ADA American Dental Association® Dental Claim Form

MAIL COMPLETED FORM TO:
Faculty Association Suffolk Community College
Benefit Fund
c/o Daniel H. Cook Associates
1040 Avenue of the Americas – 24th Floor
New York, NY 10018
(212) 505-5050

FACULTY ASSOCIATION SUFFOLK COMMUNITY COLLEGE
FA / BENEFIT FUND SCC
NYSUT · AFT LOCAL 3038

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 (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 ID # (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. 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 | 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 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

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 ____ (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 | 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

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

J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

THIS FORM WILL BE RETURNED IF IT IS INCOMPLETE OR INCORRECT

NOTICE TO MEMBERS

- **PRE-AUTHORIZATION BY THE FUND'S DENTAL CONSULTANT IS REQUIERED FOR ANY PROPOSED COURSE OF TREATMENT IN WICH A DENTIST CHARGES WILL AMOUNT TO $1,000 OR MORE. X-RAYS MUST BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-AUTHORIZATION.** Pre-determination by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the Dental Plan, the patient's eligibility or guaranteed payment.

- CLAIM MUST BE SUBMITTED WITHIN 1 YEAR AFTER COMPLETION OF COURSE OF DENTAL TREATMENT.

- Bring a claim form with you when you visit your dentist. Complete your part – give all the information required. DISCUSS FEES BEFORE SERVICES ARE PERFORMED. If you have any questions about your dental benefits, contact the Dental Program Administrator.

- A covered patient may go to any dentist, anywhere, and the amount of payment is the same regardless of the dentist chosen.

Mail this form to: **Faculty Association Suffolk Community College Benefit Fund**
c/o Daniel H. Cook Associates
1040 Avenue of the Americas – 24th Floor
New York, NY 10018
Telephone (212) 505-5050

- Active member and retiree benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees.

DEPENDENT STUDENT COVERAGE: An unmarried child who is a full time student will be covered up to the age of 25 (12 hours enrolled for undergraduate credits or 6 hours graduate credits). Proof of student status must be submitted to the Fund before a claim can be honored. Such proof consists of completion of FA Benefit Fund Student Verification Form or a letter from college or university attesting to his/her full time attendance during the period that dental services were performed. If this proof has already been recorded with the Fund, it is not necessary to resubmit it with this claim.

NOTICE TO DENTISTS

- **There is no assignment of benefits under this dental program unless you are a participating provider.**

- Pre-Treatment Authorization must be filed no later than 30 days after examination.

- **PRE-DETERMINATION BY THE FUND'S DENTAL CONSULTANT IS REQUIRED FOR ANY PROPOSED COURSE OF TREATMENT IN WHICH A DENTIST CHARGES WILL AMOUNT TO $600 OR MORE. X-RAYS MUS BE INCLUDED WITH TREATMENT PROGRAMS SUBMITTED FOR PRE-DETERMINATION.** Pre-determination by the Fund's Dental Consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services no covered under the Dental Plan, the patient's eligibility or guaranteed payment. Complete treatment amounting to $1,000 or more may require examination of patient by Fund's Consultant Dentist before payment is made.

- **ALL PROCEDURES MUST HAVE CORRESPONDING CDT/ADA PROCEDURE CODES LISTED IN ORDER TO BE PROCESSED**. Failure to comply will delay processing.

FUND DENTAL CONSULTANT REMARKS:

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ANYONE INTENTIONALLY MISUSING THIS FORM FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS IS SUBJECT TO APPROPIATE ACTION.