

## **IF YOU HAVE A PAUL REVERE DENTAL POLICY, USE THE FOLLOWING FORM.**

1. Please ask your dentist's office to complete the attached form.
2. Submit the claim form to:

**Mail: Colonial Life  
PO Box 30507  
Salt Lake City, UT 84130  
Fax: 1-855-855-1575, Attn: Dental Claims**

Please note: Dental policy claims are sent to HealthPlanServices for processing. In addition, dentist may submit the claim electronically

**To check the status of your dental policy claim:  
Phone: 877-477-4065, Web: [HPSClaimServices.com](http://HPSClaimServices.com)**

**To see the full list of Dental benefits, please visit:  
<http://www.colonial-paulrevere.com/dentalbenefits>**

**Only dental policy claims may be filed with this claim form. If you are submitting a claim under your Accident policy with Colonial Life, see Accident claim form. If you are submitting a vision rider claim, see the vision claim form**

# ADA American Dental Association® Dental Claim Form

## 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

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company 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      15. Policyholder/Subscriber ID (SSN or ID#)

M     F

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

6. Date of Birth (MM/DD/CCYY)      7. Gender      8. Policyholder/Subscriber 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

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      23. Patient ID/Account # (Assigned by Dentist)

M     F

## 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-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s)      A \_\_\_\_\_      C \_\_\_\_\_

(Primary diagnosis in "A")      B \_\_\_\_\_      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

38. Place of Treatment  (e.g. 11=office; 22=O/P Hospital)      39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims")     

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      44. Date of Prior Placement (MM/DD/CCYY)

No     Yes (Complete 44)

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

54. NPI      55. License Number

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

57. Phone Number      58. Additional Provider ID

Comprehensive completion instructions for the ADA Dental Claim Form are found in the current version of the CDT manual published by the ADA. Five relevant extracts from that manual follow.

## GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
- C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
- D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

## COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

## NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 **NPI (National Provider Identifier):** This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (**Type 1 NPI**) or dental entity (**Type 2 NPI**), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: [www.ada.org/goto/mpi](http://www.ada.org/goto/mpi)

## ADDITIONAL PROVIDER IDENTIFIER

52A and 58 **Additional Provider ID:** This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

## PROVIDER SPECIALTY CODES

- 56A **Provider Specialty Code:** Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

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 (see following list)</b>	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

Dental 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)

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at: [www.ada.org/goto/dentalcode](http://www.ada.org/goto/dentalcode)