DELTA DENTAL

Delta Dental of Arizona

HOW TO FILL OUT DENTAL CLAIM FORMS SO YOU'LL BE PAID FASTER

Claim forms that are submitted with missing or misplaced information can slow or even stop our ability to process claims. Use this guide to understand how to complete your claim forms correctly and get paid faster!

Orange boxes must be clearly checked or marked

Blue fields indicate the most common missing or inaccurate details that stop a claim in its tracks

ADA American Dental Association® Dental Claim Form

DELTA DENTAL

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

Delta Dental of Arizona
Attn: Claims Department
PO Box 9092
Farmington Hills, MI 48333-9092

3a. Payer ID 86027

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/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

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

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

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. 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	29b. Qty.	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.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

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

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

31a. Other Fee(s)

32. Total Fee

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 (alll dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) | 39a. Date Last SRP

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

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

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

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

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

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

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

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

57. Phone Number ( ) - | 58. Additional Provider ID

J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

DDAZ_0154-rev1223

To reorder call 800.947.4746 or go online at ADAstore.org

Ask these questions before you submit a claim:

- ☐ Does the policyholder's name (box 12) match what is listed on their ID card?
- ☐ Is the patient's relationship to the policyholder (box 18 and box 10, if applicable) marked as "Self," "Spouse" or "Dependent Child"? (Although uncommon, "Other" may be checked if the patient's relationship to the policyholder is not listed.)
- ☐ If the patient's relationship to the policyholder (box 18) is anything other than "Self," are boxes 20–22 completed?
- ☐ If there is a second policy covering the patient, are boxes 4–11 completed?
- ☐ Are all procedures the patient received listed on the claim, even if they are not covered?
- ☐ Is the applicable quadrant, tooth number and/or tooth surface (boxes 25, 27–28) provided on the claim as appropriate?
- ☐ Am I using one code per service line?
- ☐ Am I using the most current CDT codes on the claim?
- ☐ If treatment does not have a corresponding CDT code, is a narrative and appropriate unspecified coding (e.g. D2999, D4999, D9999) provided?
- ☐ For multi-visit procedures like crowns, root canals or dentures, is the date of completion/seat/delivery submitted as the treatment date (box 24)?
- ☐ Is the billing dentist or dental entity information (boxes 48–52) provided on the claim?
- ☐ Is your billing and treatment address (boxes 48 and 56) listed exactly as contracted?
- ☐ If your practice has an NPI Type 2 (box 49), is it provided on the claim? (Type 2 is for incorporated businesses, such as group practices with more than 1 practicing provider.)
- ☐ Is the treating dentist information (boxes 53–58) provided on the claim?
- ☐ Is the NPI Type 1 (box 54) for the treating dentist provided on the claim? (NPI type 1 is different than the NPI type 2.)

If you answered "no" to any of these questions, your claim may be delayed or rejected. Please correct these common issues before submitting the claim to Delta Dental.

NOTE: If your electronic claim is denied, make the necessary corrections before re-submitting. Do not submit a paper claim instead of correcting issues. Mailing a claim containing errors will continue to cause delays/rejections.

Additional tips for paper claims:

- Use the current claims form, which you can download at deltadentalaz.com/dentist
- Copied or faxed X-rays are not high-quality. Please submit X-rays electronically through DOT or at deltadentalaz.com/dentist.
- Do not highlight information on the claim. Paper claims are scanned upon receipt and highlighting appears as a black box.
- Save postage and mail multiple claims in a single envelope or submit your claim with associated attachemnts for FREE at deltadentalaz.com/dentist.
- Free form text, comments and additional notes should only be placed in the "Remarks" section (box 35).

Save time and get paid faster!
Submit claims electronically for FREE by signing in to the Dental Office Toolkit (DOT).