



Hawaii Dental Service
700 Bishop Street #700
Honolulu, HI 96813-4196

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

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

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)

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 #

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

32. Diagnosis code list qualifier _____

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

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

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									

43. Place an 'X' on each missing tooth	Permanent								Primary								42. Total Amount charged \$										
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		A	B	C	D	E	F	G	H	I	J
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

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 multiple 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