Rules of

Department of Insurance

Division 400—Life, Annuities and Health
Chapter 8—Forms, Procedures and Fees

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Title 20—DEPARTMENT OF INSURANCE
Division 400—Life, Annuities and Health
Chapter 8—Forms, Procedures and Fees

20 CSR 400-8.100 Filing Fees

PURPOSE: This rule prescribes forms and procedures to be followed in proceedings before the insurance department involving the filing of forms with the life and health section.

(1) For the purposes of assessing a fee for the filing of all forms required to be filed with the life and health section of the Department of Insurance, the following shall be considered a filing:

(A) A policy face page and all supporting documentation enclosed with it shall be considered a single filing;

(B) Any application, rider, endorsement, amendment, certificate or policy insert submitted separately, subsequent to the original policy, shall be considered a separate filing; and

(C) Any filing resubmitted to comply with requests or requirements of Department of Insurance personnel shall not be considered a new filing.

AUTHORITY: sections 287.310, RSMo Supp. 1992, 374.045, RSMo Supp. 1993, 374.230, RSMo Supp. 1989, 375.920, 376.405, 376.675, 376.777, 379.160 and 379.321, RSMo 1986. This rule was previously filed as 4 CSR 190-10.110(1). Emergency rule filed Nov. 12, 1982, effective Dec. 1, 1982, expired March 31, 1983. Original rule filed Dec. 14, 1982, effective April 11, 1983.*

**Original authority: 287.310, RSMo 1939, amended 1992; 374.045, RSMo 1967, amended 1993; 374.230, RSMo 1939, amended 1945, 1949, 1967, 1989; 375.920, RSMo 1979; 376.405, RSMo 1959, amended 1984; 376.675, RSMo 1963, amended 1984; 376.777, RSMo 1959, amended 1984; 379.160, RSMo 1939, amended 1957, 1963; and 379.321, RSMo 1972.*

20 CSR 400-8.200 Procedures for the Filing of All Policy Forms and Certain Rates for Life or Health Policies, Contracts or Related Forms

PURPOSE: This rule outlines the procedure for filing life or accident and health insurance policies, annuities and other contracts, and related forms which must be approved by the director prior to their use in Missouri. This rule also establishes the procedure for the filing of certain rates and sets forth the manner in which filing fees are calculated.

(1) Applicability—This regulation applies to all policies, contracts and related forms, rates and advertisements which must be filed with the director.

(2) Definitions.

(A) Insurer means all companies authorized to transact the business of life or health insurance in this state, fraternal benefit societies, health service corporations, health maintenance organizations (HMOs) or any other prepaid plan providing health care, dental, vision or similar types of services or benefits to citizens of this state.

(B) Policies, contracts and related forms means group or individual policies or contracts issued by an insurer, including any:

1. Individual policies and group policies, certificates and insert pages;
2. Endorsements, riders, amendments or addendums to the policy or contract;
3. Group certificates of coverage as set forth in subsection (4)(C) of this regulation;
4. Applications and enrollment forms or any forms supplemental to them;
5. Any schedule pages filed separately from the policy or contract when they are used to set forth the provisions and conditions of coverage provided under contracts issued by insurers; and
6. Any form used by an HMO or other prepaid plan to contract with persons providing care, services or supplies to enrollees.

(3) Filing Requirements for All Policies, Contracts and Related Forms.

(A) All policies, contracts and related forms must be submitted in duplicate to the life and health section for approval prior to use in this state.

(B) Each filing of forms must be accompanied by a letter of transmittal, in duplicate, which references the forms and which briefly describes the benefits or other purpose of the forms and the intended market in which it will be utilized.

(C) The letter of transmittal must disclose if a form is new or a replacement to a previously approved form. If a form is replacing a previously approved form, the letter must give the reason for the replacement and provide the form number and approval date for the form being replaced.

(D) Life insurance forms must be submitted separately from health insurance forms. However, this restriction does not apply where the combination of coverage is inherent to the plan design of group coverage.

(E) Group forms must be submitted separately from individual forms.

(F) Life insurance and annuity submissions must be accompanied by actuarial demonstrations of compliance with section 376.670, 376.671 or 376.697, RSMo, where appropriate.

(G) Each policy, contract or related form must contain a form number in the lower left corner of the face page. In the case of riders, amendments or applications, the form number must appear in the lower left corner of the first page.

(4) Filing Requirements for Group Policies and Contracts.

(A) The type of group to which the filing is intended to be issued clearly shall be identified in the letter of transmittal. The group type shall be described pursuant to classifications enumerated in section 376.421, 376.691, 376.693 and 376.951.2(4)(d), RSMo.

(B) If the policy is intended to be issued to a group as defined in section 376.421.2, 376.693 or 376.951.2(4)(d), RSMo, actuarial justification that the proposed group meets the criteria set forth in these sections must accompany the filing. Subsequent changes to the policy affecting the original actuarial assumptions must be accompanied by additional actuarial justifications.

(C) If a group policy as described in section 376.421.2, 376.693 or 376.951.2(4)(d), RSMo is issued in another state but coverage is offered to residents of Missouri, the certificate of coverage must be filed for approval prior to use in Missouri.

1. Each filing also must be accompanied by the actuarial justifications required of Missouri sitused groups under subsection (4)(B).
2. The filing for approval required in subsection (4)(C) need not be provided if the insurer demonstrates that the group policy was delivered and approved in a state which adopted the 1983 version or a more recent version of the National Association of Insurance Commissioners (NAIC) Model Group Law, which includes provisions substantially similar to those contained in the statutes referenced in subsection (4)(C).

(5) Filing Requirements for *pro forma* HMO Provider Contracts and Risk-Sharing Arrangements.

(A) *Pro forma* provider contracts must contain an identifying form number in the lower left corner of the first page.

(B) Each *pro forma* provider contract, including any amendments or endorsements, and any risk-sharing arrangements or terms, must be filed with a transmittal document as specified in section (6).

(C) The filing fee for *pro forma* provider contracts and for all risk-sharing arrangements or terms shall be calculated in the

same manner as for policies, contracts and related forms as set forth in section (7) of this regulation.

(6) Transmittal Document Required.

(A) All filings must include a completed transmittal document (form TD-1) in the form illustrated in Exhibit I to this regulation.

(B) The TD-1 must be submitted in triplicate and list each form by form number and title in the appropriate area.

(7) Computation of Filing Fees for Policies, Contracts and Related Forms.

(A) The fee for each separately filed group or individual policy, including any certificates, riders, applications, etc. to be used with that policy is fifty dollars ($50).

(B) The fee for each separately filed group certificate, including any riders, applications, endorsements, etc. to be used with that certificate is fifty dollars ($50).

(C) The fee for any applications, riders, amendments, etc. filed independent of a policy or certificate is fifty dollars ($50) per form.

(D) The fee for group policy or certificate insert pages is fifty dollars ($50) for each group policy with which they will be used.

(E) The fee for group insert pages which are filed on a general use basis is fifty dollars ($50) per insert page.

(F) The fee for filing each *pro forma* provider contract and each risk-sharing arrangement or term is fifty dollars ($50) per contract, arrangement or term.

(8) Filing of Rates.

(A) All rates, rate increases and rate decreases must be filed no later than sixty (60) days prior to the date the rate is to become effective when—

1. The coverage to which the rate applies is Medicare Supplement coverage as defined in section 376.854, RSMo; and

2. The coverage to which the rate applies is credit life or disability coverage subject to Chapter 385, RSMo.

(B) Any rate which must be filed pursuant to this subsection must be accompanied by—

1. A transmittal document (TD-1) which lists each policy form to which the rate change applies; and

2. A fifty dollar ($50) filing fee for each rate schedule filed.

(9) Advertisement—Any statutorily required filing of advertisements must be accompanied by a fifty dollar ($50) filing fee, a transmittal letter and TD-1 form.

AUTHORITY: sections 354.485, 376.405, 376.670, 376.675 and 376.777, RSMo 1994, and 354.624 and 374.045, RSMo Supp. 1997. This rule was previously filed as 4 CSR 190-13.010. Original rule filed Dec. 5, 1969, effective Dec. 15, 1969. Amended: Filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded and readopted: Filed Jan. 13, 1984, effective May 11, 1984. Amended: Filed March 3, 1986, effective Aug. 25, 1986. Rescinded and readopted: Filed Oct. 24, 1991, effective April 4, 1992. Amended: Filed Nov. 3, 1997, effective May 30, 1998.*

**Original authority: 354.485, RSMo 1983, 354.624, RSMo 1997, 374.045, RSMo 1967, amended 1993, 1995, 376.405, RSMo 1959, amended 1984, 376.670, RSMo 1943, amended 1959, 1961, 1965, 1975, 1979, 1982, 376.675, RSMo 1963, amended 1984; and 376.777, RSMo 1959, amended 1984.*

Op. Atty. Gen. No. 112, Edmiston (6-21-76). *Insurance companies are required to pay a filing fee pursuant to section 374.230(6), RSMo for documents filed with the director of the Division of Insurance pursuant to sections 376.405, 376.675, 376.777, RSMo Supp. 1975. The filing fee imposed by section 374.230(6) is for each document and not each page of each document. The filing fee paid pursuant to section 374.230(6) is not pursuant to section 148.400, RSMo, deductible from the premium tax payable by such companies.*

Survivors Ben. Ins. Co. v. Farmer, *514 SW2d 565 (Mo. 1974). Superintendent of insurance has the duty to approve or disapprove life insurance contracts and forms and no contract or form may be used in Missouri without the approval of the superintendent.*

STATE OF MISSOURI
DEPARTMENT OF INSURANCE

LIFE AND ACCIDENT AND HEALTH TRANSMITTAL DOCUMENT

TD-1

P.O. BOX 690
JEFFERSON CITY, MO 65102-0690
(573) 751-4363

FOR DEPARTMENT OF INSURANCE USE ONLY

STATUS OF FILING (DATE AND CODE)						

FORM(S) COUNT	DATE OF SUBSTITUTION	ANALYST

REMARKS	DATE FILING RECEIVED	DATE APPROVED
FEE I.D. NUMBER		

INSURER INFORMATION

COMPANY NAME	9 DIGIT NAIC CODE NUMBER
MAILING ADDRESS	
NAME AND TITLE OF CONTACT PERSON FOR THIS FILING	TOLL FREE OR COLLECT TELEPHONE NO. ( )

FILING INFORMATION

DATE OF SUBMISSION	LIST ALL PREVIOUSLY APPROVED FORMS ACCOMPANYING THIS FILING IN SPACE BELOW:	
FOR ANALYST USE ONLY	LIST ALL NEW FORMS ACCOMPANYING THIS FILING IN SPACE BELOW: FORM NUMBER(S)	TITLE OF FORM(S)
	(IF ADDITIONAL SPACE IS REQUIRED, CONTINUE ON PLAIN WHITE PAPER)	$

MO 375-0024 (2-98)

TD-1

20 CSR 400-8.300 Uniform Health Care Billing Forms

PURPOSE: This rule is intended to standardize the forms used in the billing and reimbursement of health care services, reduce the number of forms utilized and increase efficiency in the reimbursement of health care services through standardization in accordance with section 374.184, RSMo.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Definitions.

(A) CDT-2 Codes means the current dental terminology prescribed by the American Dental Association (ADA).

(B) CPT-4 Codes means the current procedural terminology published by the American Medical Association (AMA).

(C) HCFA means the Health Care Financing Administration of the United States Department of Health and Human Services.

(D) HCFA Form 1450/UB-92 Form (see 13 CSR 70-3.100) means the health insurance claim form published by HCFA for use by institutional care practitioners.

(E) HCFA Form 1500 (see 13 CSR 70-3.100) means the health insurance claim form published by HCFA for use by health care practitioners.

(F) HCPCS means HCFA's Common Procedure Coding System that is based upon the AMA's Physician Current Procedural Terminology, Fourth Edition (CPT-4).

1. HCPCS Level 1 Codes means the AMA's CPT-4 Codes.

2. HCPCS Level 2 Codes means the codes for physicians and nonphysician services that are not included in CPT-4.

3. HCPCS Level 3 Codes means the codes for physicians and nonphysician services that are not included in CPT-4 or HCPC Level 2 Codes but which are approved by HCFA.

(G) Health care practitioner shall include, but not be limited to, the following persons who provided health care services under the authority of a license or certificate of Missouri.

1. A chiropractor licensed under Chapter 331, RSMo;

2. A corporation or partnership of health care practitioners defined in this section;

3. A dentist licensed under Chapter 332, RSMo;

4. A nurse licensed under Chapter 335, RSMo;

5. An ophthalmologist licensed under Chapter 334, RSMo;

6. An optometrist licensed under Chapter 336, RSMo;

7. A physician or physical therapist licensed under Chapter 334, RSMo;

8. A podiatrist licensed under Chapter 330, RSMo;

9. A psychologist licensed under Chapter 337, RSMo;

10. A speech pathologist or clinical audiologist licensed under Chapter 345, RSMo; and

11. A home health care provider licensed under Chapter 197, RSMo;

(H) ICD-9-CM Codes means the disease codes in the International Classification of Diseases, Ninth Revision, clinical modifications published by the United States Department of Health and Human Services.

(I) Institutional care practitioner means—

1. A hospice licensed under Chapter 197, RSMo;

2. A hospital licensed under Chapter 197, RSMo; and

3. A skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home and personal care facility licensed under Chapter 344, RSMo.

(J) Insurer means an insurance company, health services corporation fraternal benefit society, health maintenance organization, third-party administrator and any other entity processing claims or reimbursing the costs of health care expenses.

(K) J500 Form Series means the uniform dental claim forms approved by the ADA for use by dentists and includes the J510, J511 and J512 versions of the form.

(L) Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965.

(M) Medical Assistance or Medicaid means Title XIX of the federal Social Security Act (42 U.S.C. 1936).

(N) Revenue Code means the codes established for use by institutional care practitioners by the National Uniform Billing Committee.

(2) Applicability and Scope.

(A) Except as otherwise specifically provided, the requirements of this rule apply to insurers, health care practitioners and institutional care practitioners.

(B) Nothing in this rule shall prevent an insurer from requesting additional information that is not contained on the forms required under this rule to determine eligibility of the claim for payment if required under the terms of the policy or certificate issued to the claimant. The health care practitioner, the institutional care practitioner or other claimant may charge reasonable fees for copying the additional information requested by the insurer. The state Medicaid program under the Division of Medical Services shall be exempt from subsection (2)(B) so long as they comply with the timely processing deadlines set forth by HCFA.

(C) Nothing in this rule shall prohibit an insurer, health care practitioner or institutional care provider from modifying the uniform billing document where both insurer and provider believe those modifications will streamline claims processing procedures, so long as the modifications are specified in a written contract between the health care provider and the insurer.

(3) Requirements for Use of HCFA Form 1500.

(A) Health care practitioners, other than dentists, shall use the HCFA Form 1500 and instructions provided by HCFA for use of the HCFA Form 1500 when filing claims with insurers for professional services. Health care providers that bill patients directly shall provide a properly completed HCFA Form 1500 in addition to any other explanatory information used to bill the patient when requested by the patient.

(B) Insurers may not require health care practitioners to use any coding system for the initial filing of claims for health care services other than the following:

1. HCPCS Codes;

2. ICD-9-CM Codes; and

3. For anesthesia services, HCPCS Level 1 Codes.

(C) Insurers may not require health care practitioners to use any other descriptor with a code or to furnish additional information with the initial submission of a HCFA Form 1500 except under the following circumstances:

1. When the procedure code used describes a treatment or service that is not otherwise classified; or

2. When the procedure code is followed by the CPT-4 modifier 22, 52 or 99, health care practitioners may use item 19 of the HCFA Form 1500 to explain multiple modifiers.

(D) Health care practitioners may use Box 19 of the HCFA Form 1500 to indicate the

form is an amended version of a form previously submitted to the insurer by inserting the word, amended, in the space provided.

(E) Health care practitioners billing for services based on the amount of time involved shall define on line 19 the time interval in item 24 G of the HCFA Form 1500. If not defined, units will be assumed to be days of treatment.

(F) Health care practitioners shall provide the unique physician identification number, as assigned by HCFA, in box 17a.

(G) Health care practitioners shall provide the federal tax identification number or Social Security number to complete Item 25 of the HCFA Form 1500.

(4) Requirements for Use of HCFA Form 1450.

(A) Institutional care practitioners shall use the HCFA Form 1450 and instructions provided by HCFA for use of the HCFA Form 1450 when filing claims with insurers for health care services. Institutional care providers that bill patients directly shall provide a properly completed HCFA Form 1450 in addition to any other explanation information used to bill the patient when requested by the patient.

(B) Insurers may not require institutional care practitioners to use any coding system for the initial filing of claims for health care services other than the following:

1. ICD-9-CM Codes;
2. Revenue Codes;
3. HCPCS Level 1 Codes;
4. HCPCS Level 2 Codes;
5. HCPCS Level 3 Codes; and
6. If charges include direct service furnished by a health care practitioner, the information outlined in section (3) of this rule.

(C) Hospitals may use the HCFA Form 1500 to supplement an HCFA Form 1450 if necessary in billing patients or their representatives or filing claims with insurers for professional medical services.

(5) Requirements for Use of J500 Form Series.

(A) Dentists shall use the J500 Form Series and instructions provided by the ADA for use of the J500 Form Series for filing claims with insurers for professional services. Dentists that bill patients directly shall provide a properly completed form in addition to any other form used to bill the patient when requested by the patient, unless the services provided are reimbursable under other health coverage of the patient, in which case, the dentist shall use the HCFA Form 1500.

(B) Insurers may not require a dentist to use any code other than the CDT-1 Codes for the initial filing of claims for dental care services, unless the use of supplemental codes are defined and permitted in a written contract between the insurer and dentist.

(6) General Provisions.

(A) Health care practitioners and institutional care practitioners shall file claims in a manner consistent with the requirements of this rule. Claims filed in paper form shall be printed on eight and one-half by eleven-inch (8 1/2 × 11") paper.

(B) Insurers shall accept forms submitted in compliance with this rule for the processing of claims.

(C) Health care practitioners, institutional care practitioners and insurers shall—

1. Use and accept the most current editions of the HCFA Form 1500, HCFA Form 1450, UB-92 Form or J512 Form and most current instructions for these forms in the billing of patients or their representatives and filing claims with insurers; and
2. Modify their billing and claim reimbursement practices to encompass the coding changes for all billings and claim filing by ninety (90) days after the effective date of the changes by the developers of the forms, codes and procedures required under this rule.

(7) This rule shall become effective on January 1, 1995.

(8) Separability. If any provision of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected.

AUTHORITY: section 374.184, RSMo (1994). Original rule filed Nov. 29, 1993, effective Jan. 1, 1995. Amended: Filed Oct. 15, 1996, effective June 30, 1997.*

**Original authority 1992.*

Dental Claim Form

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name first m.i last
2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other ____
3. Sex m f
4. Patient birthdate MM DD YYYY
5. If full time student school city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birthdate MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no

12-a. Name and address of carrier(s)

12-b. Group no.(s)

13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)

14-b. Employee/subscriber soc. sec. or I.D. number

14-c. Employee/subscriber birthdate MM DD YYYY

15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other ____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶

Signed (Patient, or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶

Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted

City, State, Zip

18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment Office Hosp. ECF Other
23. Radiographs or models enclosed? No Yes How many?

	No	Yes	If yes, enter brief description and dates
24. Is treatment result of occupational illness or injury?			
25. Is treatment result of auto accident?			
26. Other accident?			
27. If prosthesis, is this initial placement?			(If no, reason for replacement) 28. Date of prior placement
29. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed / Mos. treatment remaining

Identify missing teeth with "x"

FACIAL 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A B C D E F G H I J LINGUAL UPPER RIGHT LEFT PRIMARY PERMANENT LOWER 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 T S R Q P O N M L K LINGUAL FACIAL

30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶

Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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J510

Dental Claim Form

Check one:
- ☐ Dentist's pre-treatment estimate
- ☐ Dentist's statement of actual services

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name first m.i. last
2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other____
3. Sex m f
4. Patient birthdate MM DD YYYY
5. If full time student school city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birthdate MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no

12-a. Name and address of carrier(s)

12-b. Group no.(s)

13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)

14-b. Employee/subscriber soc. sec. or I.D. number

14-c. Employee/subscriber birthdate MM DD YYYY

15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ Signed (Patient, or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ Signed (Insured person) Date

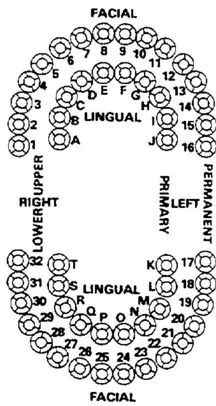
BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted

City, State, Zip

18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment Office Hosp. ECF Other
23. Radiographs or models enclosed? No Yes How many?
24. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates.
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? If services already commenced enter: Date appliances placed Mos. treatment remaining

Identify missing teeth with "x"



30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee	For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶ Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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J511

Dental Claim Form

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name first m.i. last
2. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other______
3. Sex m f
4. Patient birthdate MM DD YYYY
5. If full time student school city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birthdate MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no

12-a. Name and address of carrier(s)

12-b. Group no.(s)

13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)

14-b. Employee/subscriber soc. sec. or I.D. number

14-c. Employee/subscriber birthdate MM DD YYYY

15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other______

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ Signed (Patient, or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted

City, State, Zip

18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment Office Hosp. ECF Other
23. Radiographs or models enclosed? No Yes How many?
24. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates.
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? If services already commenced enter: Date appliances placed Mos. treatment remaining

Identify missing teeth with "x"

FACIAL / LINGUAL / RIGHT / LEFT / UPPER / LOWER / PRIMARY / PERMANENT / LINGUAL / FACIAL (tooth chart: 1–32, A–T)

30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶ Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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