MVP Medicare Advantage Dental Claim

(Please complete all three pages of this form)

MVP HEALTH CARE

HEADER INFORMATION

1. Type of Transaction (check all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/Title XIX

2. Predetermination/ Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

MVP MEDICARE ADVANTAGE DENTAL CLAIMS
1050 UNIVERSITY AVE STE A
ROCHESTER NY 14607

Electronic Payor ID: **16112**

OTHER COVERAGE

(Check applicable box and complete items 5–11. If none, leave blank)

4. ☐ Dental? ☐ Medical? (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/YYYY)	7. Gender ☐ M ☐ F	8. Policyholder/ Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION

(for Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YYYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/ Subscriber in #12 ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved for Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/YYYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/YYYY)	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. Qty.	30. Description	31. Fee
1										
2										
3										
4										

(Continued on page 2)

RECORD OF SERVICES PROVIDED (continued from page 1)

	Fee subtotal from page 1	

	24. Procedure Date (MM/DD/YYYY)	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. Qty.	30. Description	31. Fee
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information
(Place an "X" on each missing tooth)

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

34. Diagnosis Code List Qualifier (ICD-9=B; ICD-10=AB) ☐☐

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATION

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11 = Office; 22 = O/P Hospital) *Use "Place of Service Codes for Professional Claims"* ☐

39. Enclosures? ☐ Yes ☐ No

40. Is Treatment for Orthodontics? ☐ Yes (Complete 41–42) ☐ No (Skip 41–42)

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

42. Months of Treatment

43. Replacements of Prosthesis ☐ Yes (Complete 44) ☐ No

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

45. Treatment Resulting from: ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

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

47. Auto Accident State

(Continued on page 3)

BILLING DENTIST OR DENTAL ENTITY
(leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION

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 _____
Treating Dentist Signature Date

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID