Dental Claim Form

THE PREFERRED GROUP
PO BOX 15136
ALBANY, NY 12212-5136

ELECTRONIC SUBMISSION:TPGXX

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

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

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, ZIP Code

THE PREFERRED GROUP
HARRISON CSEA
PO BOX 15136
ALBANY, NY 12212-5136

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F ☐ U

8. Subscriber Identifier

9. Plan/Group Number

10. Patient's Relationship to Other Insured ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, ZIP Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix) Address, City, State, ZIP Code

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F ☐ U

15. Subscriber Identifier

16. Plan/Group Number: 7400

17. Employer Name: HARRISON CSEA

PATIENT INFORMATION

18. Patient's Relationship to Other Insured ☐ 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 ☐ 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-9 = B; 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 any 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) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

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

45. Treatment Resulting from (Check applicable box) ☐ 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 (Billing Entity)

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. Treatment completed – payment requested. I hereby certify that I have completed the procedures as indicated by date of service. I request payment in accordance with Plan rules and regulations.

X _____
Signed (Treating Dentist) Date

54. NPI (Treating Dentist)

55. License Number

56. Address, City, State, ZIP Code

57. Phone Number ( ) -

58. Treating Provider Specialty

PLEASE SEE REVERSE SIDE FOR DEFINITION OF INCURRED DATES (DATE OF SERVICE).
IMPORTANT: THE INCURRED DATE OF LIABILITY, AND THUS THE DATE OF SERVICE, IS THE DATE THE SERVICE IS COMPLETED. A SERVICE MUST NEVER BE BILLED UNTIL COMPLETED.

(ADA 11/20)