

How to Complete a Foreign Claim Form

The dental claim form is designed to capture the information that is essential for an accurate claim processing. Please complete this claim form in English to ensure a prompt processing of your claim.

All claims must be printed or typed to ensure accuracy. When submitting your claim you must let Northeast Delta Dental know if the claim was paid in U.S. currency. If the claim is submitted in non U.S. currency, the currency submitted will be translated to U.S. currency as of the date of service.

Please follow these instructions when completing the Northeast Delta Dental claim form:

Box 1: Please check one; Statement of actual service (service performed) or request for Predetermination (service that will be performed)

Box 2: Complete this area when you previously submitted a Predetermination and you are submitting the claim in for processing. Please provide us with the predetermination number that you were given.

Box 3: Please fill out your insurance carrier information.

Example: Northeast Delta Dental
PO Box 2002
Concord N.H. 03302

Other Coverage

Boxes 4-11 are to be filled out if there is another dental carrier involved. For Oral Surgery claims (extractions) please provide us with your medical carrier information and your effective date with them.

Primary Insured Information

Box 12: Please fill out your complete address and provide us with a daytime telephone number or email address where you can be reached.

Boxes 13-17 are to be filled out with the **primary** subscriber information, please refer to your dental card.

Patient information

Box 18: Please indicate the patient's relationship to the primary subscriber.

Box 19: Please indicate if the patient is a fulltime student (if applicable).

Box 20: Please provide patients first and last name and complete address.

Box 21: Please provide patients date of birth.

Box 22: Please provide patients gender.

Box 23: Please provide subscriber identification number (same as box15).

Record of Services Provided

Box 24: Please provide date of service in which services were rendered and please list the date in the month, date and year order.

Box 25: No information needed.

Box 26: If you are submitting for a denture, please indicate upper or lower, or if you're submitting for periodontal procedures please indicate the quadrant: UL is Upper Left, LL is Lower Left, LR is Lower Right, and UR is Upper Right section of the mouth.

Box 27: Write in the tooth number (adult teeth) or letter (baby teeth) involved in the procedure.

We will not process your claim without the tooth number or letter.

Box 28: List the tooth surface(s) in the space provided. Tooth surfaces to be used when describing posterior teeth (back) are mesial, distal, occlusal, lingual, or buccal. Tooth surfaces to be used when describing anterior (front) teeth are mesial, distal, occlusal, lingual or facial. Please ask your dentist to help you with this section. You may place more than one surface into the box and abbreviate the surface name by using the first letter of the surface. **We will not process any claims submitted without surfaces.**

Box 29: Please add the American Dental Association procedure code. If you are unsure add notes to use box 30.

Box 30: Please provide us with a description of the procedure.

Examples: root canal, extraction, implant, crown, bridge, white filling, silver filling.

Box 31-33: Please list the fee for the procedure and the currency you paid the dentist with.

Box 34: Please indicate in this area if you had any teeth extracted by putting an "X" on the missing teeth.

Box 35: Please indicate any remarks you want to tell us pertaining to the procedures on the claim form.

Authorization-Patient's Signature

Box 36: Endorse this box in the space provided, with the patient or guardian signature (if the patient is a minor).

Box 37: Do not complete for foreign claims as all benefit payments will be sent to the subscriber for foreign claims.

Boxes 38: Please indicate where treatment took place.

Boxes 39: Please indicate if you are enclosing x-rays.

Boxes 40-42: Complete these boxes for orthodontic claim.

Box 43: Please indicate if this is a prosthesis being replaced (example: bridge, crown, and denture).

Box 44: If a bridge, denture or crown is being replaced please indicate the year that it was originally completed.

Boxes 45-47: Please indicate if treatment was done due to an injury/accident.

Boxes 48-52: Please leave blank if the office is not submitting the claim form for you.

Dentist's Signature

Boxes 53-58: The dentist should sign the claim form in the space provided, or you must have permission from the dentist to place his/her name in the signature space. If you do not have his/her permission please leave this space blank.

Please mail a copy of the claim form with itemized bills and receipts. We will be unable to process any claims without an itemized bill or receipts. Please mail claims to:

Northeast Delta Dental
PO Box 2002
Concord N.H. 03302

Please feel free to contact Customer Service at 1-800-832-5700 or CustomerService@nedelta.com, with any questions or concerns you may have regarding your claim submission.