Clear Fields

Group Dental Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

CIGNA

DO NOT USE STAPLES

PART I - TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME

2. RELATIONSHIP TO EMPLOYEE — *Self* ☐ *Spouse* ☐ *Child* ☐ *Other* ☐

3. SEX — *M* ☐ *F* ☐

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? ☐ Yes ☐ 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? ☐ Yes ☐ 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.

PART II - TO BE COMPLETED BY ATTENDING DENTIST

14. DENTIST NAME

15. MAILING ADDRESS

CITY, STATE, ZIP

16. TAX I.D. # TO BE USED FOR TAX REPORTING. | TAX I.D. # | SOC. SEC. #

17. DENTIST LICENSE NO. | 18. DENTIST PHONE NO.

19. FIRST VISIT DATE CURRENT SERIES | 20. PLACE OF TREATMENT *Office* ☐ *Hosp.* ☐ *ECF* ☐ *Other* ☐ | 21. RADIOGRAPHS OR MODELS ENCLOSED? ☐ Yes ☐ No | HOW MANY?

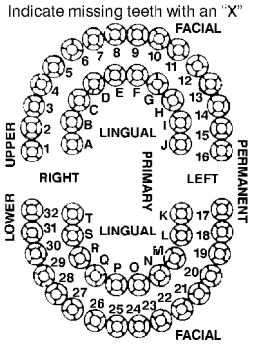
	NO	YES	
22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	☐	☐	IF YES, ENTER BRIEF DESCRIPTION AND DATES
23. IS TREATMENT RESULT OF AUTO ACCIDENT?	☐	☐	
24. OTHER ACCIDENT?	☐	☐	
25. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	☐	☐	IF YES, NAME OF OTHER PLAN:
26. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	☐	☐	(IF NO, REASON FOR REPLACEMENT) / 27. DATE OF PRIOR PLACEMENT
28. IS TREATMENT FOR ORTHODONTICS?	☐	☐	IF SERVICES ALREADY COMMENCED, ENTER / DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

CHECK ONE:
☐ **PREDETERMINATION OF BENEFITS**
☐ 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. CIGNA HealthCare 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 Alveoloplasty (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)