The City of New York

MANAGEMENT BENEFITS FUND

DENTAL CLAIM FORM
Payor ID# CX076

Send Completed Forms to:
ASO INC.
PO Box 9005
Lynbrook, NY 11563
877-844-7667
asombf.com

PLEASE SUBMIT PRE-OPERATIVE X-RAYS FOR INLAYS, CROWNS, BRIDGES, DENTURES, PERIO SURGERY, ROOT CANAL THERAPY AND NON-ROUTINE EXTRACTIONS.
X-RAYS OF FULL ARCH REQUIRED FOR ALL BRIDGE WORK.
POST TREATMENT X-RAYS REQUIRED FOR ALL ROOT CANAL THERAPY CLAIMS.

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

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

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

7. Gender M ☐ F ☐

8. Policyholder/Member ID (SSN or 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/MEMBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Member Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

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

14. Gender M ☐ F ☐

15. Policyholder/Member ID (SSN or ID#)

16. Plan/Group Number V53

17. Employer Name/Group Name

PATIENT INFORMATION

18. Relationship to Policyholder/Member 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/YYYY)

22. Gender M ☐ F ☐

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

RECORD OF SERVICES PROVIDED - TO BE COMPLETED 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	29a. Diagnostic Pointer	29b. Quantity	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 = BB; ICD-10 = AB)

34a. Diagnosis Codes (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 plans 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. I understand that benefits will automatically be assigned to my dentist if he or she is a Participating Provider.

X _____
Signed (Patient or Member/Guardian) 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, if allowed under my group guidelines. I understand that benefits will automatically be assigned to my dentist if he or she is a Participating Provider.

X _____
Signed (Member/Guardian) Date

BILLING DENTIST OR DENTAL ENTITY

(Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/member)

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? No ☐ Yes ☐

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

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

42. Months of Treatment

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

44. Date of 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 procedure(s) 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. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Specialty Provider Code

57. Phone Number

58. Additional Provider ID

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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

GENERAL INSTRUCTIONS

A. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

B. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

C. All dates must include the four-digit year.

D. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
Item 34a – Diagnosis Code(s) / A, B, C, D (up to four with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, A HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:
11 = Office 12 = Home 21 = Inpatient Hospital 22 = Outpatient Hospital 31 = Skilled Nursing Facility 32 = Nursing Facility
The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicated the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
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.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	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

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

E-mail inquiries
For additional information visit asombf.com

Dedicated Customer Service Line for Management Benefits Fund Members: 1-877-844-7667
Provider Hotline: 1-800-537-1238