N.J.A.C. 11:22?
   _____
   _____
   _____
   _____
   _____
5. Is the filer requesting an extension of time to comply with the timetable now or in the future?
   _____ No _____ Yes
   If yes, why: _____
   _____
   _____
   _____
   _____
6. Is the filer requesting a waiver from compliance with the HINT Electronic System request now or in the future?
   _____ No _____ Yes
   If yes, why: _____
   _____

7. Will the filer comply with the timetable for implementation of the additional transaction identified in N.J.A.C. 11:22–3.7?

8. Other issues:

_____ hereby certifies that the foregoing statements of fact are true and understand that he/she is subject to punishment for any intentional misstatements of fact.

Date

Name

Agency

Title of Signatory

APPENDIX
EXHIBIT 3

Dental Claim Form

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services Specialty (see backside)	3. Carrier Name
2. ☐Medicaid Claim ☐EPSDT Prior Authorization #	4. Carrier Address
	5. City / 6. State / 7. Zip

PATIENT

8. Patient Name (Last, First, Middle)	9. Address		10. City	11. State
12. Date of Birth (MM/DD/YYYY) / /	13. Patient ID #	14. Sex ☐M ☐F	15. Phone Number ( )	16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other_____			18. Employer/School Name_____ Address_____	

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#	20. Employer Name	21. Group #		
22. Subscriber/Employee Name (Last, First, Middle)				
23. Address		24. Phone Number ( )		
25. City	26. State	27. Zip Code		
28. Date of Birth (MM/DD/YYYY) / /	29. Marital Status ☐Married ☐Single ☐Other	30. Sex ☐M ☐F		
39. 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 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 under applicable law, I authorize release of any information relating to this claim. X_____ Signed (Patient/Guardian) Date (MM/DD/YYYY)				

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐Medical		32. Policy #
33. Other Subscriber's Name		
34. Date of Birth (MM/DD/YYYY) / /	35. Sex ☐M ☐F	36. Plan/Program Name
37. Employer/School Name_____ Address_____		
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student		
40. Employer/School Name_____ Address_____		
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X_____ Signed (Employee/subscriber) Date (MM/DD/YYYY)		

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity	43. Phone Number ( )	44. Provider ID #	45. Dentist Soc. Sec. or T.I.N.
46. Address	47. Dentist License #	48. First visit date of current series:	49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City / 51. State / 52. Zip Code	53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No		54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No	If no, reason for replacement: _____	Date of prior placement: _____	
56. Is treatment result of occupational illness or injury? ☐No ☐Yes Brief description and dates_____	57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates_____		

58. Diagnosis Code Index (optional)
1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

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

61. Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

62. 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) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City / 65. State / 66. Zip Code

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate or statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.

3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.

8-11, 16. Patient name address, city, state, and zip code: Include the patient's legal name.

12. Patient date of birth: Necessary to determine eligibility.
13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
14. Sex: Necessary for identification purposes and for statistical analysis.
15. Patient phone number: Necessary if questions arise that require immediate attention.
17. Relationship to subscriber/employee: Relationship between the insured person and the patient may affect the patient's eligibility, as well as level of benefits available.
18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
19. Subscriber/Employee ID # or Social Security number: This information refers to the insured person and is not necessarily the patient. The Social Security number (SSN) is commonly used for computer and manual processing of claims.
20. Employer name: Self explanatory.
21. Group number: Refers to the master contract policy number assigned to the employer group.

22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.

31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
32. Policy #: Refers to master contract policy number assigned to the employer group.

33-35. Other subscriber's information: Refers to employee with policy number in box #32.

36. Plan/Program name: Necessary to identify national programs such as TRICARE.
37. Employer/School: Refers to person in box #33. Necessary for eligibility requirements and COB.
38. Subscriber/Employer status: Refers to person in box #22. May be necessary for eligibility and COB.
39. Patient signature block: The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
41. Employee/subscriber block: Necessary when the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.

42-43,46,50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.

44. Provider ID #: Necessary when carriers assign unique numbers to providers that differ from the Social Security number or the tax payer identification number (T.I.N).
45. Dentist's Social Security number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security or T.I.N. of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated or the entity T.I.N. when the billing entity is a group practice or clinic.
47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
54. Is treatment for orthodontics? Necessary to determine the prorated benefit.
55. If prosthesis is for a crown, bridge or denture, is this initial placement? Determines eligibility and liability.
56. Is treatment result of occupational illness or injury? Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
57. Is treatment result of auto accident? Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
58. Diagnosis Code Index: When reporting the diagnoses for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnoses code(s) in spaces 1-8, as necessary. The submitter should record the 5-digit diagnosis codes on line 1 through 8. In box 59, the numbers 1-8 would be entered under the diagnosis index # column.
59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnoses as necessary for each procedure code. When a patient has more than one diagnoses per procedure, separate index number with comma.
60. Identify all missing teeth with "x".
61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
62. Dentist's signature block: The treating dentist's signature and license number. Dentists should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.

63-66. Address where treatment was performed: Necessary if the treatment was performed at a different location than indicated in boxes #46,50-52.

For administrative use only: Area where carrier calculates benefits.

Payment itemization: The spaces under "payment by other plan" will be completed by the carrier and may vary from carrier to carrier.