MVP Medicare Advantage Plans Dental Claim

(Please complete all three pages of this claim form)

MVP HEALTH CARE

Header Information

1. Type of Transaction (check all that apply)
- ☐ Statement of Actual Services
- ☐ Request for Predetermination/Pre-authorization

2. Predetermination/ Pre-authorization No.

Insurance Company/Dental Benefit Plan Information

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

MVP HEALTH CARE
PO BOX 763
SCHENECTADY NY 12301-0763

Electronic Payor ID: **14165**

Other Coverage

(Check applicable box and complete items 5–11. If none, leave blank)

4. ☐ Dental? ☐ Medical (if both, complete items 5–11 for other dental only)

5. Name of Member in #4 (last, first, middle initial, suffix)

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

7. Gender ☐ M ☐ F

8. Member ID (SSN or ID No.)

9. Plan/Group No.

10. Patient's Relationship to Person in #5
☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Member Information (for Insurance Company named in #3)

12. Member Name (last, first, middle initial, suffix), and Address, City, State, Zip Code

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

14. Gender ☐ M ☐ F

15. Member ID

16. Plan/Group No.

17. Employer Name

Patient Information

18. Relationship to Member in #12
☐ Self ☐ Spouse
☐ Dependent Child ☐ Other

19. Reserved for Future Use

20. Name (last, first, middle initial, suffix), and Address, City, State, Zip Code

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

22. Gender ☐ M ☐ F

23. Patient ID/Account No. (assigned by Dentist)

Record of Services Provided

	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. Diagonal Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										

Record of Services Provided *(continued form page 1)*

Fee Subtotal from Page 1 ▶

	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. Diagonal Pointer	29b. Qty.	30. Description	31. Fee
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) A _____ C _____
(Primary diagnosis in "A") A _____ C _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

Authorization

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 _____
Parent/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 _____
Member 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? ☐ Yes ☐ No

40. Is Treatment for Orthodontics ☐ Yes (complete 41–42) ☐ No (skip 41–42)

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

42. Months of Treatment

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

44. Date of Prior Placement (MM/DD/YYYY)

45. Treatment Resulting From:
☐ Occupational Illness/Injury ☐ Auto Accident
☐ Other Accident

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

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 member)

48. Name, Address, City, State, Zip Code

49. NPI	**50.** License No.
51. SSN or TIN	
52. Phone No. ( ) -	
52a. Additional Provider ID	

Treating Dentist and Treatment Location

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 _____

Treating Dentist Signature Date

54. NPI	**55.** License No.
56. Address, City, State, Zip Code	**56a.** Provider Specialty Code
57. Phone No. ( ) -	**58.** Additional Provider ID