



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

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION
3. Name, Address, City, State, ZIP Code

OTHER COVERAGE
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Subscriber Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender ☐ M ☐ F 8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number 10. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent
11. Other Carrier Name, Address, City, State, Zip Code

Companion Dental Claims Processing Unit
P.O. Box 1535 • Dubuque, IA 52004-1534
FAX: 563-557-3350

PRIMARY SUBSCRIBER INFORMATION
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code
13. Date of Birth (MM/DD/YYYY) 14. Gender ☐ M ☐ F 15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION
18. Relationship to Primary Subscriber (Check applicable box)
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other 19. Student Status
☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code
21. Date of Birth (MM/DD/CCYY) 22. Gender ☐ M ☐ F 23. Patient ID/Account # (Assigned 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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION		Permanent																Primary										32. Other Fee(s)	
34. (Place an "X" on each missing tooth)		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	33. 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 a direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X _____
Subscriber signature Date

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. Provider ID 50. License Number 51. SSN or TIN
52. Phone Number () -

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment (Check applicable box)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99)
Radiograph(s) Oral Images(s) Model(s)
40. Is Treatment for Orthodontics?
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/YYYY)
42. Months of Treatment Remaining 43. Replacement of Prosthesis
☐ No ☐ Yes (Complete 44)
44. Date 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 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) Date
54. Provider ID 55. License Number
56. Address, City, State, ZIP Code
57. Phone Number () - 58. Treating Provider Specialty

General Instructions:

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. Please fold the form using the "tick-marks" printed in the left and right margins. The upper-right blank space is provided for insertion of the third-party payer's claim or control number.

- a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow.
- b) When a name and address field is required, the full entity or individual name, address and ZIP code must be entered (i.e., items 3, 11, 12, 20 and 48).
- c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44 and 53).
- d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the third-party payer.

Data Element Specific Instructions

- 1. **EPSDT / Title XIX** -- Mark box if patient is covered by state Medicaid's **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment program for persons under age 21.
- 2. Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
- 4-11. Leave blank if no other coverage.
- 8. The subscriber's Social Security number (SSN) or other identifier (ID#) assigned by the payer.
- 15. The subscriber's Social Security number (SSN) or other identifier (ID#) assigned by the payer.
- 16. Subscriber's or employer group's plan or policy number. May also be known as the Certificate Number.
[Not the subscriber's identification number.]
- 19-23. Complete only if the patient is **not** the primary subscriber (i.e., "Self" not checked in item 18).
- 19. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
- 23. Enter if dentist's office assigns a unique number to identify the patient that is **not** the same as the Subscriber Identifier number assigned by the payer (e.g., chart #).
- 25. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 "Designation System for Teeth and Areas of the Oral Cavity".
- 26. Enter applicable ANSI ASC X12 code list qualifier: Use "**JP**" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "**JO**" when using the ANSI/ADA/ISO Specification No. 3950.
- 27. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen (-) to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
- 28. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: **B** = Buccal; **D** = Distal; **F** = Facial; **L** = Lingual; **M** = Mesial; and **O** = Occlusal.
- 29. Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
- 31. Dentist's full fee for the dental procedure reported.
- 32. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
- 33. Total of all fees listed on the claim form.
- 34. Report missing teeth on each claim submission.
- 35. Use "Remarks" space for additional information such as "reports" for "999" codes or multiple supernumerary teeth.
- 36. Patient Signature: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery or 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.
- 37. Subscriber Signature: Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
- 38. ECF is the acronym for **E**xtended **C**are **F**acility (e.g., nursing home).
- 48-52. Leave blank if dentist or dental entity is **not** submitting claim on behalf of the patient or insured/subscriber.
- 48. 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.
- 49. Identifier assigned to billing dentist of dental entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim.
- 50. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
- 52. The Internal Revenue Service requires that either the Social Security number (SSN) or Tax Identification number (TIN) of the billing dentist or dental entity be supplied **only** if the provider accepts payment directly from the third-party payer.
When the payment is being accepted directly report the: 1) SSN if the billing dentist is unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
- 53. THE TREATING, OR RENDERING, DENTIST'S SIGNATURE AND DATE THE CLAIM FORM WAS SIGNED. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
- 56. Full address, including city, state and ZIP code, where treatment performed by treating (rendering) dentist.
- 58. Enter the code that indicates the type of dental professional rendering the service from the "Dental Service Providers" section of the *Healthcare Providers Taxonomy* code list. The current list is posted at: <http://www.wpc-edi.com/codes/codes.asp>. The available taxonomy codes, as of the first printing of this claim form, follow printed in **boldface**.

122300000X 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.

Many dentists are general practitioners who handle a wide variety of dental needs.

1223G0001X General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

1223D0001X	Dental Public Health	1223P0221X	Pediatric Dentistry
1223E0200X	Endodontics		(Pedodontics)
1223P0106X	Oral & Maxillofacial Pathology	1223P0300X	Periodontics
1223D0008X	Oral & Maxillofacial Radiology	1223P0700X	Prosthodontics
1223S0112X	Oral & Maxillofacial Surgery		
1223X0400X	Orthodontics		

GENERAL FRAUD WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application or contract for insurance may be found guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS SUBJECT TO PROSECUTION AND PUNISHMENT FOR INSURANCE FRAUD, AS PROVIDED IN R.S.A. 638:20.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오.
귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ááh naa'níligi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíí bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'í' ha desdzhíh nínízingo, koji' béésh bee hółne' 1-844-516-6328. (Navajo)