



# Dental Provider Supplement

## June 2025



# Keystone First

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# **Introduction**

## **Who are we**

Keystone First Health Plan is Pennsylvania's largest Medical Assistance (Medicaid) managed care health plan serving recipients in Southeastern Pennsylvania including Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

## **Our Mission**

We help people:  
Get Care  
Stay Well  
Build Healthy Communities

## **Our Values**

Our service is built on these values:

Advocacy  
Care of the Poor  
Compassion  
Competence  
Dignity  
Hospitality  
Stewardship

## **Welcome to the Keystone First Dental Provider Network!**

The information contained in this Dental Provider Supplement is in addition to the information contained in the Keystone First Provider Manual and is intended to apply only to Dental Providers and to Keystone First's Dental Program. This Dental Provider Supplement includes information on Keystone First's Dental Program that may not be otherwise included in the Keystone First Provider Manual.

### **Single point of contact**

To assist with timely, accurate Provider reimbursement and high-quality services, a Dental Account Executive is assigned to each Provider. Dental Account Executives are responsible for building relationships with the office managers at each Provider location. This approach fosters teamwork and cooperation, which results in a shared focus on improving service, Member participation, and program results.

### **Support for Members**

To further reduce costs for Providers while promoting satisfaction, Keystone First offers support with appointment scheduling for Members. Providers may also refer Members with health-related concerns to Keystone First to address any questions they may have. This highly successful program reduces administrative costs for dentists and routinely sends satisfied, eligible Members directly to Provider practice locations.

### **Consistent, transparent authorization determination logic**

Keystone First's trained Dental Program Team Members use clinical algorithms, which can be customized to ensure a consistent approach for making Utilization Management (UM) determinations. These algorithms are available to Providers through a Provider Services Website so dentists can follow the decision matrix and understand the logic behind UM decisions. In addition, Keystone First fosters a sense of partnership by encouraging Providers to offer feedback about the algorithms. A consistent, well-understood approach to UM determinations promotes clarity and transparency for Providers, which in turn reduces Provider administrative costs.

### **Technology tools**

Keystone First takes advantage of technology tools to increase speed and efficiency and keep program administration and Provider participation costs as low as possible.

Provider Services Website – <https://www.dentaquest.com/en/providers/pennsylvania>

Keystone First provides access to a Website that contains the full complement of online Provider resources. The Website features an online Provider inquiry tool for real-time eligibility, Claims status and authorization status. In addition, the Website provides helpful information such as

required forms, Provider newsletter, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines and other information to assist Providers in working with Keystone First.

The Website may be accessed at <https://www.dentaquest.com/en/providers/pennsylvania> . Keystone First's Provider Services Website allows Network Providers direct access to multiple online services. Utilization of the online services offered through the Provider Website lowers program administration and participation costs for Providers.

To access the site, enter a valid user ID and password. From your preferred internet browser, Providers and authorized office staff can log in for secured access anytime from anywhere, and handle a variety of day-to-day tasks.

## **Feedback**

At Keystone First, feedback from both Members and Providers is encouraged, logged, and acted upon when appropriate. To measure Provider and Member satisfaction, and to gather valuable feedback for its quality improvement initiatives, Keystone First makes surveys available from its Websites and through telephone calls. In addition, to help foster a sense of teamwork and cooperation, Keystone First invites feedback from Providers about its UM algorithms by direct communication with the Keystone First Dental Director which can be facilitated through your Account Executive.



# Provider Web Portal Registration & Introduction

The DentaQuest Provider Web Portal allows us to maintain our commitment to help you keep your office costs low, access information efficiently, get paid quicker and to submit Claims and Prior Authorization requests electronically along with the many other features listed here:

- Submit claims and authorizations
- Check member eligibility status (For additional information, please refer to the Accessing Member Eligibility information section.)
- View up-to-date payment information
- Upload necessary documentation
- Review claims status
- Check benefits
- Message DentaQuest through secure messaging.

To submit claims via the portal, simply log on to [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on “Providers”. From there choose your State and press “View state page”. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. The Provider Portal also allows you to attach electronic files (such as X-rays in jpeg format, reports, and charts) to the claim.

If you have questions on submitting claims or accessing the portal, please contact DentaQuest Systems Operations at **1-800-417-7140** or via e-mail at [EDITeam@greatdentalplans.com](mailto:EDITeam@greatdentalplans.com)



## Provider portal

### Sign in

Sign in to the provider portal to access member and benefits information.

**Username \***

**Password \***

☐ Remember me

**Sign in**

[Forgot password ?](#)

### Ready to register?

Create an account on the provider portal where you can access information about plans, claims and more.

**Get started**

### Have questions or need help?

Explore our provider portal training materials.

[Sun Life training & education](#)

[DentaQuest training & education](#)

# Member Eligibility Verification Procedures and Services to Members

## The Keystone First Member Identification Card

The Keystone First Identification Card lists the following information:

- Member's Name
- Keystone First Identification Number with a 3-digit alpha prefix
- Member's Sex and Date of Birth
- State ID Number
- PCP'S Name and Phone Number
- Lab Name
- Co-pays

The ID Card includes a three-digit alpha prefix "to the Member ID number. This 3-digit alpha prefix merely indicates that this is a program under Keystone First. Please omit the alpha prefix when submitting all paper and electronic Claims, as well as when inquiring about Member eligibility and/or Claims status telephonically at **1-800-521-6007** and/or electronically in the Provider Center at [www.keystonefirstpa.com](http://www.keystonefirstpa.com).

To see the current Keystone First Identification Card template, please visit [www.keystonefirstpa.com](http://www.keystonefirstpa.com) → Members → Getting Care → ID Cards.

Keystone First Members are issued identification cards regularly.

Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if Members have other health insurance.

## Accessing Member Eligibility Information

Enrolled Network Providers may access Member eligibility information through:

- PROMISe Provider Portal at <https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx>
- Pennsylvania Eligibility Verification System (EVS): 1-800-766-5387, 24 hours/7 days a week
  - If a Member presents to a Provider's office and states he/she is a Medical Assistance recipient, but does not have a PA Electronic Benefits Transfer (EBT) ACCESS card, eligibility can still be obtained by using the Member's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.
  - The plastic "Pennsylvania EBT ACCESS Card" has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through EVS.

- The “Providers” section of DentaQuest’s Website at <https://www.dentaquest.com/en/providers/pennsylvania>
- DentaQuest’s Interactive Voice Response (IVR) system eligibility line at **1-833-343-7401**.
- Keystone First’s Member Service Department: **1-800-521-6860**.

The eligibility information received from any of the above sources will be the same information. However, by utilizing the IVR or the Website, you can get information 24 hours a day, 7 days a week.

Access to eligibility information via the Internet currently allows Providers to verify a Member’s eligibility as well as submit claims directly to DentaQuest. You can verify the Member’s eligibility on-line by entering:

- The Member’s date of birth
- The expected date of service
- The Member’s identification number or last name and first initial

To access the eligibility information via DentaQuest’s website, simply log on to the website at [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on “Providers”. From there choose your “State” and press “View state page”. You will then be able to log in using your password and ID. First time users will have to register by utilizing:

- The Business’s NPI or TIN
- State
- ZIP code

Once logged in, select “Eligibility look up” and enter the applicable information for each Member you are inquiring about. You can check on an unlimited number of patients and print off the summary of eligibility given by the system for your records. If you have questions, contact DentaQuest’s Customer Service Department at **1-855-343-7401**.

### **Directions for using the DentaQuest IVR system to verify eligibility**

- Call the DentaQuest IVR system at **1-855-343-7401**.
- After the greeting, stay on the line for English or press 1 for Spanish.
- When prompted, press or say 2 for Eligibility.
- When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number. If you do not have this information, press or say 2.
- When prompted, enter your User ID (previously referred to as Location ID) and the last four digits of your Tax ID number.
- If the Member’s ID has numbers and letters in it, press or say 1. When prompted, enter the Member ID. If the Member’s ID has only numbers, press or say 2. When prompted, enter the Member ID.

Upon system verification of the Member’s eligibility, you will be prompted to repeat the information given, verify the eligibility of another Member, get benefit information, get limited

claim history on this Member, or get fax confirmation of this call. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat steps above for each Member.

### **Access to eligibility information via Keystone First Member Services**

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or Website, please contact the Member Service Department at **1-800-521-6860**. They will be able to assist you in utilizing either system.

### **Transportation Benefits for Certain Members**

Members who need assistance with transportation should contact Keystone First's Member Service Department directly at **1-800-521-6860**.

Keystone First offers TTY service for hearing impaired Members at **1-800-684-5505**.

## **Covered Benefits**

### **Dental Benefits for Children under the age of 21**

Children under the age of 21 are eligible to receive all Medically Necessary dental services. Members do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network. Participating dentists can be found in our online Provider Directory at <https://www.dentaquest.com/en/find-a-dentist> or by calling DentaQuest Provider Services at **1-855-343-7401**. Dental services that are covered for children under the age of 21 include, but are not limited to the following, when Medically Necessary:

- IV or Non-IV conscious sedation; nitrous oxide analgesia\*\*
- Orthodontics (braces)\*and \*\*
- Initial and periodic oral examinations
- Periodontal services\*\*
- Dental prophylaxis
- Fluoride Treatments
- Silver Diamine Fluoride
- Endodontics (including Root Canals)\*\*
- Crowns\*\*
- Sealants
- Dentures\*\*
- Dental surgical procedures\*\*
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

*\*If braces were put on before the age of 21, Keystone First will continue to cover services until treatment for braces is complete, or age 23, whichever comes first, as long as the patient remains dental eligible for Medical Assistance and is still a Member of Keystone First. If the Member changes to another HealthChoices health plan, coverage will be provided by that HealthChoices health plan. If the Member loses dental eligibility, Keystone First will pay for services through the month that the Member is eligible. If a Member loses eligibility during the course of treatment, you may charge the Member for the remaining term of the treatment after Keystone First's payments cease ONLY IF you obtained a written, signed agreement from the Member prior to the onset of treatment. For case specific clarification, please contact the Keystone First Dental Director.*

*\*\* Authorization is required and medical necessity must be demonstrated.*

## **Dental Benefits for Adults age 21 and older**

**See benefit grid for procedure codes and eligibility criteria.**

Members do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network.

The following dental services are covered for adult Members 21 years of age and older:

- IV or Non-IV conscious sedation; \*
- Initial and periodic oral evaluations\*\*
- Periodontal services\* and \*\*
- Dental prophylaxis\*\*
- Endodontics (including Root Canals)\*and\*\*
- Crowns \* and \*\*
- Dentures\*and \*\*
- Dental surgical procedures\*
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

\*Authorization is required and medical necessity must be demonstrated.

\*\* Benefit Limit Exceptions may apply

Please refer to the Benefit Limit Exception Process section of this manual for complete details.

Please call DentaQuest Provider Services at **1-855-343-7401** with questions.

- These Benefit Limit Exceptions do not apply if the Member is under age 21, or if the Member is 21 years of age or older and resides in a long-term care facility, or intermediate care facility. These Members are exempt from the Benefit Limitation Exception process. However, all current Prior Authorization policies, parameters and criteria will remain in place. Determination of Member residency can be checked when verifying Member eligibility either by phone or through the Provider web-portal.

Adult Members may be eligible to receive the following services with an approved Benefit Limit Exception:

- Crowns and related services
- Root canals and other endodontic services
- Periodontal services
- Additional cleanings and exams
- Replacement Dentures

## **Medically Necessary Dental Services for Members under 21 years of age**

Such services require Prior Authorization and should be prior authorized (following the existing Prior Authorization process), whenever possible. Claims should be submitted with supporting documentation such as letters of medical necessity and documentation and/or images to substantiate the need for services.

## **Missed Appointments**

Enrolled Network Providers are not allowed to charge Members for missed appointments. Please refer to Medical Assistance Bulletin 99-10-14 in the Appendix of the Keystone First Provider Manual.

Keystone First offers the following suggestions to decrease the number of missed appointments:

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If a Member exceeds your office policy for missed appointments and you choose to discontinue seeing the Member, please inform them to contact Keystone First for a referral to a new dentist. Please refer to your Provider agreement with the Plan for your responsibilities in this regard.

## **Payment for Non-Covered Services**

Network Providers shall hold Members, Keystone First harmless for the payment of Non-Covered Services except as provided in this paragraph. Providers may bill a Member for Non-Covered Services, if the Provider obtains an agreement in writing from the Member prior to rendering services that indicates:

- The non-covered services to be provided
- Keystone First will not pay for or be liable for said services.
- The Member will be financially liable for such services.

Please refer to the Dental Benefit Grid for a complete list of covered benefits.

## Electronic Attachments

FastAttach™ - Keystone First accepts dental radiographs electronically via FastAttach™ for Prior Authorization requests and Claims submissions. Keystone First in conjunction with National Electronic Attachment, Inc. (NEA) allows Providers the opportunity to submit all Claims electronically, even those that require attachments. This program allows secure transmissions via the Internet lines for radiographs, periodontics charts, intraoral pictures, narratives and EOBs. For more information, or to sign up for FastAttach, go to <http://www.vynedental.com/fastattach/> or call Vyne Dental at 1-463-218-9150.

## Prior Authorization, Retrospective Review, and Documentation Requirements

### Procedures Requiring Prior Authorization

Keystone First has specific dental utilization criteria as well as a Prior Authorization and Retrospective Review process to manage the utilization of services. Consequently, Keystone First's operational focus is on assuring compliance with its dental utilization criteria.

Prior Authorizations will be honored for 180 days from the date they are issued. An approval does not guarantee payment. The Member must be eligible for services at the time the services are provided. The Provider should verify eligibility at the time of service.

In order to timely process Prior Authorization requests, appropriate supporting documentation and a fully populated and most recently approved version of the Claim form must be submitted (paper or electronic). Lack of supporting documentation may result in a Claim Denial. Paper forms may be mailed to:

**Prior Authorizations may be mailed to:**  
**Keystone First Health Plan – Prior Authorizations**  
**c/o DentaQuest-Authorization**  
**PO Box 2906**  
**Milwaukee, WI 53201-2906**

The basis for granting or denying approval shall be whether the item or service is Medically Necessary. Medically Necessary is defined as follows:

A service, item, procedure, or level of care compensable under the MA program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Retrospective, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member's family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the Member. All such determinations must be made by qualified and trained practitioners.

**Please refer to the Authorization Requirements and Benefits Grid in this manual for a detailed list of services requiring Authorization.**

Prior authorization for Hospital/Special Procedure Unit/Ambulatory Surgical Center admission for dental services is required by the Hospital/Special Procedure Unit/Ambulatory Surgical Center when utilizing a Plan participating facility. The dental services associated with the admission are governed by the authorization process. Authorization process should be followed listing all dental services that will be provided by the requesting dentist. The authorization request should designate the place of service to indicate that outpatient admission for dental services are planned to be performed. Please contact DentaQuest Provider Services **1-855-343-7401** with any questions.

## **Retrospective Review**

Services that would normally require a Prior Authorization, but are performed in an emergency situation, will be subject to a Retrospective Review. Claims for Retrospective Review should be submitted to the same address utilized when submitting requests for Prior Authorization, accompanied by any required supporting documentation. Any Claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

Some services require only retrospective review due to the documentation requirement or inability to determine medical necessity pre-operatively. An example of such would be the removal of a benign odontogenic cyst or tumor (D7450/D7451). This procedure requires a pathology report describing the lesion (for determination purposes) and should only be submitted for retro authorization. Please refer to the "Medicaid Clinical Criteria for Prior Authorization of Routine and Emergency Treatment" section for a listing of all procedures and the authorization requirements.

## **Benefit Limit Exception (BLE) Process (Adults age 21 and over)**

You can request a benefit limit exception (BLE) for services to be provided to adults 21 and over before the services start or after they are finished. You can ask for a BLE up to 60 days after the



dental services are finished. When submitting the BLE request, please limit your request to only those codes requiring BLE on the dated or undated claim form.

Keystone First will consider benefit limit exceptions to the dental benefits when one of the following criteria is met:

- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member; or
- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the Member; or
- Granting a specific exception is a cost-effective alternative for Keystone First; or
- Granting an exception is necessary in order to comply with federal law

Please note that clinical criteria must still be met for all approved benefit limit exceptions.

### **The BLE Request Process:**

You must send a completed Benefit Limit Exception Request Form AND an approved Claim form by mail or electronically.

**Mail:**

**Keystone First Health Plan – Prior Authorizations  
c/o DentaQuest – Authorizations  
PO Box 2906  
Milwaukee, WI 53201-2906**

Include the following information:

- Member's name, address, and ID number
- The dental service that is needed (code(s) and description)
- The reason the exception is needed
- Supporting diagnostic documentation required for the clinical authorization
- Supporting documentation from the Member's primary care or specialty care physician
- Dentist's name and phone number

If the dental BLE request identifies that the beneficiary has one of the conditions set forth below, as part of the dental BLE review process, the Plan will review the Member's Claim history to determine if the condition was previously identified on a Claim:

1. Diabetes
2. Coronary Artery Disease or risk factors for the disease.
3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin).
4. Intellectual Disability.
5. Current Pregnancy including post-partum period.

If the condition was previously identified on a Medical Claim, the Plan will not require supporting medical record documentation of the condition. If the condition was not previously identified on a Medical Claim, the Plan will notify the dental Provider that supporting medical record documentation is needed to review the BLE request. The supporting medical record documentation if the condition was not previously identified on a Medical Claim, and any additional information requested, must be submitted to the Plan within 15 days of the date of the Plan's request to the dental Provider. Upon receipt of the medical record documentation or additional information, the Plan will review the request for a dental BLE to confirm that one of the criteria for the granting of a BLE is met. The dental Provider and Member will be informed of the Plan's determination by written Notice of Decision. If the BLE request is approved and clinical criteria met, the services can be provided and paid for as long as the beneficiary maintains MA eligibility.

You can obtain a Benefit Limit Exception Request Form online at <https://www.dentaquest.com/en/providers/pennsylvania> or [www.keystonefirstpa.com](http://www.keystonefirstpa.com) or call DentaQuest Provider Services at **1-855-343-7401**.

## Dental Benefit Limit Exception (BLE) Request Form

This form must be attached to a completed ADA dental claim form. All fields must be legibly completed, and all required documentation provided.



Keystone First

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Please print.

| Member Information          | Provider Information      |
|-----------------------------|---------------------------|
| Last name:                  | Last name:                |
| First name:                 | First name:               |
| Date of birth (mm/dd/yyyy): | NPI number:               |
| Member ID number:           | Keystone First ID number: |
| Phone:                      | Phone:                    |

Benefit exception request type: ☐ Prospective ☐ Retrospective — Date of Service:

Benefit limit criteria to be reviewed (check all that apply or do not check any boxes if none apply):

- ☐ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the patient.
- ☐ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid serious deterioration of the health of the patient.
- ☐ Granting the exception is a cost-effective alternative for Keystone First.
- ☐ Granting the exception is necessary in order to comply with federal law.

Explain below why the patient meets the criteria for a benefit limit exception. The explanation should be in narrative form and include a comprehensive justification (attach additional pages if necessary).

Keystone First will notify the provider and recipient of its decision within 21 days of our receipt of the request or within 30 days after receipt of a retrospective request. BLE retrospective requests must be submitted no later than 60 days from the date Keystone First rejects the claim because the service is over the benefit limit. Retrospective exception requests made on or after the 61st day from the claim rejection date will be denied.

I attest that the information provided and statements made herein are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail to:  
Request for Benefit Limit Exception  
Keystone First Health Plan  
c/o DentaQuest — Authorizations  
P.O. Box 2906, Milwaukee, WI 53201-2906

August 2024  
KF\_243682000-1

Consistent with 55 Pa.Code 1101.31(f)(2)(viii), the Provider may not bill a Keystone First Member for payment for services rendered in excess of the dental benefit limits unless:

- The Provider informs the Member in writing before the service is rendered that the service requires a BLE and the Member is liable for the payment if the services associated with the request for a BLE are denied; and,
- The Provider requests an exception to the limit and the Plan denies the request.

NOTE: Please only include BLE eligible codes on requests for benefit limit exceptions. Refer to the Benefit Grid for BLE eligible codes.

## Claim Submission Procedures

Keystone First receives dental Claims in four possible formats. These formats include:

- Electronic claims via DentaQuest's website ([www.dentaquest.com](http://www.dentaquest.com))
- Electronic submission via clearinghouses
- HIPAA Compliant 837D or 837P file
- Paper claims via U.S. Postal Service or Fax 1-262-834-3589

### Electronic Claim Submission Utilizing DentaQuest's Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Providers" section of the Provider Web Portal. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the portal, simply log on to [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on "Providers". From there choose your State and press "View state page". You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's:

- NPI or TIN
- State
- Zip Code

If you are experiencing difficulty logging in or for questions regarding DentaQuest's website, contact DentaQuest's Provider Service Department at **1-855-343-7401**. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry ". The Provider Portal allows you to attach electronic files (such as X-rays in jpeg format, reports, and charts) to the claim.

### Electronic Claim Submission via Clearinghouse

Dentists may submit their Claims to Keystone First via a clearinghouse such as DentalXChange. You can contact your software vendor and make certain that they have Keystone First listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted Claims are forwarded to Keystone First.

Keystone First's Payer ID is "CX014." DentalXChange will ensure that by utilizing this unique payer ID, Claims will be submitted successfully to Keystone First.

For more information on DentalXChange, please refer to their website at [www.dentalxchange.com](http://www.dentalxchange.com).

### Electronic Claim Submission via HIPAA Compliant 837D or 837P File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Providers are

advised to email [EDITeam@greatdentalplans.com](mailto:EDITeam@greatdentalplans.com) to inquire about this option for electronic claim submission.

## **Paper Claim Submission**

Claims must be submitted on the most current ADA claim form or other form approved in advance by Keystone First. Please reference the ADA Website for the most current Claim form and completion instructions. Forms are available through the American Dental Association at:

**American Dental Association  
211 East Chicago Avenue  
Chicago, IL 60611  
1-800-947-4746**

The Member's name, identification number, and date of birth must be listed on all Claims submitted. If the Member's identification number is missing or miscoded on the Claim form, the Member cannot be identified. This could result in the Claim being returned to the submitting Provider office, causing a delay in payment.

All information must be legible and contained within the appropriate boxes to allow for authorizations and claims to be scanned into our system for processing.

Please include contracted fees or UCR charges on all authorization requests and claims for all services to ensure at least your contracted fees are reimbursed. Our plan must reimburse the lesser of contracted fees and billed charges. If a claim is processed at a lower rate than those contracted due to an error with submitted charges, the claim must be voided and resubmitted for accurate reimbursement.

The Provider and office location information must be clearly identified on the Claim. To ensure proper Claim processing, the Claim form must include the following:

- Member name
- Member DOB
- Member ID #
- Provider name
- Tax ID #
- NPI
- Payee location
- Treating location

The date of service must be provided on the Claim form for each service line submitted. Approved ADA dental codes as published in the Current Dental Terminology (CDT) book or as defined in this Manual must be used to define all services.

Providers must list all arches, quadrants, tooth numbers, and surfaces for dental codes that necessitate identification (i.e., fillings, scaling and root planning). Missing tooth and surface identification codes can result in the delay or denial of a Claim payment.

Affix the proper postage when mailing bulk documentation. Keystone First does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

**Keystone First Health Plan– Claims  
c/o DentaQuest – Claims  
P.O. Box 2906  
Milwaukee, WI 53201-2906**

Claims that have been previously paid, and need adjustment should be mailed to the following address:

**Keystone First - Corrected Claims  
c/o DentaQuest – Corrected Claims  
P.O. Box 2906 Milwaukee, WI 53201-2906**

ADA American Dental Association® Dental Claim Form

|   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
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| <b>HEADER INFORMATION</b>   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Request for Predetermination/Preauthorization<br><input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> EPSDT / Title XIX   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 2. Predetermination/Preauthorization Number   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>DENTAL BENEFIT PLAN INFORMATION</b>  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 3. Company/Plan Name, Address, City, State, Zip Code  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 3a. Payer ID  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 6. Date of Birth (MM/DD/CCYY)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 8. Policyholder/Subscriber ID (Assigned by Plan)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 9. Plan/Group Number  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 10. Patient's Relationship to Person named in #5<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 11a. Other Payer ID   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>POLICYHOLDER/SUBSCRIBER INFORMATION</b> (Assigned by Plan Named in #3)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 13. Date of Birth (MM/DD/CCYY)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 15. Policyholder/Subscriber ID (Assigned by Plan)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 16. Plan/Group Number   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 17. Employer Name   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>PATIENT INFORMATION</b>  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 18. Relationship to Policyholder/Subscriber in #12 Above<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 19. Reserved For Future Use   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 21. Date of Birth (MM/DD/CCYY)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 22. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 23. Patient ID/Account # (Assigned by Dentist)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>RECORD OF SERVICES PROVIDED</b>  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <table><tr><td>24. Procedure Date (MM/DD/CCYY)</td><td>25. Area of Oral Cavity</td><td>26. Tooth System</td><td>27. Tooth Number(s) or Letter(s)</td><td>28. Tooth Surface</td><td>29. Procedure Code</td><td>29a. Diag. Pointer</td><td>29b. City</td><td>30. Description</td><td>31. Fee</td></tr><tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>7</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>8</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>9</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |                         |                  |                                  |                   |                    |                    |           |                 |         | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. Diag. Pointer | 29b. City | 30. Description | 31. Fee | 1 |  |  |  |  |  |  |  |  |  | 2 |  |  |  |  |  |  |  |  |  | 3 |  |  |  |  |  |  |  |  |  | 4 |  |  |  |  |  |  |  |  |  | 5 |  |  |  |  |  |  |  |  |  | 6 |  |  |  |  |  |  |  |  |  | 7 |  |  |  |  |  |  |  |  |  | 8 |  |  |  |  |  |  |  |  |  | 9 |  |  |  |  |  |  |  |  |  | 10 |  |  |  |  |  |  |  |  |  |
| 24. Procedure Date (MM/DD/CCYY)   | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. Diag. Pointer | 29b. City | 30. Description | 31. Fee |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 1   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 2   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 3   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 4   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 5   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 6   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 7   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 8   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 9   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 10  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 33. Missing Teeth Information (Place an "X" on each missing tooth.)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 34. Diagnosis Code/Qualifier <input type="checkbox"/> (ICD-10 = AB)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 34a. Diagnosis Code(s) A _____ C _____  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 34b. Primary diagnosis in "A" B _____ D _____   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 31a. Other Fee(s)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 32. Total Fee   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 35. Remarks   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>AUTHORIZATIONS</b>   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 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 Patient/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 Subscriber Signature _____ Date _____   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>ANCILLARY CLAIM/TREATMENT INFORMATION</b> (all dates in MM/DD/CCYY format)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 39. Enclosures (Y or N)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 39a. Date Last SRP  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 40. Is Treatment for Orthodontics?<br><input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 41. Date Appliance Placed (MM/DD/CCYY)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 42. Months of Treatment   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 43. Replacement of Prosthesis<br><input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 44. Date of Prior Placement (MM/DD/CCYY)  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 45. Treatment Resulting from<br><input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 46. Date of Accident (MM/DD/CCYY)   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 47. Auto Accident State   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| <b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 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 Signed (Treating Dentist) _____ Date _____  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 53a. Locum Tenens Treating Dentist? <input type="checkbox"/>  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 54. NPI   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 55. License Number  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 56. Address, City, State, Zip Code  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 56a. Provider Specialty Code  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 48. Name, Address, City, State, Zip Code  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 49. NPI   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 50. License Number  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 51. SSN or TIN  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 52. Phone Number ( ) -  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 52a. Additional Provider ID   |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 57. Phone Number ( ) -  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |
| 58. Additional Provider ID  |                         |                  |                                  |                   |                    |                    |           |                 |         |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |  |  |



## ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (<https://www.ADA.org/en/publications/cdt/ada-dental-claim-form>).

### GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.
- F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

### COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35).

### DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

### PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf>

### PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

| Category / Description Code  | Code       |
|--|------------|
| Dentist<br>A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license. | 122300000X |
| General Practice   | 1223G0001X |
| Dental Specialty (see following list)  | Various    |
| Dental Public Health   | 1223D0001X |
| Endodontics  | 1223E0200X |
| Orthodontics   | 1223X0400X |
| Pediatric Dentistry  | 1223P0221X |
| Periodontics   | 1223P0300X |
| Prosthodontics   | 1223P0700X |
| Oral & Maxillofacial Pathology   | 1223P0106X |
| Oral & Maxillofacial Radiology   | 1223X0008X |
| Oral & Maxillofacial Surgery   | 1223S0112X |

Provider taxonomy codes listed above are a subset of the full code set that is posted at:  
<https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40>



## Timely Filing Limits

The Provider understands that failure to submit Claims (and any required documentation) within 180 days from the date of service may result in loss of reimbursement for services provided.

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB. Providers must submit a copy of the primary insurer's EOB. Keystone First determines whether a Claim has been filed timely by comparing the date of service to the receipt date applied to the Claim when the Claim is received. If the span between these two dates exceeds the time limitation, the Claim is considered to have not been filed timely.

## Coordination of Benefits (COB)

When Keystone First is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the Claim. For electronic Claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a Provider's contracted fee with the Plan, The Plan will consider the Claim paid in full and no further payment will be made on the Claim, the Member may not be billed for any outstanding balance.

## Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than Keystone First (TPL does not affect the Member's Medicaid eligibility. Members can report TPL to Keystone First Member Services at **1-800-521-6860**). COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. A Medicaid HMO, such as Keystone First, is always the **payer of last resort**. Claims must be submitted and processed by all other insurance carriers (the "Primary Insurers") before a Claim is submitted to the Plan. Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill Keystone First for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the Timely Filing Limits section above.

## Reimbursement for Members with Third Party Resources

### Medicare as a Third-Party Resource

For Medicare services that are covered by Keystone First, Keystone First will pay, up to the Keystone First contracted rate, the lesser of:

- The difference between the Keystone First contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by Medicare and Keystone First will not exceed the Keystone First contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, Keystone First will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate. Keystone First's referral and authorization requirements are applicable if the services are covered by Medicare.

## **Continuation of Care**

The Plan provides continuing coverage of care for members who are engaged in an ongoing course of treatment with a non-participating Practitioner or Provider to promote continuity of care. Please reach out to your Account Executive for non- orthodontic continuation of care.

The process for the continuation of orthodontic coverage can be found at [www.keystonefirstpa.com](http://www.keystonefirstpa.com) → Provider → Resources → Dental. Please reach out to your Keystone First Dental Account Executive for questions regarding this process.

## **Commercial Third-Party Resources**

For services that have been rendered by a Network Provider, Keystone First will pay, up to the Keystone First contracted rate, the lesser of:

- The difference between the Keystone First contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and Keystone First will not exceed Keystone First's contracted rate.

Health Care Providers must comply with all applicable Plan referral and Prior Authorization requirements.

## **Receipt and Audit of Claims**

In order to ensure timely, accurate remittances to each dentist, Keystone First performs an edit of all Claims upon receipt. This edit validates Member eligibility, procedure codes, and Provider identifying information. A Dental Reimbursement Analyst dedicated to Keystone First dental offices analyzes any Claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact DentaQuest's Provider Services Department at **1-855-343-7401** with any questions you may have regarding Claim submission or your remittance.

Each Enrolled Network Provider office receives an “Explanation of Benefit” report with their remittance. This report includes Member information and an allowable fee by date of service for each service rendered during the period.

## **Dentist Appeal Procedures**

Providers have the opportunity to request resolution of Disputes with DentaQuest or request a Formal Appeal on behalf of the Member through submission to the internal Plan department. Submissions must be in writing and should be accompanied by any necessary additional documentation within 60 days of the date of the explanation of benefit indicating Claim denial to the following address:

**Keystone First – Appeals**  
**c/o DentaQuest ATTN: Utilization Management/Provider Appeals**  
**P.O. Box 2906 Milwaukee, WI 53201-2906**

**Refer to the Provider Manual section on “Provider Dispute/Appeal Procedures” for complete and detailed information.**

## **Health Insurance Portability and Accountability Act (HIPAA) and Fraud, Waste and Abuse**

As a healthcare Provider, you are a “Covered Entity” under HIPAA, and you are therefore required to comply with the applicable provisions of HIPAA and its implementing regulations.

In regard to the Administrative Simplification Standards, you will note that the benefit tables included in this Dental Provider Manual reflect the most current coding standards recognized by the ADA. Effective the date of this manual, Keystone First will require Providers to submit all Claims with the proper CDT codes listed in this manual. In addition, all paper Claims must be submitted on a current approved ADA Claim form.

Note: Copies of Keystone First’s HIPAA policies are available upon request by contacting DentaQuest’s Provider Service Department at **1-855-343-7401**.

**For complete detailed information regarding Keystone First’s HIPAA policies refer to the “Compliance with the HIPAA Privacy Regulations” section in the Provider Manual.**

## **Fraud, Waste & Abuse**

Under the HealthChoices program, Keystone First receives state and federal funding for payment of services provided to our Members. In accepting Claims payment from Keystone First, Health Care Providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and

regulations may be considered Fraud, Waste or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to [www.pacode.com/secure/data/055/partIII/toc.html](http://www.pacode.com/secure/data/055/partIII/toc.html) for more information regarding Fraud, Waste or Abuse, including “Provider Prohibited Acts” that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

Keystone First is dedicated to eradicating Fraud, Waste and Abuse from its programs and cooperates in Fraud, Waste and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Unit of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the HHS Office of Inspector General, as well as the Bureau of Program Integrity of DHS. As part of Keystone First's responsibilities, the Payment Integrity department is responsible for identifying and recovering Claims overpayments. This department performs several operational activities to detect and prevent fraudulent, wasteful and/or abusive activities. We expect our dental partners to share this same commitment and conduct their businesses similarly, and report suspected noncompliance, Fraud, Waste or Abuse.

Examples of fraudulent/wasteful/abusive activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a Claim for Provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement

## Reporting and Preventing Fraud, Waste and Abuse

If you, or any entity with which you contract to provide health care services on behalf of Keystone First beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact Keystone First by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**;
- E-mailing to [FraudTip@keystonefirstpa.com](mailto:FraudTip@keystonefirstpa.com); or,
- Mailing a written statement to **Special Investigations Unit, Keystone First, P. O. Box 7317, London, KY 40742**

Below are examples of information that will assist Keystone First with an investigation:

- Contact Information (e.g., name of individual making the allegation, address, telephone number);

- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent, Wasteful or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse to the Pennsylvania Department of Human Services through one of the following methods:

|         |   |
|---------|---|
| Phone:  | <b>1-844-DHS-TIPS or 1-844-347-8477</b>   |
| Online: | <a href="https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx">https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx</a> |
| Fax:    | <b>1-717-214-1200, Attn: OMAP Provider</b>  |
| Mail:   | <b>Department of Human Services<br/>Office of Administration<br/>Bureau of Program Integrity<br/>P.O. Box 2675<br/>Harrisburg, PA 17105-2675</b>  |

## Credentialing

Any Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is interested in participation with Keystone First is invited to apply by submitting a credentialing application form for review by the Keystone First Credentialing Committee.

Providers who seek participation in the Keystone First Provider Network must be credentialed prior to participation in the network.

Keystone First maintains and adheres to all applicable State and federal laws and regulations, DHS requirements, and accreditation requirements governing credentialing and re-credentialing functions. All applications reviewed by Keystone First Health Plan must satisfy these requirements, as they apply to dental services, in order to be admitted to the Keystone First Provider Network.

The process to be credentialed as a Keystone First Network Provider is fast and easy. Keystone First has entered into an agreement with the Council for Affordable Quality Healthcare (CAQH) to offer our Providers the Universal Provider Data repository that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, you provide credentialing information to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. Keystone First's goal is to have all its Network Providers enrolled with CAQH. There is no charge to Providers to submit applications and

participate in CAQH. Please access the credentialing page on <https://www.keystonefirstpa.com/provider/credentialing/index.aspx> and follow the instructions to begin the application process for participation in Keystone First's Provider Network.

**Refer to the Keystone First Provider Manual section on Credentialing and Re-credentialing Requirements for complete and detailed information.**

## Medical Recordkeeping

Keystone First adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Likewise, Keystone First expects that every office will provide quality dental services in a cost-effective manner in keeping with the standards of care in the community and dental profession nationwide.

Keystone First's expectation is that every Network Provider will submit Claims for services in an accurate and ethical fashion reflecting the appropriate level and scope of services performed, and that Network Providers are compliant with these requirements.

Keystone First will periodically conduct random chart audits in order to determine Network Providers' compliance with these conditions and expectation, as a component of Keystone First's Quality Management Program. Network Providers are expected to supply, upon request, complete copies of Member dental records. The records are reviewed by Keystone First's Dental Director, or his/her designee, such as a Registered Dental Hygienist, to determine the rate of compliance with medical recordkeeping requirements as well as the accuracy of the dental Claims submitted for payment. All dental services performed must be recorded in the patient record, which must be made available as required by your Participating Provider Agreement.

The first part of the audit will consist of the charts being reviewed for compliance with the stated record keeping requirements, utilizing a standardized audit tool. The charts are reviewed and a composite score is determined. Offices with scores above 90% are considered as passing the audit but a letter is sent to them so that they are aware of the areas that need improvement; offices that receive a score of 95% or greater are exempt from the audit the following year. Offices with scores less than 90% will have a corrective action letter sent and are re-reviewed for compliance within the next 120 days. Offices that do not cooperate with improving their scores are subject to disciplinary action in accordance with Keystone First's Provider Sanctioning Policy as outlined in the Provider Manual.

The second portion of the audit consists of a billing reconciliation whereby the patient treatment notes and diagnostics are compared to the actual Claims submitted for payment by each dental office. The records are analyzed to determine if the patient record documents the performance of all the dental services that have been submitted for payment. Payment of services not

documented/diagnostics not present are recouped, and the records may be subject to additional review and follow-up by Keystone First's Special Investigations Unit.

Results of both parts of the audit are entered into a tracking data base at Keystone First and then reported back to each office in a summary of finding format.

Keystone First recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS for primary teeth or 51 through 82 for permanent teeth. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 10 years after the end of the termination of the State of client contract.

**Refer to the Quality Management, Credentialing and Utilization Management Section of the Provider Manual for more information.**

## **Important Notice for Submitting Paper Authorizations and Claims**

All Claims need to be submitted on a current approved ADA form.

All other forms will not be accepted and will result in a rejection of the Claim or Authorization request. Additionally, when making a correction to a previously submitted and paid Claim, please send it clearly marked "Corrected Claims" on a current version of the ADA form to:

**Keystone First – Corrected Claims  
c/o DentaQuest – Corrected Claims  
PO Box 2906  
Milwaukee, WI 53201-2906**

Please contact DentaQuest Provider Services at **1-855-343-7401** if you have questions. If you are in need of the current forms, please visit the ADA Website at [www.ada.org](http://www.ada.org) for ordering information.

## **Corrected Claims**

Providers may make corrections to incorrectly submitted claims during the timely filing period. For a claim to be treated as a corrected claim, it must be submitted within the timely filing, or within 60 days from the last adverse action/denial.

- The corrected claim must clearly state the word "Corrected" in box 35 along with the claim number of the claim you are correcting.

- The corrected claim must contain clear and accurate corrections to the erroneous information. (A resubmission of identical claims data is not considered a corrected claim. The corrected claim must include additional or different information.)
- If a claim is resubmitted for correction more than once, each must be submitted within 60 days of the adverse action on the previous submission.

DentaQuest will research the resubmission and adjudicate the corrected claim according to the resubmitted information. Once adjudicated, the corrected claim will appear on the Provider's Explanation of Benefits (EOB) with a corresponding Processing Policy outlining the reason for denial.

## **Corrected Claim Submission Guidelines**

### **When should I submit a Claim?**

A corrected Claim should ONLY be submitted when an original Claim or service was PAID based upon incorrect information.

A Corrected Claim must be submitted in order for the original paid Claim to be adjusted with the correct information. As part of this process, the original Claim will be recouped and a new Claim processed in its place with any necessary changes.

If a claim or service originally denied due to incorrect or missing information, or was not previously processed for payment, DO NOT submit a corrected claim. Denied services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing.

### **What scenarios are subject to the Corrected Claim Process?**

A corrected Claim should only be submitted if the original service(s) PAID based on incorrect information. Some examples of correction(s) that need to be made to a prior PAID Claim are:

- Incorrect NPI or location, Payee Tax ID, Incorrect Member, or Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

### **How do I submit a Corrected Claim?**

The Plan receives dental Corrected Claims in three possible formats. These formats include:

- Electronic Corrected Claims via the Plan's claims website  
<https://www.dentaquest.com/en/providers/pennsylvania>
- Electronic submission via clearinghouses.
- Paper Corrected Claims.



## Electronic Claim Submission Utilizing DentaQuest's Website

Enrolled Network Providers may make corrections on original claims directly to the Plan by utilizing the "Provider" section of our website. Corrections will be allowed one time on an original dental claim when utilizing the website.

- If additional corrections are required after a corrected claim is submitted, the provider will need to submit the correction based on the most recently submitted corrected claim, not the original claim.
- The website will provide a message stating the claim can no longer be corrected if the provider attempts to correct the original claim more than once.

To submit Claims via the Website, log onto

<https://www.dentaquest.com/en/providers/pennsylvania>

If you have questions on submitting Claims or accessing the Website, please contact DentaQuest Provider Services at **1-855-343-7401** or DentaQuest Systems Operations Department at: **1-800-417-7140**.

## Electronic Claim Submission via Clearinghouse

Corrected claims via Clearinghouse File will be accepted when a specific set of criteria is met to ensure the original claim can be identified. In order for a submission to be considered a corrected claim, it must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF\*F8 element.
- Original claim in a paid status
- Original claim does not have previously resubmitted services, or a corrected claim already processed
- Original claim does not have associated service adjustments or refunds

## Paper Claim Submissions

Corrected Claims must be submitted on the most current ADA claim form or other forms approved in advance by the Plan to Corrected Claims PO Box for proper processing and include the following:

- The ADA form must be clearly noted "Corrected Claim" across the top of the form
- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.
  - *NOTE: If all information does not fit in Box 35, please attach an outline of corrections to the Claim form.*
- Attach supporting documentation and send documentation in the same package with the Corrected paper claim form.
- Submit to:  
**Keystone First – Corrected Claims**  
**c/o DentaQuest – Corrected Claims**

**PO Box 2906  
Milwaukee, WI 53201-2906**

### **What scenarios ARE NOT subject to the corrected Claim process?**

A corrected Claim should not be submitted if the original Claim or service(s) which are the subject of the correction were denied or were not previously submitted.

Some examples of items that are not considered Claim corrections are:

- Any request to “Reprocess” a Claim with no changes being made. This includes requests to reprocess a Claim based on an expired existing authorization.
- Any changes being made to a Claim or service that denied for any reason such as missing tooth, quad, or arch information, incorrect code, age-inappropriate code being billed, missing primary EOB, incorrect Provider, etc.
- Any request to recoup a denied service. You DO NOT need to recoup a denied service as denied services are invalid and have no impact on Member service/tooth history or accumulators.

If you received a Claim or service denial due to missing/incomplete/incorrect information or you have since obtained authorization for services, please submit a new Claim with the updated information per your normal Claim submission channels. Timely filing limitations apply when a denied Claim is being resubmitted with additional information for processing.

If you received a Claim or service denial which you do not agree with, including denials for no authorization, please refer to your Provider Manual for the proper method for submitting an appeal or reprocess request.

### **What happens if I submit a Corrected Claim to the wrong PO Box or don't include the required documentation?**

Following the above guidelines will allow you to receive payment as expediently as possible. Failure to follow these guidelines may result in unnecessary delay and/or rejection of your submission.

Please contact DentaQuest's Provider Services at **1-855-343-7401** if you have questions. If you are in need of the current forms, please visit the ADA Website at [www.ada.org](http://www.ada.org) for ordering information.

Claims / Authorizations with missing or invalid information may be rejected and returned to the Provider.

Prior Authorization requests must include the following:

- Member name
- Member DOB
- Member ID #
- Provider name

- Tax ID #
- NPI
- Payee location
- Treating location
- Date of service (DOS) for each service line submitted (claims only)

Prior Authorizations with missing or invalid information may be rejected and returned to the Provider.

All radiographs including digital prints, duplicates, and originals will not be returned to the dentist unless a self- addressed stamped envelope is included with the Claim/ Authorization submission.

Prior Authorizations should be mailed to the following address:

**Keystone First- Prior Authorizations**  
**c/o DentaQuest - Authorizations**  
**P.O. Box 2906**  
**Milwaukee, WI 53201-2906**

# Health Guidelines – Ages 0-20 Years

## Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special healthcare needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Refer to the guideline below from the American Academy of Pediatric Dentistry for supporting information and references.

**PEDIATRIC DENTAL PERIODICITY SCHEDULE**  
**RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE**  
 Commonwealth of Pennsylvania, Department of Human Services, Office of Medical Assistance Programs  
 (Adapted from the American Academy of Pediatric Dentistry)  
 Effective October 3, 2023

| Periodicity Recommendations   |                     |                           |  |  |   |
|---|---------------------|---------------------------|--|--|---|
| Age   | Infancy 6-12 Months | Late infancy 12-24 Months | Preschool 2-6 Years  | School Aged 6-12 Years   | Adolescence 12-20 Years   |
| <b>Clinical Oral Examination:</b> ** First examination at the eruption of the first tooth and no later than 12 months of age. Repeat every 6 months or as indicated by the child's risk status/ susceptibility to disease. Includes assessment of pathology and injury. | X                   | X                         | X  | X  | X   |
| <b>Prophylaxis/ Topical Fluoride Treatment</b><br>Especially for children at high risk for caries and periodontal disease.  | X                   | X                         | X  | X  | X   |
| <b>Radiographic Assessment</b><br>Timing, selection, and frequency determined by child's history, clinical findings and susceptibility to oral disease.   | X                   | X                         | X  | X  | X   |
| <b>Assessment for Pit and Fissure Sealants</b><br>For caries-susceptible primary molars, permanent molars, premolars and anterior teeth with deep pits and fissures, place as soon as possible after the eruption.  |                     |                           | X<br>First permanent molars as soon as possible after eruption | X<br>Premolars, first and second permanent molars as soon as possible after eruption | X<br>Second permanent molars and premolars as soon as possible after eruption |
| <b>Caries Risk Assessment</b><br>Must be repeated regularly and frequently to maximize effectiveness.   | X                   | X                         | X  | X  | X   |
| <b>Tobacco Use and Cessation Counseling</b><br>Counseling for tobacco, vaping, and substance misuse   |                     |                           |  | X  | X   |

# Keystone First Medicaid Clinical Criteria for Authorization of Routine and Emergency Treatment

A number of procedures require prior authorization before initiating treatment. When prior authorizing these procedures, please note the documentation requirements when sending in the information to Keystone First Dental. The criteria used by Keystone First Dental Reviewers for determination are listed below. Treatment may be provided if a procedure needs to be initiated under an emergency condition to relieve a patient's pain and suffering. However, to receive reimbursement for the treatment, Keystone First Dental will require the same documentation to be provided (with the Claim for payment) and the same criteria in order to receive payment for the treatment.

**Adults age 21 and older have benefit limitations. Please refer to Benefit Limit Exception Process section for information on the benefit limit exception criteria or contact DentaQuest Provider Services at 1-855-343-7401 for more information.**

## Dental Services Requiring Prior Authorization or Retrospective Review

Some of these services may also be subject to dental benefit limitations. Refer to the Benefit Grid for BLE eligible codes.

| Code  | Description  |
|-------|--|
| D2710 | Crown - resin  |
| D2721 | Crown - resin cast base metal  |
| D2740 | Crown - porcelain/ceramic  |
| D2751 | Crown - porcelain fused to metal   |
| D2752 | Crown - porcelain fused to noble metal   |
| D2791 | Crown - full cast base metal   |
| D2952 | Cast post and core in addition to crown  |
| D2954 | Prefabricated post and core in addition to crown                               |
| D3310 | Endodontic therapy, anterior (excluding final restoration)                     |
| D3320 | Endodontic therapy, premolar (excluding final restoration)                     |
| D3330 | Endodontic therapy, molar (excluding final restoration)                        |
| D3471 | Surgical repair of root resorption - anterior                                  |
| D3472 | Surgical repair of root resorption - premolar                                  |
| D3473 | Surgical repair of root resorption - molar                                     |
| D3501 | Surgical exposure of root surface without apico or repair of root resorption - |
| D3502 | Surgical exposure of root surface without apico or repair of root resorption - |
| D3503 | Surgical exposure of root surface without apico or repair of root resorption - |
| D3921 | Decoronation or submergence of an erupted tooth                                |
| D4210 | Gingivectomy or gingivoplasty - 4 or more contiguous teeth/quad                |
| D4341 | Perio scaling & root planing - 4 or more teeth/quad                            |
| D4342 | Perio scaling and root planing 1-3 teeth/quad                                  |
| D5110 | Complete denture - maxillary   |

|          |  |
|----------|--|
| D5120    | Complete denture - mandibular  |
| D5130    | Immediate denture - maxillary  |
| D5140    | Immediate denture - mandibular   |
| D5211    | Maxillary partial denture – resin base   |
| D5212    | Mandibular partial denture – resin base  |
| D5213    | Maxillary partial denture - cast metal framework                               |
| D5214    | Mandibular partial denture – cast metal framework                              |
| D7220    | Removal of impacted tooth – soft tissue  |
| D7230    | Removal of impacted tooth - partially bony                                     |
| D7240    | Removal of impacted tooth - completely bony                                    |
| D7250    | Surgical removal of residual roots   |
| D7260    | Oroantral fistula closure  |
| D7270    | Tooth reimplantation and/or stabilization                                      |
| D7280    | Exposure of an unerupted tooth   |
| D7283    | Placement of device to facilitate eruption                                     |
| D7320    | Alveoloplasty without extractions  |
| D7450*   | Removal of benign odontogenic cyst or tumor - diameter up to 1.25 cm           |
| D7451*   | Removal of benign odontogenic cyst or tumor - diameter greater than 1.25 cm    |
| D7460*   | Removal of benign nonodontogenic cyst or tumor - diameter up to 1.25 cm        |
| D7461*   | Removal of benign nonodontogenic cyst or tumor - diameter greater than 1.25 cm |
| D7510    | Incision and drainage of abscess-intraoral soft tissue                         |
| D7511    | Incision and drainage of abscess-intraoral soft tissue - complicated           |
| D7520    | Incision and drainage of abscess-extraoral soft tissue                         |
| D7521    | Incision and drainage of abscess-extraoral soft tissue - complicated           |
| D7871    | Non-arthroscopic lysis and lavage  |
| D7962    | Lingual frenectomy   |
| D7970    | Excision of hyperplastic tissue  |
| D7999    | Unspecified oral surgery procedure   |
| D8080*** | Comprehensive orthodontic treatment of the adolescent dentition                |
| D8210    | Removable appliance therapy  |
| D8220    | Fixed appliance therapy  |
| D8670    | Periodic orthodontic treatment visit   |
| D8680    | Orthodontic retention  |
| D8703    | Replacement lost/broken retainer maxillary                                     |
| D8704    | Replacement lost/broken retainer mandibular                                    |
| D9222    | Deep sedation/general anesthesia – first 15 minutes                            |
| D9223**  | Deep sedation/general anesthesia – each subsequent 15 minute increment         |
| D9239    | Intravenous moderate sedation/analgesia – first 15 minutes                     |
| D9243**  | Intravenous moderate sedation/analgesia – each subsequent 15 minute            |
| D9248    | Non-intravenous conscious sedation   |
| D9930    | Treatment of complications (post surgical)                                     |
| D9947    | Custom sleep apnea device fabrication and placement                            |

\*Please submit pathology report with claim and please utilize retrospective authorization process.

\*\*Please submit completed anesthesia log with claim for retrospective authorizations.

\*\*\* Prior Authorization required, retro authorization not permitted.

## **Crowns (D2710, D2721, D2740, D2751, D2752, D2791)**

Required documentation – Periapical radiograph showing the root and crown of the natural tooth.

Non- abutment teeth: Current periapical x-rays of the tooth/teeth to be crowned. Abutment teeth:

Current periapical x-rays of the tooth/teeth and panoramic or full mouth are needed for evaluation.

All criteria below must be met:

- Tooth to be crowned must have an opposing tooth in occlusion or be an abutment tooth for a partial denture
- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  1. The tooth is filled within two millimeters of the radiographic apex
  2. The root canal is not filled beyond the radiographic apex
  3. The root canal filling is adequately condensed and/or filled
  4. Healthy periapical tissue (healing PARL or no PARL)
- And 1 of the criteria below must be met:
  1. Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge
  2. Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
  3. Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps

## **Posts and cores (D2952, D2954)**

Required documentation – Periapical radiograph showing the root and crown of the natural tooth.

All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  1. The tooth is filled within two millimeters of the radiographic apex
  2. The root canal is not filled beyond the radiographic apex
  3. The root canal filling is adequately condensed and/or filled
  4. Healthy periapical tissue (healing PARL or no PARL)

## **Root canal therapy (D3310, D3320, D3330)**

Required documentation – Periapical radiograph showing the crown and entire root of the tooth.

All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or a furcation involvement
- Closed apex
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray
  - Evidence of apical pathology/fistula
  - Narrative describing symptoms of irreversible pulpitis

### **Surgical Repair of Root Resorption (D3471, D3472, D3473)**

Required documentation – pre- operative x-rays of adjacent and opposing teeth

All criteria below must be met:

- Minimum 50% bone support
- History of RCT
- Apical pathology
- The patient must be free of active / advanced periodontal disease
- No periodontal furcation lesion and / or furcation involvement

### **Surgical exposure of root surface without apicoectomy (D3501, D3502, D3503)**

Required documentation – pre-operative radiographs of adjacent and opposing teeth

All criteria below must be met:

- History of pain or discomfort which could not be diagnosed from clinical evaluation or radiographic images
- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No periodontal furcation lesion and / or furcation involvement
  - Tooth must be crucial to arch/occlusion
- Benefit limit exception necessary (if applicable)

### **Decoronation or submergence of an erupted tooth (D3921)**

Required documentation – post operative radiographs (excluding bitewings), narrative of medical necessity inclusive of restorative treatment plan for arch(es)

All criteria must be met:

- Clinically acceptable root canal therapy
- The patient must be free of active / advanced periodontal disease



- No periodontal furcation lesion and / or furcation involvement

## **Gingivectomy or Gingivoplasty (D4210)**

Required documentation – pre-operative radiographs, periodontal charting, narrative of medical necessity, photo (optional)

1 of the criteria below must be met:

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the periodontal charting

## **Periodontal scaling and root planning (D4341 and D4342)**

Required documentation – periodontal charting and current diagnostic radiographs of the quadrant(s) to be treated.

All criteria below must be met:

- Pocket depths of 5 mm or greater on 4 or more teeth (for D4341) or on 1-3 teeth (for D4342) indicated on the periodontal charting and:
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Involved teeth must not have poor prognosis, require or be planned for replacement by denture and/or extraction

## **Complete dentures (D5110, D5120)**

Required documentation –Complete series of radiograph images (D0120) or panoramic radiographic image (D0330)

Criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable.
- If a current denture exists that was not reimbursed by the Plan, it must be non-serviceable for reasons other than tooth loss.

## **Immediate dentures (D5130, D5140)**

Required documentation – Complete series of radiograph images (D0120) or panoramic radiographic image (D0330)

All criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable

## **Removable partial dentures (D5211, D5212, D5213, D5214)**

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

All criteria below must be met:

- Remaining teeth have greater than 50% bone support and are restorable. If a current denture exists that was not reimbursed by the plan, it must be non-serviceable for reasons other than tooth loss.

In addition, 1 of the criteria below must be met:

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)

## **Impacted teeth (D7220, D7230, D7240)**

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

- Documentation describes pain, swelling, etc. around tooth (symptomatic)
- X-ray matches type of impaction code described
- Documentation of clinical evidence indication impaction, although asymptomatic may not be disease free

## **Surgical removal of residual tooth roots (D7250)**

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

All criteria below must be met:

- Tooth root is completely covered by bony tissue on x-ray
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic)

## **Oroantral fistula closure (D7260)**

Documentation required – Narrative of medical necessity

All criteria below must be met:

- Narrative must substantiate need due to extraction, oral infection, or sinus infection

## **Tooth reimplantation and / or stabilization (D7270)**

Documentation required – Narrative of medical necessity

All criteria below must be met:

- Documentation describes an accident such as playground fall or bicycle injury
- Documentation describes which teeth were avulsed or loosened and treatment necessary to stabilize them through reimplantation and/or stabilization

### **Exposure of an unerupted tooth (D7280)**

Documentation required – Pre-operative radiographs and narrative of medical necessity.

Criteria below must be met:

- Documentation supports impacted/unerupted tooth
- Tooth not planned for extraction

### **Placement of device to facilitate eruption (D7283)**

Documentation required – Narrative of medical necessity

All criteria below must be met:

- Documentation describes condition preventing normal eruption.
- Documentation describes device type and need for placement of device.

### **Alveoloplasty without extractions (D7320)**

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

All criteria below must be met:

- Documentation supports medical necessity for fabrication of a prosthesis

### **Removal of benign odontogenic / non-odontogenic cyst or tumor (D7450, D7451, D7460, D7461)**

Documentation required – Copy of pathology report

Criteria below must be met:

- Copy of pathology report indicating lesion / tumor

### **Incision and drain abscess (D7510, D7511, D7520, D7521)**

Documentation required – Narrative of medical necessity, radiographs or photos

All criteria below must be met:

For Intraoral incision:

- Documentation describes non-vital tooth or foreign body

For Extraoral incision:

- Documentation describes periapical or periodontal abscess

## **Non-arthroscopic lysis and lavage (D7871)**

Documentation required – Narrative of medical necessity, radiographs or photos

All criteria below must be met:

- Documentation describes nature and etiology of TMJ dysfunction
- Documentation describes treatment to manage the TMJ condition

## **Lingual Frenectomy (D7962)**

Documentation required – Narrative of medical necessity, x-rays, or photos

Criteria below must be met:

- Documentation describes tongue tied, diastema or tissue pull condition

## **Excision of hyperplastic tissue (D7970)**

Documentation required – Pre-operative radiographs, narrative of medical necessity, photos

All criteria below must be met:

- Documentation describes medical necessity due to ill-fitting denture

## **Unspecified oral surgery procedure (D7999)**

Documentation required – Narrative of medical necessity and description of procedure; name, license number, and Tax ID of Assistant surgeon required if D7999 is submitted for this purpose

All criteria below must be met:

- Documentation describes medical necessity need for Asst surgeon

## **General anesthesia / IV sedation (Dental Office Setting) - (D9222, D9223, D9239, D9243)**

Documentation required – Narrative of Medical Necessity, Anesthesia Log (retrospective review)

1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant

- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)

Documentation of existing clinical condition or circumstance making the use of general anesthesia/IV sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

Note that D9222/D9223/D9239/D9243 may be prior authorized as described above and D9223/D9243 may be retro authorized (with anesthesia log required).

## **Non-intravenous conscious sedation (Dental Office Setting) (D9248)**

Documentation required – Narrative of medical necessity

1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)

Documentation of existing clinical condition or circumstance making the use of non-intravenous conscious sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

## **Treatment of complications (post-surgical) – (D9930)**

Documentation required – Narrative of Medical Necessity

- Documentation describes post-surgical condition supporting Medical Necessity for procedure

## **Custom sleep apnea appliance fabrication and placement - (D9947)**

Documentation requirements:

- Lab Rx for custom appliance with member's name
- Letter of Medical Necessity from physician containing clinical criteria listed below

Clinical Criteria:

LOMN from physician describing that all of the following took place within the past 12 months of request for authorization:

- diagnosis of obstructive sleep apnea (G47.33)  
and
- face-to-face evaluation of member by physician  
and
- patient attended a facility based polysomnogram or approved home sleep test  
and
- sleep study results demonstrated API Apnea-hypopnea Index or RDI Respiratory Disturbance Index of 5 or more events per hour
  - if between 5 and 14 events per hour, patient must have one or more of the following symptoms or findings:
    - Hypertension (HTN)
    - History of stroke
    - Ischemic heart disease
    - Excessive daytime sleepiness
    - Impaired cognition
    - Mood disorder
    - Insomnia
    - Other clinical information (add comment)
- positive airway pressure history of contraindication – skin irritation, claustrophobia or noise generated by the machine
- positive airway pressure history of non-tolerance  
or
- Other clinical information (add comment)

## **Orthodontics**

### **Fixed or removable appliance therapy (D8210, D8220)**

Documentation required – Panoramic and/or cephalometric radiographs, narrative of Medical Necessity

All criteria below must be met:

- Documentation describes thumb sucking or tongue thrusting habit.

- Documentation of existing clinical condition or circumstance making the use of minor orthodontic treatment to control harmful habits a reasonable inclusion as a medically necessary part of the therapeutic regimen.

### **Comprehensive orthodontic services (D8080)**

Documentation requirements – Panoramic and /or cephalometric radiographs, 5-7 diagnostic quality photos, completed Salzmann Criteria Index Form.

All the criteria below must be met:

- Documentation supports Salzmann Criteria Index Form score of 25 points or greater when the case is evaluated using the Salzmann Index.
- A full permanent dentition is present, with no primary teeth present (except for primary teeth where there is no permanent succedaneous tooth)
- Dentition must be free of carious lesions.
- Patient must demonstrate the ability to maintain adequate oral hygiene.

### **Periodic orthodontic treatment visit (D8670)**

Documentation requirements – Completed AmeriHealth Caritas PA or Keystone First Orthodontic Continuation of Care form. Photos of current orthodontic status.

The criteria below must be met:

Ongoing active comprehensive orthodontic treatment

### **Orthodontic Retention (D8680)**

Documentation required – diagnostic quality photos

All criteria below must be met:

- Photos demonstrate malocclusion was corrected through comprehensive orthodontic treatment.

### **Replacement of lost or broken retainer – Maxillary/Mandibular (D8703/D8704)**

Documentation requirements – narrative/evidence of previous lost/broken D8680

# Dental Benefit Grid

## Procedure Codes And Eligibility Criteria

Procedure Codes not listed in this benefit grid are not considered benefits

| A= Arch<br>N = No reporting requirements |  | T = Tooth reporting requirement<br>Q = Quadrant reporting requirement |         |         |          | ***BLE only required for replacement denture |         |         |           |               |   |
|--|--|---|---------|---------|----------|--|---------|---------|-----------|---------------|---|
| Code                                     | Code Description   | Authorization Requirements  |         |         |          | Benefit Details                              |         |         |           |               |   |
|  |  | Auth Req d  | Age Min | Age Max | Req Docs | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type   |
| D0120                                    | Periodic oral Evaluation-established patient   | No  |         |         |          | N  | 0       | 999     | 1         | 180           | Days Per patient per Provider (1 of any D0120, D0145, D0150). Additional requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D0140                                    | Limited oral evaluation-problem focused  | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Days Per patient (audio or video teledentistry allowed...pt initiated by call in to office for POS 02,10)   |
| D0145                                    | Oral evaluation for a patient under three years of age and counseling with primary caregiver | No  |         |         |          | N  | 0       | 2       | 1         | 180           | Days 1 per patient per provider/provider groupd (1 of any D0120, D0145, D0150)  |
| D0150                                    | Comprehensive oral evaluation- new or established patient                                    | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Lifetime Per patient per dentist/dental group   |



| A= Arch<br>N = No reporting requirements |   | T = Tooth reporting requirement<br>Q = Quadrant reporting requirement |         |         |          | ***BLE only required for replacement denture |         |         |           |               |   |
|--|---|---|---------|---------|----------|--|---------|---------|-----------|---------------|---|
|  |   | Authorization Requirements  |         |         |          | Benefit Details                              |         |         |           |               |   |
| Code                                     | Code Description  | Auth Req d  | Age Min | Age Max | Req Docs | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type   |
| D0150                                    | Comprehensive oral evaluation- new or established patient                                   | No  |         |         |          | N  | 0       | 999     | 1         | 180           | Days per patient per dentist/dental group (any D0120, D0145, D0150).                            |
|  |   |   |         |         |          |  |         |         |           |               |   |
| D0190                                    | Screening of a patient  | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Year per patient. Not allowed on same DOS as D0120, D0140, D0145, D0150. Only allowed at POS 27 |
| D0191                                    | Assessment of a patient   | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Year per patient. Not allowed on same DOS as D0120, D0140, D0145, D0150. Only allowed at POS 27 |
| D0210                                    | Intraoral – comprehensive series of radiographic images                                     | No  |         |         |          | N  | 0       | 999     | 1         | 5             | Year per patient  |
| D0220                                    | Intraoral- periapical first radiographic image  | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Day per patient   |
| D0230                                    | Intraoral – periapical each additional radiographic image                                   | No  |         |         |          | N  | 0       | 999     | 10        | 1             | Day per patient   |
| D0240                                    | Intraoral -occlusal radiohgraphic image   | No  |         |         |          | N  | 0       | 999     | 2         | 1             | Day per patient   |
| D0250                                    | Extra oral 2-D radiographic image created using a stationary radiation source, and detector | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Day per patient   |
| D0251                                    | Extra oral posterior dental radiographic image  | No  |         |         |          | N  | 0       | 999     | 10        | 1             | Day per patient   |
| D0270                                    | Bitewing - single radiographic image  | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Day per patient   |

| A= Arch<br>N = No reporting requirements |  | T = Tooth reporting requirement<br>Q = Quadrant reporting requirement |         |         |          | ***BLE only required for replacement denture |         |         |           |               |   |
|--|--|---|---------|---------|----------|--|---------|---------|-----------|---------------|---|
|  |  | Authorization Requirements  |         |         |          | Benefit Details                              |         |         |           |               |   |
| Code                                     | Code Description   | Auth Req d  | Age Min | Age Max | Req Docs | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type   |
| D0272                                    | Bitewings -two radiographic images   | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Day per patient   |
| D0273                                    | Bitewings - three radiographic images  | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Day per patient   |
| D0274                                    | Bitewings – four radiographic images   | No  |         |         |          | N  | 0       | 999     | 1         | 1             | Day per patient   |
| D0330                                    | Panoramic radiographic image   | No  |         |         |          | N  | 0       | 999     | 1         | 5             | Year per patient  |
| D0340                                    | 2D Cephalometric radiographic image – acquisition, measurement and analysis  | No  |         |         |          | N  | 0       | 20      | 1         | 1             | Day per patient   |
| D0372                                    | intraoral tomosynthesis - comprehensive series of radiographic images; A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. | No  |         |         |          | N  | 0       | 999     | 1         | 5             | Year per patient  |
| D0373                                    | intraoral tomosynthesis - bitewing radiographic image  | No  |         |         |          | N  | 0       | 999     | 4         | 1             | Day per patient   |
| D0374                                    | intraoral tomosynthesis - periapical radiographic image  | No  |         |         |          | N  | 0       | 999     | 11        | 1             | Day per patient   |
| D1110                                    | Prophylaxis -adult   | No  |         |         |          | N  | 12      | 999     | 1         | 180           | DAYS (per patient . Additional requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D1120                                    | Prophylaxis - child  | No  |         |         |          | N  | 0       | 11      | 1         | 180           | DAYS per patient  |
| D1206                                    | Topical application of Fluoride varnish  | No  |         |         |          | N  | 0       | 20      | 6         | 1             | Year per patient (teledentistry POS 02,10)  |

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|--|--|---|---------|---------|----------|--|---------|---------|-----------------------------|---------------|---|
|  |  | Authorization Requirements  |         |         |          | Benefit Details                              |         |         |                             |               |   |
| Code                                     | Code Description   | Auth Req d  | Age Min | Age Max | Req Docs | Reporting Requirements                       | Age Min | Age Max | Max Count                   | Period Length | Period Type   |
| D1208                                    | Topical application of Fluoride – excluding varnish  | No  |         |         |          | N  | 0       | 20      | 1                           | 180           | Days per patient                                    |
| D1310                                    | Nutritional counseling for control of dental disease   | No  |         |         |          | N  | 0       | 999     | 1                           | 180           | Days per patient (teledentistry P02, 10)            |
| D1320                                    | Tobacco counseling for the control and prevention of dental disease  | No  |         |         |          | N  | 0       | 999     | 1(D1320 or D1321 or 99407)  | 1             | Day per patient ( teledentistry allowed POS 02, 10) |
| D1320                                    | Tobacco counseling for the control and prevention of dental disease  | No  |         |         |          | N  | 0       | 999     | 70(D1320 or D1321 or 99407) | 1             | Year per patient teledentistry allowed POS 02, 10)  |
| D1321                                    | Counseling for the control and prevention of adverse oral behavioral and system health effects associated with high-risk substance abuse | No  |         |         |          | N  | 0       | 999     | 1(D1320 or D1321 or 99407)  | 1             | Day per patient                                     |
| D1321                                    | Counseling for the control and prevention of adverse oral behavioral and system health effects associated with high-risk substance abuse | No  |         |         |          | N  | 0       | 999     | 70(D1320 or D1321 or 99407) | 1             | Year per patient                                    |
| D1330                                    | Oral hygiene instructions  | No  |         |         |          | N  | 0       | 999     | 1                           | 180           | Days per patient(teledentistry POS 02, 10)          |

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|  |   | Authorization Requirements  |         |         |          | Benefit Details                              |         |         |           |               |   |
| Code                                     | Code Description  | Auth Req d  | Age Min | Age Max | Req Docs | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type   |
| D1351                                    | Sealant per tooth   | No  |         |         |          | T  | 0       | 20      | 1         | 1             | Lifetime per patient Allowed on 1 <sup>st</sup> and 2nd premolars. Allowed on 1 <sup>st</sup> and second molars and on 1 <sup>st</sup> and second molars where a buccal restoration might exist |
| D1354                                    | Application of caries arresting medicament – per tooth          | No  |         |         |          | T  | 0       | 999     | 10 teeth  | 1             | Day per patient   |
| D1354                                    | Application of caries arresting medicament – per tooth          | No  |         |         |          | T  | 0       | 999     | 4         | 1             | Year per tooth per patient  |
| D1354                                    | Application of caries arresting medicament – per tooth          | No  |         |         |          | T  | 0       | 999     | 6         | 1             | Lifetime per tooth per patient  |
| D1510                                    | Space maintainer - fixed, unilateral per quadrant               | No  |         |         |          | Q  | 0       | 20      | 4         | 1             | 1 appliance Per quadrant 4 per lifetime per patient   |
| D1516                                    | Space maintainer – fixed - bilateral, maxillary                 | No  |         |         |          | T  | 0       | 20      | 1         | 1             | 1 appliance Per arch per lifetime per patient   |
| D1517                                    | Space maintainer – fixed - bilateral, mandibular                | No  |         |         |          | T  | 0       | 20      | 1         | 1             | 1 appliance Per arch per lifetime per patient   |
| D1551                                    | Re-cement or re-bond bilateral space maintainer – maxillary     | No  |         |         |          | N  | 0       | 20      | 1         | 1             | Day appliance per patient   |
| D1552                                    | Re-cement or re-bond bilateral space maintainer – mandibular    | No  |         |         |          | N  | 0       | 20      | 1         | 1             | Day appliance per patient   |
| D1553                                    | Re-cement or re-bond unilateral space maintainer – per quadrant | No  |         |         |          | N  | 0       | 20      | 4         | 1             | Day appliances per patient  |
| D1556                                    | Removal of fixed unilateral space maintainer – per quadrant     | No  |         |         |          | N  | 0       | 20      | 4         | 1             | Day appliances per patient  |
| D1557                                    | Removal of fixed bilateral space maintainer – maxillary         | No  |         |         |          | N  | 0       | 20      | 1         | 1             | Day appliance per patient   |
| D1558                                    | Removal of fixed bilateral space maintainer – mandibular        | No  |         |         |          | N  | 0       | 20      | 1         | 1             | Day appliance per patient   |

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|  |  | Authorization Requirements  |         |         |          | Benefit Details                              |         |         |           |               |  |
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| D2140                                    | Amalgam - one Surface primary or permanent                               | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2150                                    | Amalgam – two surface primary or permanent                               | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2160                                    | Amalgam – three surface primary or permanent                             | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2161                                    | Amalgam – four surface primary or permanent                              | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2330                                    | Resin-based composite - 1 surface, Anterior                              | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2331                                    | Resin- based composite -2 surface, anterior                              | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2332                                    | Resin- based composite 3 surface, anterior                               | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2335                                    | Resin- based composite 4+ surfaces or involving incisal angle (anterior) | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2390                                    | Resin-based composit crown -anterior                                     | No  |         |         |          | T  | 0       | 20      | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2391                                    | Resin - based Composite - 1 surface, posterior                           | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2392                                    | Resin - based Composite - 2 surface, posterior                           | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2393                                    | Resin - based Composite - 3 surface, posterior                           | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |
| D2394                                    | Resin - based composite-4+ surface, posterior                            | No  |         |         |          | T  | 0       | 999     | 1         | 1             | Day per patient. No reimbursement if performed within 30 days of a crown |

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|  |   | Authorization Requirements  |         |         |   | Benefit Details                              |         |         |           |               |  |
| Code                                     | Code Description                                  | Auth Req d  | Age Min | Age Max | Req Docs  | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type  |
| D2710                                    | Crown - resin - based composite (indirect)        | Yes   | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity | T  | 0       | 999     | 1         | 3             | Year per patient<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF   |
| D2721                                    | Crown-resin with predominantly base metal         | Yes   | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity | T  | 0       | 999     | 1         | 5             | Year per patient<br>1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D2740                                    | Crown-porcelain/ceramic                           | Yes   | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity | T  | 0       | 999     | 1         | 5             | Year per patient<br>1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D2751                                    | Crown-porcelain fused to predominantly base metal | Yes   | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity | T  | 0       | 999     | 1         | 5             | Year per patient<br>1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |

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|  |  | Authorization Requirements  |         |         |   | Benefit Details                              |         |         |           |               |  |
| Code                                     | Code Description   | Auth Req d  | Age Min | Age Max | Req Docs  | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type  |
| D2752                                    | Crown-porcelain fused to noble metal                                     | Yes   | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity | T  | 0       | 999     | 1         | 5             | Year per patient<br>1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D2791                                    | Crown - full cast predominantly base metal                               | Yes   | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity | T  | 0       | 999     | 1         | 5             | Year per patient<br>1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D2910                                    | Recement or rebond inlay, onlay, veneer or partial coverage restoration  | No  |         |         |   | T  | 0       | 999     | 1         | 1             | Day per tooth per patient  |
| D2915                                    | Recement or re-bond indirectly fabricated or prefabricated post and core | No  |         |         |   | T  | 0       | 999     | 1         | 1             | Day per tooth per patient  |
| D2920                                    | Recement or re-bond crown  | No  |         |         |   | T  | 0       | 999     | 1         | 1             | Day per tooth per patient  |
| D2929                                    | Prefabricated porcelain or ceramic crown places on a primary tooth       | No  |         |         |   | T  | 0       | 20      | 1         | 1             | Day per tooth per patient (C-H, M-R only)  |
| D2930                                    | Prefabricated Stainless Steel Crown - primary tooth                      | No  |         |         |   | T  | 0       | 20      | 1         | 1             | Day per tooth per patient  |
| D2931                                    | Prefabricated Stainless Steel Crown - permanent tooth                    | No  |         |         |   | T  | 0       | 20      | 1         | 1             | Day per tooth per patient  |

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| Code                                     | Code Description   | Auth Req d  | Age Min | Age Max | Req Docs  | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type   |
| D2932                                    | Prefabricatedresin crown   | No  |         |         |   | T  | 0       | 20      | 1         | 1             | Day per tooth per patient   |
| D2933                                    | Prefabricated Stainless Steel Crown with resin window              | No  |         |         |   | T  | 0       | 20      | 1         | 1             | Day per tooth per patient   |
| D2934                                    | Prefabricated esthetic coated stainless steel crown- primary tooth | No  |         |         |   | T  | 0       | 20      | 1         | 1             | Day per tooth per patient   |
| D2952                                    | Post and core in addition to crown, indirectly fabricated          | Yes   | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity | T  | 0       | 999     | 1         | 1             | PER DAY/PER TOOTH/PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |



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|---|---|----------------------------|---------|---------|--|------------------------|---------|---------|-----------|---------------|---|
|   |   | Authorization Requirements |         |         |  | Benefit Details        |         |         |           |               |   |
| Code  | Code Description  | Auth Reqd                  | Age Min | Age Max | Req Docs   | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type   |
| D2954   | Prefabricated post and core in addition to crown  | Yes                        | 0       | 999     | Pre-operative x-rays of adjacent teeth and opposing teeth.<br>Narrative of medical necessity | T                      | 0       | 999     | 1         | 1             | PER DAY/PER TOOTH/PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D2980   | Crown repair necessitated by restorative material failure   | No                         |         |         |  | T                      | 0       | 999     | 1         | 1             | PER DAY/PER TOOTH/PER PATIENT   |
| D2991   | Application of hydroxyappetite regeneration medicament – per tooth  | No                         |         |         |  | T                      | 0       | 999     | 1         | 1             | LIFETIME/PER TOOTH/PER PATIENT. NOT ALLOWED IF TOOTH WAS PREVIOUSLY RESTORED (D2140-D2161, D2391-D2394, D2330-D2335)                          |
| D3220   | Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | No                         |         |         |  | T                      | 0       | 20      | 6         | 1             | PER DAY/PER TOOTH/PER PATIENT   |
| D3230   | Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)   | No                         |         |         |  | T                      | 0       | 20      | 1         | 1             | PER DAY/PER TOOTH/PER PATIENT   |
| D3240   | Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)  | No                         |         |         |  | T                      | 0       | 20      | 1         | 1             | PER DAY/PER TOOTH/PER PATIENT   |

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|---|--|----------------------------|---------|---------|--|------------------------|---------|---------|-----------|---------------|--|
|   |  | Authorization Requirements |         |         |  | Benefit Details        |         |         |           |               |  |
| Code  | Code Description   | Auth Reqd                  | Age Min | Age Max | Req Docs   | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type  |
| D3310   | Endodontic therapy, Anterior tooth (excluding final restoration) | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings), Narrative of medical necessity | T                      | 0       | 999     | 1         | 1             | LIFETIME PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3320   | Endodontic therapy, Premolar tooth (excluding final restoration) | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings), Narrative of medical necessity | T                      | 0       | 999     | 1         | 1             | LIFETIME PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3330   | Endodontic therapy, molar tooth (excluding final restoration))   | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings), narrative of medical necessity | T                      | 0       | 999     | 1         | 1             | LIFETIME PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3410   | Apicoectomy anterior   | No                         |         |         |  | T                      | 0       | 999     | 2 teeth   | 1             | DAY PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF      |

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|  |   | Authorization Requirements  |         |         |  | Benefit Details                              |         |         |           |               |  |
| Code                                     | Code Description                              | Auth Reqd   | Age Min | Age Max | Req Docs   | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type  |
| D3421                                    | Apicoectomy premolar – (first root)           | No  |         |         |  | T  | 0       | 999     | 2 teeth   | 1             | DAY PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF      |
| D3425                                    | Apicoectomy molar – first root                | No  |         |         |  | T  | 0       | 999     | 2 teeth   | 1             | DAY PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF      |
| D3426                                    | Apicoectomy-(each additional root)            | No  |         |         |  | T  | 0       | 999     | 2 teeth   | 1             | DAY PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF      |
| D3471                                    | Surgical repair of root resorption - anterior | YES   | 0       | 999     | Pre-operative x-rays excluding bitewings. Narrative of medical necessity | T  | 0       | 999     | 1         | 1             | LIFETIME PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3472                                    | Surgical repair of root resorption - premolar | YES   | 0       | 999     | Pre-operative x-rays excluding bitewings. Narrative of medical necessity | T  | 0       | 999     | 1         | 1             | LIFETIME PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3473                                    | Surgical repair of root resorption - molar    | YES   | 0       | 999     | Pre-operative x-rays excluding bitewings. Narrative of medical necessity | T  | 0       | 999     | 1         | 1             | LIFETIME PER TOOTH PER PATIENT<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |

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|  |  | Authorization Requirements  |         |         |  | Benefit Details                              |         |         |                         |               |  |
| Code                                     | Code Description   | Auth Reqd   | Age Min | Age Max | Req Docs   | Reporting Requirements                       | Age Min | Age Max | Max Count               | Period Length | Period Type  |
| D3501                                    | Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior      | YES   | 0       | 999     | Pre-operative x-rays excluding bitewings. Narrative of medical necessity   | T  | 0       | 999     | 1                       | 1             | LIFETIME PER TOOTH<br>PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3502                                    | Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar      | YES   | 0       | 999     | Pre-operative x-rays excluding bitewings. Narrative of medical necessity   | T  | 0       | 999     | 1                       | 1             | LIFETIME PER TOOTH<br>PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3503                                    | Surgical exposure of root surface without apicoectomy or repair of root resorption - molar         | YES   | 0       | 999     | Pre-operative x-rays excluding bitewings. Narrative of medical necessity   | T  | 0       | 999     | 1                       | 1             | LIFETIME PER TOOTH<br>PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D3921                                    | Decoronation or submergence of an erupted tooth  | Yes   | 0       | 999     | Post operative x-rays (excluding bitewings), narrative of medical necessity inclusive of restorative treatment plan for arch(es) | T  | 0       | 999     | 1                       | 1             | Lifetime per tooth PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF    |
| D4210                                    | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | Yes   | 0       | 999     | Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)   | Q  | 0       | 999     | 4 (different quadrants) | 24            | MONTHS<br>PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF             |

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| Code                                     | Code Description  | Auth Reqd   | Age Min | Age Max | Req Docs  | Reporting Requirements                       | Age Min | Age Max | Max Count                                | Period Length | Period Type  |
| D4341                                    | Periodontal scaling and root planing – four or more teeth per quadrant                                      | Yes   | 0       | 999     | Periodontal charting and pre- op x-rays. Narrative of medical necessity | Q  | 0       | 999     | 2 different quadrants                    | 1             | day<br>PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF  |
| D4341                                    | Periodontal scaling and root planing – four or more teeth per quadrant                                      | Yes   | 0       | 999     | Periodontal charting and pre- op x-rays. Narrative of medical necessity | Q  | 0       | 999     | 4 different quadrants inclusive of D4342 | 24            | MONTHS<br>PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF   |
| D4342                                    | Periodontal scaling and root planing one to three teeth per quadrant  | Yes   | 0       | 999     | Periodontal charting and pre- op x-rays. Narrative of medical necessity | Q  | 0       | 999     | 4 (different quadrants)                  | 1             | Day PER PATIENT<br><br>PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF  |
| D4342                                    | Periodontal scaling and root planing one to three teeth per quadrant  | Yes   | 0       | 999     | Periodontal charting and pre- op x-rays. Narrative of medical necessity | Q  | 0       | 999     | 4 (different quadrants)                  | 24            | Months PER PATIENT<br><br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF   |
| D4355                                    | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit | No  |         |         |   | N  | 0       | 999     | 1  | 1             | year PER PATIENT<br>No history of prophylaxis or periodontal treatment in past 12 months.<br>Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF. |

|  |   |   |         |         |          |  |         |         |           |               |                  |
|--|---|---|---------|---------|----------|--|---------|---------|-----------|---------------|------------------|
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|  |   | Authorization Requirements  |         |         |          | Benefit Details                              |         |         |           |               |                  |
| Code                                     | Code Description  | Auth Reqd   | Age Min | Age Max | Req Docs | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type      |
| D4346                                    | Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation | No  |         |         |          | N  | 0       | 999     | 1         | 180           | Days per patient |

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|--|--------------------------------|---|---------|--|--|------------------------|---------|---------|-----------|---------------|---|
|  |                                | Authorization Requirements  |         |  |  | Benefit Details        |         |         |           |               |   |
| Code                                     | Code Description               | Auth Reqd   | Age Min | Age Max                                      | Req Docs   | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type   |
| D4910                                    | Periodontal maintenance        | No  |         |  |  | N                      | 0       | 999     | 1         | 90            | days per patient with past history of therapeutic periodontal treatment or periodontal maintenance  |
| D5110***                                 | Complete denture - maxillary   | Yes   | 0       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity), | N                      | 0       | 999     | 1         | 1             | Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D5120***                                 | Complete denture - mandibular  | Yes   | 0       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity,  | N                      | 0       | 999     | 1         | 1             | Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age   |
| D5130                                    | Immediate denture - maxillary  | Yes   | 0       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity,  | N                      | 0       | 999     | 1         | 1             | Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D5140                                    | Immediate denture - mandibular | Yes   | 0       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity,  | N                      | 0       | 999     | 1         | 1             | Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception   |

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|--|--|---|---------|--|---|------------------------|---------|---------|-----------|---------------|---|
|  |  | Authorization Requirements  |         |  |   | Benefit Details        |         |         |           |               |   |
| Code                                     | Code Description   | Auth Reqd   | Age Min | Age Max                                      | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type   |
|  |  |   |         |  |   |                        |         |         |           |               | for individuals 21 years of age and older unless they reside in a NF or ICF   |
| D5211***                                 | Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)  | Yes   | 6       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity, | N                      | 6       | 999     | 1         | 1             | Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |
| D5212***                                 | Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth) | Yes   | 6       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity  | N                      | 6       | 999     | 1         | 1             | Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF |



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|--|--|---|---------|--|---|------------------------|---------|---------|-----------|---------------|--|
|  |  | Authorization Requirements  |         |  |   | Benefit Details        |         |         |           |               |  |
| Code                                     | Code Description   | Auth Re qd  | Age Min | Age Max                                      | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type  |
| D5213***                                 | Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)  | Yes   | 6       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity, | N                      | 6       | 999     | 1         | 1             | Lifetime appliance per arch per patient <i>limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF</i> |
| D5214***                                 | Mandibular partial Denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | Yes   | 6       | 999  | Full mouth or panorex x-rays. Narrative of medical necessity, | N                      | 6       | 999     | 1         | 1             | Lifetime appliance per arch per patient <i>limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF</i> |
| D5410                                    | Adjust complete denture – maxillary  | No  |         |  |   | N                      | 0       | 999     | 1         | 1             | DAY per patient<br>ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.<br><br>dentist/group  |
| D5411                                    | Adjust complete denture – mandibular   | No  |         |  |   | N                      | 0       | 999     | 1         | 1             | DAY per patient<br>ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.<br><br>dentist/group  |
| D5421                                    | Adjust partial denture – maxillary   | No  |         |  |   | N                      | 0       | 999     | 1         | 1             | DAY per patient<br>ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.<br><br>dentist/group  |

| <b>A= Arch</b> <b>T = Tooth reporting requirement</b> <b>***BLE only required for replacement denture</b><br><b>N = No reporting requirements</b> <b>Q = Quadrant reporting requirement</b> |   |                            |         |         |          |                        |         |         |                   |               |   |
|---|---|----------------------------|---------|---------|----------|------------------------|---------|---------|-------------------|---------------|---|
|   |   | Authorization Requirements |         |         |          | Benefit Details        |         |         |                   |               |   |
| Code  | Code Description  | Auth Re qd                 | Age Min | Age Max | Req Docs | Reporting Requirements | Age Min | Age Max | Max Count         | Period Length | Period Type   |
| D5422   | Adjust partial denture – maxillary                                | No                         |         |         |          | N                      | 0       | 999     | 1                 | 1             | DAY per patient<br>ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.<br><br>dentist/group |
| D5511   | Repair complete broken denture base mandibular                    | No                         |         |         |          | N                      | 6       | 999     | 1                 | 1             | DAY per patient   |
| D5512   | Repair complete broken denture base maxillary                     | No                         |         |         |          | N                      | 6       | 999     | 1                 | 1             | DAY per patient   |
| D5520   | Replace missing or broken teeth – complete denture (each tooth)   | No                         |         |         |          | T                      | 0       | 999     | 3                 | 1             | DAY per patient   |
| D5611   | Repair resin partial denture base mandibular                      | No                         |         |         |          | N                      | 0       | 999     | 1                 | 1             | DAY per patient   |
| D5612   | Repair resin partial denture base maxillary                       | No                         |         |         |          | N                      | 0       | 999     | 1                 | 1             | DAY per patient   |
| D5621   | Repair cast partial framework - mandibular                        | No                         |         |         |          | N                      | 0       | 999     | 1                 | 1             | DAY per patient   |
| D5622   | Repair cast partial framework - maxillary                         | No                         |         |         |          | N                      | 0       | 999     | 1                 | 1             | DAY per patient   |
| D5630   | Repair or replace broken retentive/clasping materials - per tooth | No                         |         |         |          | T                      | 0       | 999     | 1 clasp per tooth | 1             | DAY per patient   |
| D5630   | Repair or replace broken retentive/clasping materials - per tooth | No                         |         |         |          | T                      | 0       | 999     | 4 clasps          | 1             | Year per patient  |

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|--|---|---|---------|--|----------|------------------------|---------|---------|-------------|---------------|---|
|  |   | Authorization Requirements  |         |  |          | Benefit Details        |         |         |             |               |   |
| Code                                     | Code Description                                | Auth Reqd   | Age Min | Age Max                                      | Req Docs | Reporting Requirements | Age Min | Age Max | Max Count   | Period Length | Period Type   |
| D5640                                    | Replace broken teeth-per tooth                  | No  |         |  |          | T                      | 0       | 999     | 3 teeth     | 1             | Day per patient   |
| D5650                                    | Add tooth to existing partial denture           | No  |         |  |          | T                      | 0       | 999     | 2 teeth     | 1             | Day per patient   |
| D5660                                    | Add clasp to existing partial denture per tooth | No  |         |  |          | T                      | 0       | 999     | 1 PER TOOTH | 1             | Lifetime per patient  |
| D5730                                    | Reline complete maxillary denture (direct)      | No  |         |  |          | N                      | 0       | 999     | 1           | 2             | Year Relines are included in the fee for the denture through 180 days post placementDAY (RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE. Beginning 180 days post insertion. Same Dentist/Group dentist/group |
| D5731                                    | Reline complete mandibular denture (direct)     | No  |         |  |          | N                      | 0       | 999     | 1(per arch) | 2             | Year Relines are included in the fee for the denture through 180 days post placement  |
| D5740                                    | Reline maxillary partial denture (direct)       | NO  |         |  |          | N                      | 0       | 999     | 1(per arch) | 2             | Year Relines are included in the fee for the denture through 180 days post placement  |
| D5741                                    | Reline mandibular partial denture (direct)      | No  |         |  |          | N                      | 0       | 999     | 1(per arch) | 2             | Year Relines are included in the fee for the denture through 180 days post placement  |
| D5750                                    | Reline complete maxillary denture (indirect)    | No  |         |  |          | N                      | 0       | 999     | 1(per arch) | 2             | Year Relines are included in the fee for the denture through 180 days post placement  |

|  |   |   |         |         |          |   |         |         |             |               |  |
|--|---|---|---------|---------|----------|---|---------|---------|-------------|---------------|--|
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|  |   | Authorization Requirements  |         |         |          | Benefit Details                                     |         |         |             |               |  |
| Code   | Code Description                              | Auth Reqd   | Age Min | Age Max | Req Docs | Reporting Requirements                              | Age Min | Age Max | Max Count   | Period Length | Period Type  |
| D5751  | Reline complete mandibular denture (indirect) | No  |         |         |          | N   | 0       | 999     | 1(per arch) | 2             | Year Relines are included in the fee for the denture through 180 days post placement |
| D5760  | Reline maxillary partial denture (indirect)   | No  |         |         |          | N   | 0       | 999     | 1(per arch) | 2             | Year Relines are included in the fee for the denture through 180 days post placement |
| D5761  | Reline mandibular partial denture (indirect)  | No  |         |         |          | N   | 0       | 999     | 1(per arch) | 2             | Year Relines are included in the fee for the denture through 180 days post placement |

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|---|---|----------------------------|---------|---------|---|------------------------|---------|---------|-------------|---------------|----------------------|
|   |   | Authorization Requirements |         |         |   | Benefit Details        |         |         |             |               |                      |
| Code  | Code Description  | Auth Reqd                  | Age Min | Age Max | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count   | Period Length | Period Type          |
| D6930   | Re-cement or re-bond fixed partial denture  | No                         |         |         |   | N                      | 0       | 999     | 1           | 1             | Day per patient      |
| D6980   | Fixed partial denture repair necessitated by restorative material failure   | No                         |         |         |   | Q                      | 0       | 999     | 1           | 1             | Day per patient      |
| D7140   | Extraction, erupted tooth or exposed root (elevation and/or forceps removal)  | No                         |         |         |   | T                      | 0       | 999     | 1 per tooth | 1             | Lifetime per patient |
| D7210   | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | No                         |         |         |   | T                      | 0       | 999     | 1 per tooth | 1             | Lifetime per patient |
| D7220   | Removal impacted tooth-soft tissue  | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings) and narrative of medical necessity | T                      | 0       | 999     | 1 per tooth | 1             | Lifetime per patient |
| D7230   | Remove impacted tooth-partiallybony   | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings) and narrative of medical necessity | T                      | 0       | 999     | 1 per tooth | 1             | Lifetime per patient |

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|---|---|----------------------------|---------|---------|---|------------------------|---------|---------|-------------|---------------|----------------------|
|   |   | Authorization Requirements |         |         |   | Benefit Details        |         |         |             |               |                      |
| Code  | Code Description  | Auth Req                   | Age Min | Age Max | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count   | Period Length | Period Type          |
| D7240   | Remove impacted tooth – completely bony   | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings) and narrative of medical necessity | T                      | 0       | 999     | 1 per tooth | 1             | Lifetime per patient |
| D7250   | Removal of residual tooth roots (cutting procedure)                                   | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings) and narrative of medical necessity | T                      | 0       | 999     | 1 per tooth | 1             | Lifetime per patient |
| D7260   | Oroantral fistula closure   | Yes                        | 0       | 999     | Narrative of medical necessity  | N                      | 0       | 999     | 1           | 1             | Day per patient      |
| D7270   | Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth | Yes                        | 0       | 20      | Narrative of medical necessity  | T                      | 0       | 20      | 1 per tooth | 1             | Day per patient      |
| D7280   | Exposure of unerupted tooth   | Yes                        | 0       | 22      | Pre-operative x-  | T                      | 0       | 22      | 1 per tooth | 1             | Lifetime per patient |
| D7283   | Placement of device to facilitate eruption of impacted tooth                          | Yes                        | 0       | 22      | rays (excluding bitewings)  | T                      | 0       | 22      | 1 per tooth | 1             | Day per patient      |
| D7288   | Brush biopsy - transepithelial sample collection                                      | No                         |         |         |   | N                      | 0       | 999     | 2           | 1             | Day per patient      |

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|---|--|----------------------------|---------|---------|---|------------------------|---------|---------|----------------|---------------|-----------------|
|   |  | Authorization Requirements |         |         |   | Benefit Details        |         |         |                |               |                 |
| Code  | Code Description   | Auth Req                   | Age Min | Age Max | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count      | Period Length | Period Type     |
| D7310   | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant     | No                         |         |         |   | Q                      | 0       | 999     | 1 per quadrant | 1             | Day per patient |
| D7320   | Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | Yes                        | 0       | 999     | Pre-operative x-rays (excluding bitewings) and narrative of medical necessity | Q                      | 0       | 999     | 1 per quadrant | 1             | Day per patient |
| D7450   | Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25cm                             | Yes                        | 0       | 999     | Copy of pathology report  | N                      | 0       | 999     | 2 lesions      | 1             | Day per patient |
| D7451   | Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25cm                      | Yes                        | 0       | 999     | Copy of pathology report  | N                      | 0       | 999     | 2 lesions      | 1             | Day per patient |
| D7460   | Removal of benign non-odontogenic cyst or tumor-lesion diameter up to 1.25cm                         | Yes                        | 0       | 999     | Copy of pathology report  | N                      | 0       | 999     | 2 lesions      | 1             | Day per patient |
| D7461   | Removal of benign non-odontogenic cyst or tumor-lesion diameter greater than 1.25cm                  | Yes                        | 0       | 999     | Copy of pathology report  | N                      | 0       | 999     | 2 lesions      | 1             | Day per patient |
| D7471   | Removal of lateral exostosis – maxilla or mandible-  | No                         |         |         |   | A                      | 0       | 999     | 2              | 1             | Day per patient |
| D7472   | Removal of torus palatinus   | No                         |         |         |   | N                      | 0       | 999     | 2              | 1             | Day per patient |
| D7473   | Removal of torus mandibularis  | No                         |         |         |   | N                      | 0       | 999     | 2              | 1             | Day per patient |

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|---|--|----------------------------|---------|---------|---|------------------------|---------|---------|-----------|---------------|-----------------|
|   |  | Authorization Requirements |         |         |   | Benefit Details        |         |         |           |               |                 |
| Code  | Code Description   | Auth Reqd                  | Age Min | Age Max | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type     |
| D7485   | Reduction of osseous tuberosity  | No                         |         |         |   | N                      | 0       | 999     | 2         | 1             | Day per patient |
| D7509   | Marsupialization of odontogenic cyst   | No                         |         |         |   | N                      | 0       | 999     | 2         | 1             | Day per patient |
| D7510   | Incision and drainage of abscess - intraoral soft tissue   | Yes                        | 0       | 999     | Narrative of medical necessity, xrays or photos optional  | N                      | 0       | 999     | 2         | 1             | Day per patient |
| D7511   | Incision and drainage of abscess- intraoral – complicated (includes drainage of multiple fascial spaces) | Yes                        | 0       | 999     | Narrative of medical necessity, xrays or photos optional  | N                      | 0       | 999     | 2         | 1             | Day per patient |
| D7520   | Incision and drainage of abscess extraoral soft tissue   | Yes                        | 0       | 999     | Narrative of medical necessity, xrays or photos optional  | N                      | 0       | 999     | 2         | 1             | Day per patient |
| D7521   | Incision and drainage of abscess- extraoral – complicated (includes drainage of multiple fascial spaces) | Yes                        | 0       | 999     | Narrative of medical necessity, xrays or photos optional  | N                      | 0       | 999     | 2         | 1             | Day per patient |
| D7871   | Non-arthroscopic lysis and lavage  | Yes                        | 0       | 999     | Narrative of medical necessity, x-rays or photos optional | N                      | 0       | 999     | 1         | 1             | Day per patient |



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|---|---|----------------------------|---------|---------|---|------------------------|---------|---------|------------|---------------|----------------------|
|   |   | Authorization Requirements |         |         |   | Benefit Details        |         |         |            |               |                      |
| Code  | Code Description                              | Auth Reqd                  | Age Min | Age Max | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count  | Period Length | Period Type          |
| D7961   | Buccal/ labial frenectomy (frenulectomy)      | No                         | 0       | 999     | Narrative of medical necessity, xrays or photos optional                        | N                      | 0       | 999     | 2          | 1             | Lifetime per patient |
| D7962   | Lingual Frenectomy (frenulectomy)             | Yes                        | 0       | 999     | Narrative of medical necessity, xrays or photos optional                        | N                      | 0       | 999     | 1          | 1             | Lifetime per patient |
| D7970   | Excision of hyperplastic tissue - per arch    | Yes                        | 0       | 999     | Pre-operative x-rays, narrative of medical necessity, photos optional           | N                      | 0       | 999     | 1 per arch | 1             | Day per patient      |
| D7999   | Unspecified oral surgery procedure, by report | Yes                        | 0       | 999     | Narrative of medical necessity, name, license number and tax ID of Asst surgeon | N                      | 0       | 999     | 1          | 1             | Day per patient      |

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|--|--|---|---------|--|---|------------------------|---------|---------|-----------|---------------|--------------------------------|
| Code                                     | Code Description   | Authorization Requirements  |         |  |   | Benefit Details        |         |         |           |               |                                |
|  |  | Auth Reqd   | Age Min | Age Max                                      | Req Docs  | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type                    |
| D8080                                    | Comprehensive Orthodontic treatment of the adolescent dentition                          | YES   | 0       | 20   | Panorex and /or cephalometric x-rays, 5-7 diagnostic quality photos, completed Salzman Criteria Index Form.completed Salzman Criteria Index Form. | N                      | 0       | 20      | 1         | 1             | Lifetime per patient           |
| D8660                                    | Pre-orthodontic treatment examination to monitor growth and development                  | No  |         |  |   | N                      | 0       | 20      | 1         | 1             | Year(per patient/per provider) |
| D8670                                    | Periodic orthodontic treatment visit   | Yes   | 0       | 22   | Panorex and /or cephalometric x-rays, 5-7 diagnostic quality photos, completed Salzman Criteria Index Form.                                       | N                      | 0       | 22      | 7         | 1             | Lifetime per patient           |
| D8680                                    | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | Yes   | 0       | 22   | Evidence of successful completion of comprehensive orthodontics   | N                      | 0       | 22      | 1         | 1             | Lifetime per patient           |
| D8703                                    | Replacement of lost/broken retainer - maxillary  | Yes   | 0       | 22   | Evidence of previous lost/broken D8680  | N                      | 0       | 22      | 1         | 1             | Lifetime per patient           |
| D8704                                    | Replacement of lost/broken retainer - mandibular   | Yes   | 0       | 22   | Evidence of previous lost/broken D8680  | N                      | 0       | 22      | 1         | 1             | Lifetime per patient           |

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|--|--|---|---------|---------|---|--|---------|---------|------------|---------------|--|
| Code                                     | Code Description   | Authorization Requirements  |         |         |   | Benefit Details                              |         |         |            |               |  |
|  |  | Auth Reqd   | Age Min | Age Max | Req Docs  | Reporting Requirements                       | Age Min | Age Max | Max Count  | Period Length | Period Type                                  |
| D8210                                    | Removable appliance therapy  | Yes   | 0       | 20      | Panoramic/cephalometric x-ray, Narr of medical necessity. | N  | 0       | 20      | 1 per arch | 1             | Lifetime per patient (either D8210 or D8220) |
| D8220                                    | Fixed appliance therapy  | Yes   | 0       | 20      | Panoramic/cephalometric x-ray, Narr of medical necessity. | N  | 0       | 20      | 1 per arch | 1             | Lifetime per patient (either D8210 or D8220) |
| D9110                                    | Palliative treatment of dental pain – per visit                        | No  |         |         |   | N  | 0       | 999     | 1          | 1             | Day per patient                              |
| D9222                                    | Deep sedation/general anesthesia – first 15 minutes                    | Yes   | 0       | 999     | Narrative of medical necessity                            | N  | 0       | 999     | 1          | 1             | Day per patient                              |
| D9223                                    | Deep sedation/general anesthesia – each subsequent 15 minute increment | Yes   | 0       | 999     | Narrative of medical necessity                            | N  | 0       | 999     | 7          | 1             | Day per patient                              |
| D9230                                    | Inhalation of nitrous oxide / analgesia, anxiolysis                    | No  |         |         |   | N  | 0       | 20      | 1          | 1             | Day per patient                              |
| D9239                                    | Intravenous moderate (conscious) sedation/analgesia – first 15 minutes | Yes   | 0       | 999     | Narrative of medical necessity                            | N  | 0       | 999     | 1          | 1             | Day per patient                              |

| A= Arch<br>N = No reporting requirements |   | T = Tooth reporting requirement<br>Q = Quadrant reporting requirement |         |         |                                | ***BLE only required for replacement denture |         |         |           |               |                           |
|--|---|---|---------|---------|--------------------------------|--|---------|---------|-----------|---------------|---------------------------|
| Code                                     | Code Description  | Authorization Requirements  |         |         |                                | Benefit Details                              |         |         |           |               |                           |
|  |   | Auth Reqd   | Age Min | Age Max | Req Docs                       | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type               |
| D9243                                    | Intravenous moderate (conscious) sedation/ analgesia – each subsequent 15 minute increment  | Yes   | 0       | 999     | Narrative of medical necessity | N  | 0       | 999     | 7         | 1             | Day per patient           |
| D9248                                    | Non-intravenous conscious sedation  | Yes   | 0       | 999     | Narrative of medical necessity | N  | 0       | 999     | 1         | 1             | Day per patient           |
| D9920                                    | Behavior management fee (a visit fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy) | No  |         |         |                                | N  | 0       | 999     | 1         | 1             | Day per patient           |
| D9920                                    | Behavior management fee (a visit fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy) | No  |         |         |                                | N  | 0       | 999     | 4         | 1             | Calendar Year per patient |

| A= Arch<br>N = No reporting requirements |   | T = Tooth reporting requirement<br>Q = Quadrant reporting requirement |         | ***BLE only required for replacement denture |  |                        |         |         |           |               |   |
|--|---|---|---------|--|--|------------------------|---------|---------|-----------|---------------|---|
| Code                                     | Code Description  | Authorization Requirements  |         |  |  | Benefit Details        |         |         |           |               |   |
|  |   | Auth Reqd   | Age Min | Age Max                                      | Req Docs   | Reporting Requirements | Age Min | Age Max | Max Count | Period Length | Period Type                                       |
| D9930                                    | Treatment of complications (postsurgical) – unusual circumstances, by report                    | Yes   | 0       | 999  | Narrative of medical necessity                   | N                      | 0       | 999     | 1         | 1             | Day per patient                                   |
| D9947                                    | Custom sleep apnea appliance fabrication and placement  | Yes   | 0       | 999  | Lab Rx containing members name, Physician letter | A                      | 0       | 999     | 1         | 1             | Lifetime per patient                              |
| D9948                                    | Adjustment of custom sleep apnea appliance  | No  |         |  |  | A                      | 0       | 999     | 1         | 1             | Day per patient at least 180 days post placement  |
| D9949                                    | Repair of custom sleep apnea appliance  | No  |         |  |  | N                      | 0       | 999     | 1         | 1             | Day per patient at least 180 days post placement  |
| D9953                                    | Reline custom sleep apnea appliance (indirect)  | No  |         |  |  | N                      | 0       | 999     | 1         | 2             | Year per patient at least 180 days post placement |
| D9995                                    | Teledentistry – synchronous; real time encounter  | No  |         |  |  | N                      | 0       | 999     | 1         | 1             | Day per patient                                   |
| D9996                                    | Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review | No  |         |  |  | N                      | 0       | 999     | 1         | 1             | Day per patient                                   |

| A= Arch<br>N = No reporting requirements |   | T = Tooth reporting requirement<br>Q = Quadrant reporting requirement |         |         |   | ***BLE only required for replacement denture |         |         |           |               |   |
|--|---|---|---------|---------|---|--|---------|---------|-----------|---------------|---|
|  |   | Authorization Requirements  |         |         |   | Benefit Details                              |         |         |           |               |   |
| Code                                     | Code Description  | Auth Reqd   | Age Min | Age Max | Req Docs                                | Reporting Requirements                       | Age Min | Age Max | Max Count | Period Length | Period Type   |
|  | Cleft Palate Services   |   |         |         |   |  |         |         |           |               |   |
| D0160                                    | Detailed and Extensive Oral Evaluation, by report                                     | No  |         |         | Complete initial examination at a Cleft | N  | 0       | 20      | 1         | 1             | Day per provider (Complete initial examination at a Cleft Palate Clinic only) |
| D0170                                    | Re-evaluation, Limited Problem Focused (established patient; not postoperative visit) | No  |         |         | Cleft Palate Clinic                     | N  | 0       | 20      | 1         | 1             | Day per patient   |