DELTA DENTAL

Claim Form Checklist

The claim form checklist provides a guide to completing the required claim form that will be submitted to Delta Dental of Colorado for each completed procedure. The checklist also denotes with an asterisk * and in bold commonly missed claim information that when missed, can result in claim processing delays.

☑	Box	Element	Description
		Header	
	1	Type of Transaction	Check the box for the type of treatment that is being submitted.
	2	Predetermination/Preauthorization Number	Only complete if a predetermination was submitted previously.
		Insurance Company/Dental Benefit Plan Information	
	3	Primary Payer Information	Delta Dental of Colorado PO Box 173803 Denver, CO 80217-3803
		Other Coverage	
	4-11	Other Coverage	Complete only if the member has additional dental insurance. Complete all fields if Delta Dental of Colorado is secondary coverage and attach primary EOB.
		Policy Holder/Subscriber Information	
	12	Primary Subscriber Information	Enter last name, first name, and middle name of the primary subscriber.
	13	Date of Birth	Enter date of birth of the primary subscriber.
	14	Gender	Enter the gender of the primary subscriber.
	15*	Policyholder/Subscriber ID (SSN or ID#)	Enter the DDCO policy holder ID number.
	16	Plan/Group Number	Enter the DDCO group number.
	17	Employer Name	Enter the primary subscriber's employer name.
		Patient Information	
	18	Relationship to Policyholder/Subscriber	Mark the appropriate relationship of the patient to the primary subscriber.
	19	Reserved for Future Use	No entry required.
	20	Name	Enter last name, first name, and middle name of the patient.
	21*	Date of Birth	Enter date of birth of the patient.
	22	Gender	Enter the gender of the patient.
	23	Patient ID/Account #	No entry required.
		Record of Services Provided	
	24*	Procedure Date (MM/DD/YYYY)	Enter procedure date for actual services performed or leave blank if predetermination.

	25*	Area of Oral Cavity	Report area of the oral cavity when procedure code refers to an area. Valid entries: 00 Entire Oral Cavity 01 Maxillary Arch 02 Mandibular Arch 10 Upper Right Quadrant 20 Upper Left Quadrant 30 Lower Left Quadrant 40 Lower Right Quadrant
	26	Tooth System	Enter applicable code list: "JP" ADA Universal/National Tooth Designation System (1-32 or A-T) "JO" ANSI/ADA/ISO Specification
	27*	Tooth Number(s) or Letter(s)	Enter applicable tooth number/letter when procedure code directly involves a tooth. Otherwise, leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth on separate lines of the claim form. When a procedure involves a range of teeth, use a hyphen (-) or comma (,) to separate the first and last tooth in the range.
	28	Tooth Surface	Enter the tooth surface(s) when procedure code directly involves a tooth surface. B = Buccal D = Distal F = Facial or Labial I = Incisal L = Lingual M = Mesial O = Occlusal
	29*	Procedure Code	Enter appropriate procedure code from the current version of Code on Dental Procedures and Nomenclature from the ADA. **NOTE: Procedure code 9999 is not a valid code.**
	29a	Diagnosis Code Pointer	Required only if a diagnosis is entered in Box 34a.
	29b	Qty	Enter number of times the procedure code is delivered to patient. Default value is "01."
	30	Description	Enter a description of the procedure.
	31	Fee	Enter the dentist's full fee for the procedure reported.
	32	Total Fee	Total of all fees listed on the claim form.
	33	Missing Teeth	Report any missing teeth on the form, for identifying missing permanent teeth only.
	34	Diagnosis Code List	Only required if the diagnosis of a health condition may have an impact on the claim processing.
	35	Remarks	This space may be used for additional information for a procedure code that requires a report or further explanation. Remarks should be concise and related to the claim submission. Remarks are required for any "By Report" codes, DX999.
Authorizations			
	36	Patient Signature	Patient signature or signature on file.
	37	Authorize Direct Payment	Patient signature or signature on file.

	38	Place of Treatment	Enter the 2-digit place of service code: 11 = Office 12 = Home 21 = Inpatient Hospital 22 = Outpatient Hospital 31 = Skilled Nursing Facility 32 = Nursing Facility
	39	Enclosures	Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included.
	40-42	Orthodontics Treatment	Only complete if this claim is related to orthodontic treatment. If no, skip to item #43.
	43-44	Replacement of Prosthesis, Prior Placement	Applies to crowns and all fixed or removable prostheses (e.g., bridges and dentures). If no, proceed to Item #45. If yes, complete Items #43-44.
	45-47	Treatment Resulting from Accident	If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box and complete Items #46-47. If this does not apply, skip to item #48.
Billing Dentist or Dental Entity			
	48	Name and Address	Name and complete address of dentist or dental entity (corporation, group practice).
	49*	Billing NPI	Enter the National Provider Identifier as entered in Delta Dental credentialing application*, for the billing entity.
	50	License Number	Dentist's license number if billing dentist is an individual. If corporation, leave blank.
	51	SSN or TIN	Enter as follows: -SSN or TIN as entered in Delta Dental credentialing application* if the billing dentist is unincorporated. -Corporation TIN as entered in Delta Dental credentialing application* if the practice is incorporated. -Entity TIN as entered in Delta Dental credentialing application* if a group practice or clinic.
	52	Phone Number	Enter the business phone number of the practice.
	52a	Additional Provider ID	No entry required.
Treating Dentist and Treatment Location			
	53	Signature of Treating Dentist	Signature of the dentist who performed procedures on the date indicated on the claim. No signature is required for predeterminations.
	54*	NPI	Enter the treating dentist's Type 1 - Individual Provider NPI.
	55*	License Number	Enter the license number of the treating dentist.
	56*	Address	Enter the location where treatment occurred. Only street address, not a PO Box.
	56a	Provider Specialty Code	Enter code that indicates type of dental professional who provided treatment. Ex: General Dentist-122300000X
	57	Phone Number	Enter the business phone number of the treating dentist.
	58	Additional Provider ID	No entry required.

*You may cross reference or find this information on the Facility Report that can be downloaded from the secure provider portal, simply click on the drop down next to provider name and click My Profile.