DELTA DENTAL

HDS
Hawaii Dental Service

Hawaii Dental Service
900 Fort Street Mall, Suite 1900
Honolulu, HI 96813-3705

SUBSCRIBER INFORMATION

1. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code, Phone Number

2. Date of Birth (MM/DD/YYYY)

3. Gender ☐ Male ☐ Female

4. HDS Subscriber ID

5. Plan or Group Number

6. Employer Name

PATIENT INFORMATION

7. Relationship to Policyholder/Subscriber in #1 above

☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

8. Patient Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code, Phone Number

9. Date of Birth (MM/DD/YYYY)

10. Gender ☐ Male ☐ Female

11. Patient ID/office Acct #

32. Diagnosis code list qualifier ____ ____ ____

32a. Diagnosis Codes A. _____ B._____ C._____ D._____

TYPE OF TRANSACTION

12. Check one:
☐ Statement of actual services ☐ Request for pre-authorization

TREATMENT INFORMATION

13. Treatment resulting from:
☐ Occupational Illness/Injury ☐ Auto Accident ☐ Other Accident

14. Date of Accident (MM/DD/YYYY)

15. Auto Accident State

16. Place of Treatment
☐ Provider's Office ☐ Hospital
☐ ECF ☐ Other

17. Number of Enclosures (00-99)
Radiograph(s)_____ Oral Images (s)_____
Model(s)_____

18. Is Treatment for Orthodontics?
☐ Yes (Complete 19-20) ☐ No (Skip 19-20)

19. Date Appliance Placed (MM/DD/YYYY)

20. Months of Treatment Remaining:

21. Replacement of Prosthesis?
☐ No ☐ Yes (Complete 22)

22. Date of Prior Placement (MM/DD/YYYY)

OTHER INSURANCE COVERAGE

23. Other coverage? ☐ None ☐ Dental (Complete 24-31) ☐ Medical (Complete 24-31)

24. Name of Other Coverage Policyholder/Subscriber (Last, First, Middle Initial, Suffix)

25. Date of Birth (MM/DD/YYYY)

26. Gender ☐ Male ☐ Female

27. Policyholder/Sub ID#

28. Plan or Group Number

29. Patient's Relationship to Person Named in #24:
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

30. Employer Name

31. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code, Phone Number

RECORD OF SERVICES PROVIDED

	33. Procedure Date (MM/DD/YYYY)	34. Area of Oral Cavity	35. Tooth Number(s) or Letter(s)	36. Tooth Surface	37. Diagnosis Pointer (A, B, etc.)	38. Qty	39. Procedure code	40. Description	41. Fee
1									
2									
3									
4									
5									
6									
7									
8									

MISSING TEETH INFO:

43. Place an 'X' on each missing tooth

Permanent

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Primary

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

42. Total Amount charged $

44. Remarks:

AUTHORIZATION - RELEASE OF INFORMATION

45. 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. I hereby declare that the information on this form is true and correct.

X_____ _____
Patient/Guardian Signature Date

ACKNOWLEDGMENT

46. I understand that payment of dental benefits is payable to the treating dentist who is an HDS or Delta Dental participating dentist. Payment of dental benefits for services performed by a non-participating HDS or Delta Dental dentist is payable to me.

X_____ _____
Patient/Guardian Signature Date

BILLING DENTIST OR DENTAL ENTITY

47. Dentist or Entity Name, Address, City, State, ZIP Code

48. NPI

49. License Number

50. TIN

51. Phone number

52. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require mulitiple visits) or have been completed.

X _____ _____
Signed (Treating Dentist) Date

54. Treatment Location Address, City, State, ZIP Code

55. NPI

56. License Number

57. Filing Number

58. Additional Provider ID

59. Phone number