DELTA DENTAL
HDS
Hawaii Dental Service

For Dentists in HI, GU and MP
All others, please register at
www.deltadental.com

HDSProfessionalRelations@HawaiiDentalService.com
Phone 529-9222 or toll free 1-844-379-4324

E-Fax 808-529-9223

CLAIM SUBMISSION AND PROVIDER PORTAL AUTHORIZED AGENT FORM

SECTION A. PROVIDER AND PRACTICE INFORMATION; CERTIFICATION & ACKNOWLEDGMENTS			
Dentist Last Name	First Name	License No.	Email Address
Legal Business Name		TIN	Phone Number
Treatment Address (attach a list of additional treating locations if necessary)			

CERTIFICATION & ACKNOWLEDGMENTS:

I hereby certify that the individuals listed in Section B ("Authorized Agents") are authorized:

(i) to execute, on my behalf and as my duly authorized agent(s), all claims and related transactions for services rendered.

(ii) to access the HDS online provider portal ("Provider Portal") and interactive voice response systems to conduct claims and administrative activities on behalf of me and my dental practice.

If I treat patients at a practice to which I have assigned my payments, I agree that any Authorized Agents designated by that practice shall also be my Authorized Agents.

I agree that this form will keep my signature on file for claim submissions (paper and electronic).

I certify that I maintain the patient's signature on file for submission of all claims sent to HDS and release of all information related thereto. I agree to accept full responsibility for the accuracy and propriety of each submitted transaction and understand that the execution of each submission shall constitute a certification that the charges indicated are proper and correct and that no payments have been received except as noted.

I agree that the appointment of the Authorized Agents listed in Section B shall remain in effect, and may be conclusively relied upon by HDS, until HDS receives a verbal or written cancellation either by me or my Authorized Agent(s), which shall be done promptly, but no later than one (1) business day, following the termination of the authority of any Authorized Agent listed. I understand and agree that I must execute and submit an updated copy of this form if I want to add additional Authorized Agents.

I certify that I and my Authorized Agents agree to comply with all rules and regulations concerning the privacy and security of protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when submitting claims and accessing the Provider Portal.

I understand that for security purposes HDS may monitor the IP addresses from which my Authorized Agents access HDS systems including the Provider Portal and may send email notifications from time to time regarding access activity. I acknowledge and agree that HDS may modify, revoke, or terminate access to HDS systems at any time for any reason or no reason, in its sole discretion and without notice.

RELEASE AND INDEMNIFICATION: I hereby release and indemnify HDS against any claims, lawsuits, or allegations arising from or in connection with: (i) inaccurate or improper claims submitted by me or my Authorization Agents, (ii) improper access or use of any HDS system by me or my Authorized Agents or any person or entity using my Authorized Agent's access credentials, and (iii) any violation of law, including HIPAA requirements, state or local privacy or data breach laws, or the rights of a third party.

Dentist Signature _____ Date _____

Dentist Name (please print) _____

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SECTION B. AUTHORIZED AGENTS (Please use a second page if needed)

1) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information ☐ Terminate this Agent's access	HDS Use Only User ID:
2) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information ☐ Terminate this Agent's access	HDS Use Only User ID:
3) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information ☐ Terminate this Agent's access	HDS Use Only User ID:
4) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information ☐ Terminate this Agent's access	HDS Use Only User ID:
5) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information ☐ Terminate this Agent's access	HDS Use Only User ID:
6) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information ☐ Terminate this Agent's access	HDS Use Only User ID:
7) Print Authorized Agent's Name: Last Name _____ First Name _____	Select Access Levels: ☐ Patient eligibility verification ☐ Claim submission ☐ Remittance advice information ☐ Terminate this Agent's access	HDS Use Only User ID: