CLAIM INQUIRY FORM

IMPORTANT:

- Allow one month for the status of the document to appear on your Explanation of Benefits (EOB) or Remittance Advice (RA)
- Type or print all information clearly
- Use an envelope for your x-ray and attach to this form
- For clarification, please call the Provider Call Center at: STAR Health 866-287-3252, STAR+PLUS & Superior STAR-Pregnant Women 866-512-8274, Advantage by Superior 866-512-8305

DELTA DENTAL®

Delta Dental of California
State Government Programs
P.O. Box 537030
Sacramento, CA 95853-7030

Billing Provider Name (last, first, MI)	Provider ID Number	NPI Number	TPI Number

Service Office Address	Telephone Number

City	State	ZIP

USE THIS FORM FOR ONE CLAIM/TAR ONLY

Patient Name (last, first, MI)		Document Control Number (necessary for re-evaluation)	
Patient Identification Number	Patient Dental Record Number	Patient Group Number	Date Billed

INQUIRY REASON – CHECK ONLY ONE BOX

CLAIM / TAR TRACER ONLY

Please advice status of:

☐ Claim for payment. Attach a copy of form.
Date of Service _____

☐ Treatment Authorization Request (TAR). Attach a copy of the form.

CLAIM RE-EVALUATION ONLY

☐ Please re-evaluate modification/denial of claim for payment. I have attached all necessary x-rays and/or documentation.

REMARKS (Corrections or Additional information)

This is to certify that the information contained above and any attachments provided is true, accurate, and complete and that the provider has read, understands, and agrees to be bound and comply with the statements and conditional contained on the back of this form.

Signature Date

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

FOR INTERNAL USE ONLY

Operator ID _____

Action Code _____

IMPORTANT

AUTHORIZATIONS AND PAYMENTS

The services listed on this form have been personally provided to the patient by the provider or, under his or her direction, by another person authorized under the Delta Dental State Government Programs (DDSGP) Contracting Provider Agreement to provide such services, and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, necessary to the health of the patient. The provider understands that payment for services rendered will be made from Federal and/or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and/or State laws. The provider agrees to keep for a minimum of (10) ten years, from the date of service, all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any other information regarding payments claimed for providing the service, on request, to Delta Dental State Government Programs (DDSGP), the Texas Health and Human Services Commission (HHSC), Texas State Auditor's Office ("SAO") or any successor agency; Office of Inspector General and/or the Texas Medicaid Fraud Control Unit; and the U.S. Department of Health and Human Services or their duly authorized representatives.

Delta Dental shall pay Dentist for Covered Dental Services provided to Enrollees in accordance with the fees specified by Program. A State Government Programs Dentist may not charge or collect any fee from a State Government Programs enrollee, or from any persons acting on behalf of the enrollee, for any dental service covered by State Government Programs. Neither Enrollees nor the State of Texas shall be liable to the provider for any sums owed by DDSGP. This prohibition shall not apply to co-payments, third party collections, non-covered dental services, services in excess of program maximums or optional treatments.

Dental care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability, marital status, or sexual orientation.