Genesee Area Healthcare Plan

Dental Benefits

2025-2026

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

PLAN DESCRIPTION

PLAN ADMINISTRATOR:	GENESEE AREA HEALTHCARE PLAN (GAHP) c/o Genesee Valley BOCES 27 Lackawanna Ave Mount Morris, NY 14510
TYPE OF PLAN:	Dental
AGENT FOR SERVICE OF LEGAL PROCESS:	GENESEE AREA HEALTHCARE PLAN (GAHP)
PLAN NUMBER:	501
PLAN YEAR:	July 1 through June 30
PLAN REVISION DATE:	July 1, 2025
FUNDING AND ADMINISTRATION:	The Plan is fully insured with Excellus BlueCross BlueShield.
HOW TO CONTACT US:	Excellus BlueCross BlueShield 165 Court Street Rochester, NY 14647 585-325-3630 Toll-Free 877-253-4797
BENEFIT AND CLAIMS:	Customer Service 585-325-3630 or 1-877-253-4797 Monday - Thursday 8AM - 7PM Friday 9AM - 7PM Saturday 9AM - 1PM E-Mail: CustomerService@excellus.com *E-mail our Customer Service Department with any inquiries*
HOW TO FIND A PPO PROVIDER:	Visit www.excellusbcbs.com or call 1-800-810-BLUE (2583) or Download the Excellus BCBS app on your smartphone via the Apple App Store or the Google Play Store

DENTAL PLAN RIDERS

Your annual benefit maximums are based on the calendar year and services will follow you throughout the calendar year even when you switch plans mid-year during open enrollment.

Must stay in the dental rider for a minimum of 1 year. However, in order to receive the full orthodontic benefit, you must stay in the dental rider for a minimum of 2 years.

Participating Dentists

Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas. You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

You now have National GRID Dental + DenteMax

National GRID + DenteMax is a network of multiple Blue Cross and Blue Shield Plans that, when combined, offers one of the largest national PPO dental networks and provides patients with lower out-of-pocket costs and broad access to participating dentists.

Non-participating Dentists

Dental Blue plans give you the freedom to see any dentist. **Non-participating** dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of **non-participating** dentists' charges.

DENTAL BENEFIT EXCLUSIONS

Coverage under Dental Blue Basic, Dental Blue Select, and Dental Blue Premier will not apply to:

1. Charges for dentures or bridgework (including crowns and inlays forming the abutments) when such charges are incurred for replacement teeth, all of which were extracted prior to the date the individual became a covered employee;
2. Charges for services not considered necessary and appropriate;
3. Charges for replacement of a lost or stolen prosthetic device;
4. Charges for dentistry for cosmetic purposes, including the alteration or extraction and replacement of sound teeth to change appearance;
5. Charges for the replacement of dentures less than 5 years after a preceding placement, except a replacement made necessary by the initial placement of an opposing full denture which necessitates the replacement of an existing denture;
6. Charges incurred for myofunctional therapy, oral hygiene, dietary or plaque control programs or other educational programs;
7. Charges in connection with an injury or illness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law.

DENTAL BLUE BASIC BENEFITS

Dental Blue Basic represents a basic plan design to encourage preventive care and early treatment and includes coverage for specialized treatment.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 50% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants to age 17

Restorative Services

All restorative services are paid at 50% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit

Orthodontia Services

1. Initial banding and monthly follow up treatment

For Orthodontia services, no more than $750 per individual up to age 19 will be covered per lifetime. One-half total Orthodontia maximum paid in year one and the other half paid in year two.

Dental Blue Basic Deductible and Maximums

There is a $50 annual individual deductible or a $150 family deductible that applies to restorative services per calendar year.

For all restorative services, the maximum payable in a calendar year shall be $500 per individual. Maximums do not apply to Preventive/Diagnostic services.

DENTAL BLUE SELECT BENEFITS

Dental Blue Select represents an enhanced plan design to encourage preventive care and early treatment, and also includes coverage for specialized treatment.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 100% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants to age 19

Restorative Services

All restorative services are paid at 50% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit
4. Occlusal Guards

Orthodontia Services

1. Initial banding and monthly follow up treatment

For Orthodontia services, no more than $1,000 per individual up to age 19 will be covered per lifetime. One-half total Orthodontia maximum paid in year one and the other half paid in year two.

Dental Blue Select Deductible and Maximums

There is a $25 annual individual deductible or a $75 family deductible that applies to restorative and orthodontia services per calendar year.

For all restorative services, the maximum payable in a calendar year shall be $1,000 per individual. Maximums do not apply to Preventive/Diagnostic services.

DENTAL BLUE PREMIER BENEFITS

Dental Blue Premier represents an enhanced plan design to encourage preventive care and early treatment, and also includes coverage for specialized treatment.

Preventive/Diagnostic Services

Preventive and diagnostic services are paid at 100% of BlueShield Fee Schedule. The following are covered under this category:

1. Oral Examination (2 per year)
2. Prophylaxis (2 per year)
3. Dental X-rays;
    a. Full-Mouth Series (once every 3 years)
    b. Bitewings (one set of 4 bitewings per year)
4. Topical fluoride application up to age 16
5. Emergency treatment
6. Sealants to age 19

Restorative Services

All restorative services are paid at 100% of the BlueShield Fee Schedule.

Basic restorative services:

1. Extractions
2. Endodontics (including pulpotomy, pulp capping and root canal treatment)
3. Fillings (consisting of silver amalgam and anterior composite restorations)
4. Oral Surgery (routine extractions, surgical & impacted tooth removal including fracture treatment, cyst removal, and surgical extractions not covered under the medical plan)
5. Periodontics (including gingival curettage, gingivectomy and gingivoplasty)
6. Osseous surgery (bone surgery)
7. IV Sedation for extraction of 3rd molars
8. Repair of dentures

Major restorative services (pre-determination estimates recommended):

1. Prosthodontic (full or partial dentures, fixed or removable bridges, all necessary abutment work, all prosthetic x-rays)
2. Inlays, crowns, porcelain crowns on molars and space maintainers.
3. Implants covered to maximum benefit
4. Occlusal Guards

Orthodontia Services

1. Initial banding and monthly follow up treatment

For Orthodontia services, no more than $1,500 in the individual's lifetime will be covered. One-half total Orthodontia maximum paid in year one and the other half paid in year two.

Dental Blue Premier Deductible and Maximums

There is a $25 annual individual deductible or a $75 family deductible that applies to restorative and orthodontia services per calendar year.

For all restorative services, the maximum payable in a calendar year shall be $1,500 per individual. Maximums do not apply to Preventive/Diagnostic services.

GAHP Disclosure Notices

GAHP HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent, as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within **60 days** of the loss of coverage or the determination of eligibility for premium assistance.

To request special enrollment or obtain more information, contact your school district's designated Benefits Administrator. Any additional questions, contact the GAHP office at 585-344-7566 or 585-344-7564.

COBRA Initial Notice

Your school district will assist you in determining if and when you are eligible for COBRA and will provide any required COBRA notices when a qualifying event occurs.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires employers with 20 or more employees to offer continuation of group health coverage to "qualified beneficiaries" when coverage would otherwise end because of a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the following qualifying events:

- Termination of employment for any reason other than gross misconduct (36 months);
- Reduction in hours causing loss in coverage (36 months);
- Death of the employee (36 months);
- Divorce or legal separation (36 months) employee required to notify school district;
- Dependent children who become ineligible for coverage due to age limitation (36 months) employee required to notify school district;
- Employee becomes entitled to Medicare benefits (under Part A, Part B or both) employee required to notify school district;
- Qualified beneficiaries with a disability (36 months) employee required to notify school district.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the GAHP, and that bankruptcy results in the loss of coverage of any retired employee, retired employee's spouse, surviving spouse, and dependent children covered under the Plan, they will become a qualified beneficiary.

Qualified beneficiaries are required to complete the enrollment form provided to them by their school district in order to be enrolled for any COBRA qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. At the end of the COBRA continuation period, a qualified beneficiary may choose to purchase alternative coverage on an individual basis.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Benefits department at your school district.

HIPAA Notice of Privacy Practices

Excellus Privacy Notice: https://news.excellusbcbs.com/documents/d/global/exc-privacy-policy

GAHP Privacy Notice: https://www.gvboces.org/o/gvb/page/hippa-privacy-and-disclosure-notice

ELIGIBILITY

Eligible subscribers must be US citizens, permanent residents, or non-immigrants whose authorization status permits employment.

New Hires/Rehires

You are eligible to enroll in the group health plan of a participating school district if:

1. You are an eligible employee; AND
2. You are performing the essential job duties according to your job description pursuant to the collective bargaining agreement or other contractual obligations of your position; AND
3. You are receiving your contractual salary if a salaried employee or your hourly rate if an hourly employee; AND
4. You are working a minimum of 20 hours per week if hired as a full-time employee or averaging a minimum of 17.5 hours per week if hired as a part-time employee; AND
5. You are meeting any additional eligibility requirements of your school district.

When all of these criteria are met, you may be considered an active and eligible participant of the health plan. However, if a participant is not actively working on the effective date of coverage, coverage will be delayed for the participant and his/her dependents until the participant begins work as a new hire or returns to work as a rehire. All required enrollment forms must be submitted within 30 days of becoming an eligible employee.

Active Employees

An eligible employee who is currently enrolled in the District's health plan may choose to elect other coverage options offered by the school district (if applicable) during the open enrollment period with an effective date of July 1; OR

An eligible employee who is currently NOT enrolled in the District's health plan may choose to elect coverage from the options offered by the school district during the open enrollment period with an effective date of July 1.

See "How to Enroll" section for other enrollment eligibility.

Ineligible Subscribers Include:

- Employees working fewer than the required hours listed in the New Hire / Re-hire section above;
- An employee in the employer's probationary period (if applicable);
- Individuals paid for periodic services, such as consultants;
- Temporary employees;
- Volunteers;
- Subcontractors.

It's your plan. Get more out of it online.

When you sign up for an Excellus BlueCross BlueShield online member account, you get instant access to all your benefits, tools, member-only resources and more.

Member Card(s)
View or order

Claims
Submit, view and download

Find Providers
Find in-network doctors or specialists

Costs and Spending
Estimate medical costs, track deductibles, and view out-of-pocket spending

Benefits and Coverage
View a summary

Get Rewards
Access available spending and rewards programs

Go Paperless

Receive available documents electronically.

Register or log in today

Visit ExcellusBCBS.com

Scan the QR code with your smartphone camera

Take your plan with you 24/7

Download the app!

5 easy steps

It's easy to get started with an online member account.

1. **Have your member card handy**

2. **Visit our website or download our app**

3. **Complete registration**

4. **Choose username and password**

5. **Verify your email**
(Tip: an email will be sent to you during registration)

New member? Or new plan year?

You can register and log in prior to your effective date with limited access to your online account tools until after your effective date.

Thank you for being an Excellus BCBS member!

B-7184/17544-23M REV 07/23

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Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at https://www.excellusbcbs.com and search for "Manage Your Privacy".

- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO EXCELLUS HEALTH PLAN, INC. ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.**

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)

CURRENT ADDRESS	CITY	STATE/ZIP CODE

PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)

NAME OF PERSON/ORGANIZATION	ADDRESS
NAME OF PERSON/ORGANIZATION	ADDRESS

PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE

☐ At my request ☐ Other: _____

PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION *(select D-1 **or** D-2 and if applicable, D-3)*

NOTE: Skip this section if psychotherapy was checked at the top of this form

D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed.

- OR –

D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information.

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation: _____
☐ Date Range _____ to _____

- AND, IF APPLICABLE -

D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions.

____ Genetic testing
____ Substance use disorder
____ Mental health *(excluding psychotherapy notes)*
____ Sexually transmitted diseases
____ Abortion

Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

CONTINUED ON THE NEXT PAGE

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- Unless you receive revocation in writing, this authorization will be valid until the date specified here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ **Date:** _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

** You must provide documentation supporting your legal authority to act on behalf of the member*

RETURN TO:

Excellus Health Plan
P.O. Box 21146
Eagan, MN 55121

or Fax: 315-671-7079

Please keep a copy for your records

Customer Submitted Dental Claim Form

Excellus

Mail Completed Forms To: PO Box 21146
Eagan, MN 55121-0146

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

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE

4. Other Dental or Medical coverage? No (Skip 5 – 11) Yes (Complete 5 – 11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

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

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID

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

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 ☐ M ☐ F

15. Policyholder/Subscriber ID

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
☐ 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)

RECORD OF SERVICES PROVIDED

	24. Date of Service (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 Tooth 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; ICD10 = A8)

34a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
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 _____
Patient/Guardian 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. NPI

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment
☐ Provider's Office ☐ Hospital ECF Other

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
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

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

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date 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

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 information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

I certify that the procedures as indicated by date, have been completed, personally supervised or rendered by me the attending dentist, that the fees submitted are actual fees I have charged and intended to collect.
Dentist signature: Date:

For assistance in filing your claim, please read the instructions on the back.