



## International Emergency and Expatriate Dental Program

# Instructions for Dentists

### **PROGRAM OUTLINE**

We want to ensure you have the information you need to assist our members. Members of Delta Dental of North Carolina, managed by DeCare Dental, have enrolled in either the International Dental Emergency Services Program or the Expatriate Dental Benefits Program and are eligible to receive coverage for dental care, as per their dental benefit plan.

Members have been instructed to visit participating dentists to receive appropriate dental care. Members find a participating dentist by either visiting their dental benefit plan's Web site or calling our international customer service team.

### **WHAT DENTISTS CAN EXPECT**

As a dentist participating in the Delta Dental of North Carolina international program, you may see patients belonging to one of the many dental benefit brands we manage. Patients enrolled in the International Emergency program may visit you for urgent, emergency dental treatment needs. Patients enrolled in the Expatriate Dental Program may visit you for more routine dental care.

### **PATIENT PAYS YOU DIRECTLY**

In all instances, **the patient is responsible for paying you in full at the time services are rendered** or upon receipt of your invoice or bill. Any payment arrangement you have with your patient regarding individual billing is between you and the patient; this includes immediate deferred or installment payments.

### **COMPLETION OF CLAIM FORM**

You may complete or assist your patient in completing the dental claim form. For your convenience, we have included detailed instructions on **How to Complete the Claim Form**. In addition, you also may call our international customer service center in the Republic of Ireland at + 353-94-9372257. Customer Service staff are available between the hours of 0830 and 1700 Greenwich Mean Time (GMT), Monday through Friday, for assistance in completing the claim form.

In addition to the completed claim form, the patient will also require an invoice detailing all treatment services received during their visit. The patient must submit (you may submit it on behalf of the patient as well) the completed claim form and detailed invoice to receive reimbursement. Please note, all International Emergency program claims are submitted to our U.S. office. All Expatriate Dental Program claims are submitted to our offices in the Republic of Ireland.

### **PATIENT REIMBURSED DIRECTLY BY DENTAL CARRIER**

The patient will receive reimbursement for services, per their plan, from their specific dental carrier.

## How to Identify a Patient Belonging to the International Emergency Dental Program

Please remove the card below, fold in half and carry it with you whenever you travel outside the United States. DDMN.004.015

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<p><b>COVERED SERVICES</b></p> <p>Only emergency treatment is a covered service under this plan.</p> <p>Emergency treatment is defined as dental services:</p> <ul style="list-style-type: none"> <li>• to treat or control acute infections;</li> <li>• to treat injuries to, or trauma of the teeth and/or supporting structures.</li> </ul> <p>The following are considered dental injuries or trauma: enamel fracture, crown fracture, root fracture, crown-root fracture, laceration, avulsion, or fracture of the alveolar process (maxillary or mandible).</p> <ul style="list-style-type: none"> <li>• to relieve acute pain (not chronic pain or continuing undiagnosed pain) with palliative measures;</li> <li>• to identify the source of pain, the extent of trauma or the source of infection (diagnostic services);</li> <li>• to determine the extent of a dental emergency via examination.</li> </ul>	<p style="text-align: center;">DELTA DENTAL OF MINNESOTA</p> <p>The following are not considered emergency treatment services:</p> <ul style="list-style-type: none"> <li>• Periodic examinations</li> <li>• Prescriptive dental services (dental prophylaxis, topical fluoride treatment, sealant to, space main treatment)</li> <li>• Restorative dental services in the absence of pain, trauma, or acute infection</li> <li>• Major restorative dental services in the absence of pain, trauma, or acute infection</li> <li>• Periodontics                      • Prosthodontics</li> <li>• Implants                            • Orthodontics</li> </ul>	<p><b>LOCATE AN INTERNATIONAL DENTIST</b></p> <p>Remember: This number is NOT toll-free. If you are using an international calling card, please follow the card's specific instructions first.</p> <p><b>STEP 1:</b> Are you in a hotel, office building or other location that requires you to dial a specific number to "dial out"? If so, do this first.</p> <p><b>STEP 2:</b> To make an appointment for emergency dental treatment, dial the outbound calling code for the country you are in (for example, Switzerland is 01) plus <b>353-94-9372257</b> if calling from Ireland, dial <b>0-94-9372257</b></p> <p style="text-align: center;"><b>CLAIM INQUIRIES ONLY (IN THE USA) 1-800-553-5536</b></p>
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## How to Identify a Patient Belonging to the Expatriate Program

<b>EXPATRIATE DENTAL PROGRAM</b>	<LOGO>
<b>GROUP NAME</b> ABC COMPANY	
<i>NAME</i> JOHN SMITH	<i>SUBSCRIBER ID</i> ABC123456
<Web address of carrier>	

<p><b>Member Services</b></p> <p>Telephone Numbers +353- 94-9372257 (outside Ireland) 0-94-9372257 (inside Ireland) 0830 to 1700 GMT Monday through Friday Facsimile number +353-94-9362685 (outside Ireland) 0-94-9362685 (inside Ireland)</p>	<p><b>Claims Submission Address</b></p> <p>DeCare International Industrial Estate Claremorris Mayo, Ireland E-mail Address: XXX@XXX.XXX</p>
<p><i>Call our customer service representatives to locate a dentist, determine coverage or inquire about a claim</i></p>	

## How to Complete the Claim Form

The dental claim form is designed to capture the information that is essential for an accurate payment. Please complete this form in English to ensure prompt payment. All claims should either be printed or typed to ensure accuracy and ease of administration. You may submit this claim in local or U.S. currency. If a claim is submitted with a non-U.S. currency, the currency submitted will be translated to U.S. currency as of the date of service using the Web site [www.OANDA.com/converter/classic](http://www.OANDA.com/converter/classic) as the source.

### Section A. General Information

- Item 1.) Use this box only if you are a member who resides in the United States, was traveling abroad and received emergency dental care while outside of the United States.
- Item 2.) Use this box only if you are a member who is enrolled in the Expatriate Dental Program, lives outside of the United States and received any dental care, including emergency care.

### Section B. Employee and Patient Information

The employee and/or patient should complete the information in this section. This will ensure that the information is accurate for proper dental plan eligibility determination.

#### Follow the complete instructions for each numbered item in this section. Print or type the following information:

- Item 1.) The name of the country where services are given
- Item 2.) The name of the employer providing the dental benefit coverage
- Item 3.) The name of the patient receiving the services identified on this claim
- Item 4.) The U.S. Identification Number of the patient receiving services
- Item 5.) The date of birth, in month-day-year format, for the patient receiving services
- Item 6.) The local Identification Number of the patient receiving services
- Item 7.) Place a checkmark in this box if the patient is a full-time student
- Item 8.) The name of the employee who is employed by the employer providing the dental benefits coverage
- Item 9.) The U.S. Identification Number of the employee identified in Item 8
- Item 10.) The date of birth, in month-day-year format, for the employee identified in Item 8
- Item 11.) The local Identification Number of the employee identified in Item 8
- Item 12.) The reason treatment is being performed (for example to diagnose, provide preventive care, emergency treatment, restoration)
- Item 13 – 17.) The mailing address of the employee including street, city, state/province, country and postal/ZIP code
- Item 18.) The home telephone number of the employee identified in Item 8
- Item 19.) The work telephone number of the employee identified in Item 8
- Item 20.) The facsimile number of the employee identified in Item 8, if available
- Item 21.) The e-mail address of the employee identified in Item 8, if available

### Section C. Dentist Information

The dentist or dental office personnel should complete this section. Follow the complete instructions for each numbered item in this section.

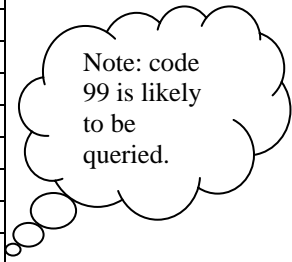
#### Print or type the following information:

- Item 22.) The dentist's complete name and title
- Item 23 – 27.) The mailing address of the dentist's surgery or practice. This includes street, city, state/province, country and postal code/ZIP code
- Item 28.) The telephone number of the dentist's surgery or practice, including country and city code

**Section D. Description of Services, Item 29.**

- Print the name of the service in the space provided for “Service Rendered.” List only one service per line on the claim form. This section is for non-emergency dental care services.
- Depending on the service provided, please use the following codes in the space provided for “Code.” Place the two-digit code in the space provided under the heading “Code.” List only one code per line.

Service Type	Code
Preventive Service	19
Diagnostic Service or Examination	09
Restorative Service (amalgams)	28
Major Restorative Service (crowns, inlays, onlays)	29
Endodontic	39
Periodontics	49
Prosthodontics, removable	58
Maxillofacial Prosthetics	59
Implant Services	60
Prosthodontics	69
Simple Extractions	78
Oral Surgery	79
Orthodontics	88
Miscellaneous	99 **



- Identify the date the service was rendered and place the date in the space provided by listing the month, day and year.
- List the tooth number in the space provided for “Tooth Number.” Use the tooth numbering system of the country where services are provided.
- List the tooth surface in the space provided. Tooth surfaces to be used when describing posterior teeth are mesial, distal, occlusal, lingual, or buccal. Tooth surfaces to be used when describing anterior teeth are mesial, distal, occlusal, lingual, or facial. You may place more than one surface per line and abbreviate the surface name by using the first letter of the surface.
- List the fee or the charge to the patient for each dental care service provided in local currency or U.S. dollars. Please indicate the currency type in the space allocated on the claim for “Fee.”

**Section E. Emergency Services, Item 30.**

Check the “Yes” or “No” box if dental services were obtained while traveling outside of the United States. If “Yes” is checked and the dental service(s) were performed to treat a dental emergency, attach the invoice from the dentist to the claim form. Complete the claim form and insert the date the service(s) were performed.

**Patient’s Signature**

In the space provided, the patient or guardian (if the patient is a minor) should sign the bottom of the claim form. If this form is submitted via e-mail, the signature is deemed authorized and present if the patient’s name is typed in the space provided.

**Dentist’s Signature**

The dentist should sign the claim form in the space provided. If either the dentist or the member submits this form via e-mail, the signature is deemed present if the dentist’s name is typed in the space provided. If you are submitting the claim electronically, you must have the dentist’s permission to place his/her name in the signature space. If you do not have his/her authorization, leave this space blank.

**SECTION A. Please mail or fax completed Claim Form with itemized bills and receipts. All Claims must be in English. Fees may be submitted in either local or U.S. currency.**

1.)  I live in the U.S., traveled abroad and this claim is for an emergency. Complete all applicable boxes except number 29.  
 If you checked # 1, the address to submit your claim in the United States is: **International Dental Emergency Program**  
 3560 Delta Dental Drive  
 Eagan, MN 55122-3166

2.)  I live outside of the U.S. and am submitting a claim for dental services under the Expatriate Dental Program. Complete all applicable boxes.  
 If you checked # 2, the address to submit your claim internationally is: **DeCare International** Phone: 0-94-9372257 (in Ireland)  
 Industrial Estate Phone: + 353-94-9372257 (outside Ireland)  
 Claremorris Facsimile: 0-94-9362685 (in Ireland)  
 Mayo, Ireland Facsimile: + 353-94-9362685 (outside Ireland)  
 + Dial your country's outbound calling code (for example, Switzerland is 00) plus 353-94-9372257

Please print or type on this Claim Form.  
 Complete Sections A, B, C and Signature line. Complete a Separate Claim Form for each Family Member.

**SECTION B. EMPLOYEE AND PATIENT INFORMATION**

1.) Country where services were rendered \_\_\_\_\_ 2.) Employer \_\_\_\_\_  
 3.) Patient's name \_\_\_\_\_ 4.) Identification Number: \_\_\_\_\_  
 5.) Patient's Date of Birth \_\_\_\_\_ (month) (day) (year) 6.) Local Identification Number: \_\_\_\_\_  
 7.) If patient is a full-time student, check this box   
 8.) Employee's Name: \_\_\_\_\_ 9.) Identification Number: \_\_\_\_\_  
 10.) Employee's Date of Birth \_\_\_\_\_ (month) (day) (year) 11.) Local Identification Number: \_\_\_\_\_  
 12.) Reason for treatment \_\_\_\_\_  
 Employee's Mailing Address  
 13.) \_\_\_\_\_ (Street) 14.) \_\_\_\_\_ (City) 15.) \_\_\_\_\_ (State/Province) 16.) \_\_\_\_\_ (Country)  
 17.) \_\_\_\_\_ (Postal Code/Zip Code)  
 Please provide the Employee's telephone and facsimile numbers, with country and city codes.  
 18.) \_\_\_\_\_ (Home Number) 19.) \_\_\_\_\_ (Work Number) 20.) \_\_\_\_\_ (Fax Number) 21.) \_\_\_\_\_ (E-mail Address)

**SECTION C. DENTIST INFORMATION.**

22.) \_\_\_\_\_ (Dentist Name) 23.) \_\_\_\_\_ (Surgery/Practice Street)  
 24.) \_\_\_\_\_ (City) 25.) \_\_\_\_\_ (State/Province) 26.) \_\_\_\_\_ (Country)  
 27.) \_\_\_\_\_ (Postal Code/Zip Code) 28.) ± \_\_\_\_\_ (Telephone Number - Include country and city code)

**29.) SECTION D. DESCRIPTION OF SERVICES (Please retain X-rays and keep records, including Clinical Narrative for future reference)**

Service Rendered	Code **	Date of Service (mm/dd/yy)	Tooth #	Surface (mesial/distal/occlusal/lingual/buccal/facial)	Fee (Identify currency) (Inclusive of tax, if any)
	00				
	00				
	00				
	00				
	00				

\*\* Note 99 in this area is likely to be queried.

**SECTION E.**  
 30.) **Emergency Services**  Yes  No  
 For emergency claim, attach invoice from dentist and insert date of service here \_\_\_\_\_ (Date)

**PATIENT'S SIGNATURE AND RELEASE: (Parent or Guardian, if claim is for a minor). I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine benefits payable.**  
 31.) **PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 32.) **DENTIST'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Electronic dispatch of this form will be deemed to be a signature.



## Claim Form Mailing Instructions

### Emergency Claims

If your patient lives in the United States, traveled abroad, received emergency dental services and you are completing the invoice/claim for them and are mailing it on their behalf, please submit the claim form to the following mailing address or return the completed claim form to your patient for them to mail.

#### Address to Submit Emergency Dental Claims

International Dental Emergency Program  
3560 Delta Dental Drive  
Eagan, MN 55122-3166

### Expatriate Dental Program Claims

If your patient is a member of the Expatriate Dental Program and received dental care while living and working abroad, and you are completing the invoice/claim for them and are mailing it on their behalf, please submit the claim form to the following mailing address:

#### Address to Submit Expatriate Dental Claims

DeCare International  
Industrial Estate  
Claremorris  
Mayo  
Ireland

Facsimile: within Ireland 0-94-9362685  
Outside of Ireland + 353-94-9362685

E-mail address: [expatriate@deltadentalnc.org](mailto:expatriate@deltadentalnc.org)

### International Telephone Numbers and Instructions For Dental Claims Inquiry or Questions

**When calling within Ireland: 0-94-9372257**

**When calling outside of Ireland: Contact your international operator and  
Request: + 353-94-9372257**

**Hours for Claim query: 0830 – 1700 GMT  
Monday through Friday**

**Facsimile: within Ireland 0-94-9362685  
Outside of Ireland + 353-94-9362685**

- **What if I have a question about how to complete the claim form?**  
Call the International Customer Service number with any questions you have, Monday through Friday, 0830 through 1700 Greenwich Mean Time (GMT) at + 353-94-9372257 (outside of Ireland) or 0-94-9372257 (within Ireland).
- **How do I get paid for dental treatment services?**  
In all instances, the patient is responsible for paying you in full at the time services are rendered or upon receipt of your invoice or bill. Any payment arrangement you have with your patient regarding individual billing is between you and the patient; this includes immediate deferred or installment payments.
- **Do I need to provide a detailed invoice to my patient?**  
Yes, the patient will require an invoice detailing all treatment services received during their visit. The patient must submit (you may submit it on behalf of the patient as well) the completed claim form and detailed invoice in order to receive reimbursement.
- **May the patients covered under these programs refer non-covered family members or friends to my dental practice?**  
Yes, the members of this program may refer family members and friends to your practice, but there is no plan benefit coverage for the non-covered members who are referred.
- **How long will it take my patients to receive payment from their carrier?**  
Patients will receive payment from their carrier within thirty (30) days of receipt of the claim form. The check will be made payable to the patient.
- **What added value is there in being a dentist participating in this program?**  
Your name is listed in the member's program information, which may provide your practice with additional patients and referral sources. The program is uniformly administered and easy to work with, making it easy to submit claims on behalf of your patients.
- **Will I be able to submit the claim form via email?**  
Yes, you may access an electronic claim form by e-mailing a request to [expatriate@deltadentalnc.org](mailto:expatriate@deltadentalnc.org). We will forward a claim to you via e-mail. Retrieve and complete the electronic claim form. Attach the completed claim form to an e-mail and submit to [expatriate@deltadentalnc.org](mailto:expatriate@deltadentalnc.org).
- **How are signatures submitted electronically?**  
When either a member or a dentist submits an electronic claim form and the names are typed into the appropriate space(s), it is deemed to be signed by that person when the form is transmitted via e-mail. Type in only the name(s) for which you have an authorization to sign the claim form.
- **Is there a website with an electronic claim form?**  
Yes, Delta Dental has an electronic claim form on its website at <http://www.deltadentalnc.org> and click on the link for International Dental Program.
- **Where do I call if I have questions about my Delta Dental arrangement?**  
Call + 353-94-9372257 (Outside of Ireland) or 0-94-9372257 (Within Ireland).