HealthPlan OF SAN MATEO
HPSM Dental

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080
tel 650.616.0050
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1
www.hpsm.org

September 9, 2024

Orthodontics No Longer Require Prior Authorization

Dear HPSM Dental providers,

**Effective September 1, 2024, prior authorization will no longer be required for orthodontic services for HPSM Dental members. These codes will no longer require prior authorization:**

| Code | Description |
|---|---|
| D8080 | comprehensive ortho |
| D8210 | removable appliance therapy |
| D8220 | fixed appliance therapy |
| D8660 | pre-ortho visit |
| D8670 | periodic ortho treatment visit |
| D8680 | orthodontic retention (removal of appliances, construction and placement of retainers) |
| D8999 | unspecified orthodontic procedure |

*Please see page two for additional things to consider.*

HPSM Dental

**Orthodontists are the only providers that can initiate and supervise an orthodontic case. Things to consider on the dental claims form:**

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE (Mark 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/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ 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/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

| | 24. Procedure Date (MM/DD/CCYY) | 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 | | | | | | | | | | |
| 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-10 = AB )
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. Total Fee

35. Remarks

AUTHORIZATIONS

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 (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

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

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

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 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. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

©2019 American Dental Association
J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

1. For claims to not require prior authorization, the Handicapping Labio-Lingual Deviations (HLD) score must be 21 or above, and/or meet one of the automatic qualifying options listed on the California Medi-Cal Dental HLD form. Providers can either attach the HLD score sheet **or type it into "35. Remarks" field of the ADA Dental Claim Form, as noted in the example to the left in red.**

2. If a case does not meet the HLD handicapping score of 21 or above or meet one of the automatic qualifying conditions, and the treating orthodontist would like to request a review from the Dental Director, please email or call the Dental Benefits Manager at **dental@hpsm.org**.

3. HPSM Dental allows for orthodontic screening for members aged seven (7) years to 21 years old without prior authorization.

Please direct questions to HPSM Dental Provider Services at **dental@hpsm.org**.

Thank you,

The Health Plan of San Mateo