

# Dental Claim Form



KANAWHA  
**HealthCare**  
SOLUTIONS, INC.

Mail to:

Kanawha HealthCare Solutions, Inc.  
P.O. Box 1000  
Lancaster, South Carolina 29721  
800-822-1274

**DO NOT USE STAPLES**

1. PATIENT NAME		2. RELATIONSHIP TO EMPLOYEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. PATIENT BIRTH DATE Mo. Day Year		5. IF FULL TIME STUDENT School City		
6. EMPLOYEE / MEMBER / SUBSCRIBER NAME (First, Middle, Last)					7. EMPLOYEE SOCIAL SECURITY NO.			EMPLOYEE BIRTH DATE Mo. Day Year	
8. EMPLOYEE MAILING ADDRESS CITY, STATE, ZIP					9. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION				
10. ACCOUNT / POLICY #		11. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Member's Name SOCIAL SECURITY NO.			12. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 11			SPOUSE BIRTH DATE Mo. Day Year	
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate		DENTAL PLAN NAME		GROUP NO.		NAME AND ADDRESS OF CARRIER			
AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature.					SIGNED (PATIENT OR PARENT IF MINOR)			DATE	
AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.					SIGNED (EMPLOYEE)			DATE	
CERTIFICATION - I certify that the foregoing information is true and correct.					SIGNED (EMPLOYEE)			DATE	

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT 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.

14. DENTIST NAME		22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO <input type="checkbox"/>	YES <input type="checkbox"/>	IF YES, ENTER BRIEF DESCRIPTION AND DATES						
15. MAILING ADDRESS CITY, STATE, ZIP		23. IS TREATMENT RESULT OF AUTO ACCIDENT?		<input type="checkbox"/>	<input type="checkbox"/>							
16. TAX I.D. # TO BE USED FOR TAX REPORTING.		TAX I.D. #	24. OTHER ACCIDENT?		<input type="checkbox"/>	<input type="checkbox"/>	IF YES, NAME OF OTHER PLAN:					
17. DENTIST LICENSE NO.		18. DENTIST PHONE NO.		25. ARE ANY SERVICES COVERED BY ANOTHER PLAN?		<input type="checkbox"/>	<input type="checkbox"/>	(IF NO, REASON FOR REPLACEMENT)			27. DATE OF PRIOR PLACEMENT	
19. FIRST VISIT DATE CURRENT SERIES	20. PLACE OF TREATMENT Office; Hosp.; ECF; Other		21. RADIOGRAPHS OR MODELS ENCLOSED?		HOW MANY?	28. IS TREATMENT FOR ORTHODONTICS?		<input type="checkbox"/>	<input type="checkbox"/>	IF SERVICES ALREADY COMMENCED, ENTER	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING
CHECK ONE: <input type="checkbox"/> PREDETERMINATION OF BENEFITS <input type="checkbox"/> Statement of Actual Services			29. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32-USE CHARTING SYSTEM SHOWN									
			TOOTH # OR LETTER	SURFACE (i.e., M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE (Including X-Rays, Prophylaxis, Materials Used, Etc.)			DATE SERVICE COMPLETED Mo. Day Year	PROCEDURE NUMBER (See Reverse)	FEE		
Indicate missing teeth with an "X" 												
30. Remarks for unusual services			I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.			SIGNED (DENTIST)			DATE			
									TOTAL FEE CHARGED			

## INSTRUCTIONS

### FOR THE EMPLOYEE

1. Please answer all questions in Part I entitled "TO BE COMPLETED BY EMPLOYEE".
2. Sign and Date the "Authorization to Release Information".
3. If you wish to have your benefits paid directly to the Dentist, sign and date the "Authorization to pay Benefits to Dentist".  
If authorized, payment will be made directly to your Dentist. A copy of the payment will be sent to you for your records. Otherwise, payment will be made directly to you.
4. If the patient has coverage under any other group or Government plan, submit the same bills to the other plan at the same time.

The following supportive documentation, as indicated below, may be necessary to determine benefits:

- A. Pre-operative X-rays and/or Narrative
- B. Periodontal Case Type and Pocket Depth Chart
- C. Narrative

### FOR THE DENTIST

For claims involving Predetermination of Benefits:

1. Complete the section "TO BE COMPLETED BY ATTENDING DENTIST". Be sure to itemize charges for each proposed procedure.
2. Kanawha HealthCare Solutions, Inc. will review the treatment plan and will provide the estimate of benefits payable.
3. Review the form and benefit estimates with your patient before the work is done.
4. When you complete treatment, return the form with the treatment dates completed and your signature.

For claims not involving Predetermination of Benefits:

1. Complete Part II. Be sure to date and itemize charges.
2. Sign and date bottom of claim form when work is completed.

**PLEASE NOTE: IF THE CLAIM FORM IS NOT COMPLETED IN FULL AND SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING OF PAYMENT WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED.**

## DENTAL PROCEDURE REFERENCE LIST

### I. DIAGNOSTIC / GENERAL

- Examinations  
0120 Periodic Oral Examination  
0150 Comprehensive Oral Examination
- Radiographs  
0210 Intraoral - complete series (including bitewings)  
0220 Intraoral - single, first film  
0230 Intraoral - each additional film  
0272 Bitewing, two films  
0274 Bitewing, four films  
0330 Panoramic - maxillary and mandibular - single film

### II. PREVENTATIVE

- Dental Prophylaxis (including scaling & polishing)  
1110 Adults  
1120 Children under 14
- Fluoride Treatments  
1201 Topical application of fluoride, including prophylaxis - Child  
1203 Topical application of fluoride, excluding prophylaxis - Child  
1204 Topical application of fluoride, excluding prophylaxis - Adult  
1205 Topical application of fluoride, including prophylaxis - Adult

- C** Space Maintainers  
1510 Fixed, unilateral type  
1515 Fixed, bilateral type  
1520 Removable, unilateral type  
1525 Removable, bilateral type

### III. RESTORATIVE

- Amalgam Restorations (deciduous teeth)  
2110 Amalgam - one surface  
2120 Amalgam - two surfaces  
2130 Amalgam - three surfaces  
2131 Amalgam - four or more surfaces
- Amalgam Restorations (permanent teeth)  
2140 Amalgam - one surface  
2150 Amalgam - two surfaces  
2160 Amalgam - three surfaces  
2161 Amalgam - four or more surfaces
- Silicate Restorations  
2210 Silicate cement - per restoration
- Filled or Unfilled Resin Restorations  
2330 Composite resin - one surface  
2331 Composite resin - two surfaces  
2332 Composite resin - three surfaces  
2335 Composite resin - four or more surfaces including the incisal angle  
2380 Composite resin - one surface, posterior - primary  
2381 Composite resin - two surfaces, posterior - primary  
2382 Composite resin - three surfaces, posterior - primary  
2385 Composite resin - one surface, posterior - permanent  
2386 Composite resin - two surfaces, posterior - permanent  
2387 Composite resin - three or more surfaces, posterior - permanent

- A** Gold Inlay Restorations  
2520 Inlay, gold - two surfaces  
2530 Inlay, gold - three surfaces

### III. Restorative (Con't.)

- A** Gold Onlay Restorations  
2543 Onlay, gold - three surfaces  
2544 Onlay, gold - four or more surfaces
- A** Crowns - Single Restorations Only  
2710 Crown resin  
2720 Crown resin with high noble  
2721 Crown resin with predominately base metal  
2722 Crown resin with noble metal  
2740 Crown porcelain  
2750 Crown porcelain fused to high noble metal  
2751 Crown porcelain fused to predominately base metal  
2752 Crown porcelain fused to noble metal  
2790 Crown full cast high noble metal  
2791 Crown full cast predominately base metal  
2792 Crown full cast noble metal  
2810 Crown 3/4 cast metal  
2930 Prefabricated stainless steel crown - primary  
2931 Prefabricated stainless steel crown - permanent  
2932 Prefabricated resin crown
- Other Restorative Services  
2910 Recement inlays  
2920 Recement crowns

### IV. ENDODONTICS

- Pulpotomy (excluding restoration)  
3220 Therapeutic pulpotomy
- A** Root Canal Therapy  
3310 Anterior  
3320 Bicuspid  
3330 Molar
- A** Endodontic Retreatment  
3346 Retreatment of previous anterior  
3347 Retreatment of previous bicuspid  
3348 Retreatment of previous molar
- A** Periradicular Services  
3410 Apicoectomy, performed as a separate surgical procedure, anterior (first root)  
3421 Apicoectomy, performed as a separate surgical procedure, bicuspid (first root)  
3425 Apicoectomy, performed as a separate surgical procedure, molar (first root)  
3426 Apicoectomy, performed as a separate surgical procedure, each additional root

### V. PERIODONTICS

- B** Surgical Services  
4210 Gingivectomy or gingivoplasty, per quadrant  
4260 Osseous surgery, per quadrant
- B** Adjunctive Services  
4341 Root Planing, per quadrant  
4355 Full mouth debridement  
9951 Occlusal adjustment - limited  
9952 Occlusal adjustment - complete
- Miscellaneous Services  
4910 Periodontal prophylaxis (periodontal maintenance procedures following active periodontal therapy)

### VI. PROSTHODONTICS - REMOVABLE

- C** Complete Dentures  
5110 Complete upper  
5120 Complete lower  
5130 Immediate upper  
5140 Immediate lower
- A** Partial Dentures  
5211 Upper, resin base, including clasps  
5212 Lower, resin base, including clasps  
5213 Upper, cast metal base  
5214 Lower, cast metal base
- Adjustments to dentures (6 mos. after installation or by dentist other than dentist providing appliances)  
5410 Complete denture (upper)  
5411 Complete denture (lower)  
5421 Partial denture (upper)  
5422 Partial denture (lower)
- Repair broken complete or partial denture  
5610 Repair denture base  
5620 Repair cast framework  
5630 Repair or replace broken clasp  
5640 Replace one broken tooth
- Adding teeth to partial to replace extracted tooth:  
5650 Each tooth not involving clasp  
5660 Each tooth involving clasp  
5730 Reline complete upper denture - chairside  
5731 Reline complete lower denture - chairside  
5740 Reline upper partial denture - chairside  
5741 Reline lower partial denture - chairside  
5750 Reline complete upper denture - laboratory  
5751 Reline complete lower denture - laboratory  
5760 Reline upper partial denture - laboratory  
5761 Reline lower partial denture - laboratory

### VII. PROSTHODONTICS - FIXED

- Fixed Bridges  
**A** Bridge Pontics  
6210 Pontic cast high noble metal  
6211 Pontic cast predominately base metal  
6212 Pontic cast noble metal  
6240 Pontic porcelain fused to high noble metal  
6241 Pontic porcelain fused to predominately base metal  
6242 Pontic porcelain fused to noble metal  
6250 Pontic resin with high noble metal  
6251 Pontic resin with predominately base metal  
6252 Pontic resin with noble metal
- A** Inlay/Onlay Abutments  
6520 Inlay metallic - two surfaces  
6530 Inlay metallic - three surfaces  
6543 Onlay metallic - three surfaces  
6544 Onlay metallic - four or more surfaces
- A** Crowns  
6720 Abutment crown resin with high noble metal  
6721 Abutment crown resin with predominately base metal  
6722 Abutment crown resin with noble metal  
6750 Abutment crown porcelain fused to high noble metal  
6751 Abutment crown porcelain fused to predominately base metal  
6752 Abutment crown porcelain fused to noble metal

### VII. Prosthodontics - Fixed (Con't.)

- A**  
6780 Abutment crown 3/4 cast high noble metal  
6790 Abutment crown full cast high noble metal  
6791 Abutment crown full cast predominately base metal  
6792 Abutment crown full cast noble metal  
2810 Crown 3/4 cast metal  
Other services  
6930 Recement bridge

### VIII. ORAL SURGERY

- (All procedures include local anesthesia and post-operative care)
- A** Simple Extractions  
7110 Single tooth  
7120 Each additional tooth
- A** Surgical Extractions  
7210 Erupted tooth  
7220 Soft tissue impaction  
7230 Partial bony impaction  
7240 Complete bony impaction  
7241 Complete bony impaction presenting unusual difficulty and circumstances
- C** Alveoplasty (surgical preparation of ridge for dentures), per quadrant:  
7310 In conjunction with extractions  
7320 Not in conjunction with extractions

### IX. ORTHODONTICS

- Comprehensive Full Banded Treatment  
8020 Preliminary Study (including cephalometric radiographs, diagnostic casts and treatment plan) and first month of active treatment including all active and retention appliances  
8030 Active treatment, per month after first month
- Other Orthodontic Treatment  
Appliances for Tooth Guidance  
8110 Removable  
8120 Fixed or cemented
- Appliances to Control Harmful Habits  
8210 Removable  
8220 Fixed or cemented

### X. ADJUNCTIVE SERVICES

- Emergency Treatment  
9110 Palliative (emergency) treatment of dental pain, minor procedures
- C** 9220 General anesthesia (first 30 minutes)  
9221 General anesthesia (each additional 15 minutes)