New York State Dental Plan Dual Coverage Process

New York State Dental Plan (NYSDP) members who have dual coverage with NYSDP (primary coverage under one NYSDP policy and secondary coverage under another NYSDP policy) no longer need to submit two separate claims to Anthem. Members and providers must complete the secondary NYSDP policy information fields on the primary NYSDP claim form; Anthem's claim system will automatically process both primary and secondary NYSDP policies.*

Claim Form Completion:

- For paper claims submitted under the primary NYSDP policy, the highlighted fields below must be completed with the secondary NYSDP policy information for proper coordination of benefits:

Attending Dentist Statement

Check one: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services				Anthem Dental P O BOX 1482 Minneapolis. MN 55440-1482		
PATIENT INFORMATION	Patient Name First M.I. Last	Relationship to Employee ☐ Self ☐ Child ☐ Spouse ☐ Other	Sex M | F | U	Patient Birthdate (MM|DD|CCYY)	Full-Time Student ☐ Yes ☐ No School Name: City:	
	Employee/subscriber name and mailing address	Employee/Subscriber ID or Soc Sec #	Employee/Subscriber Birthdate (MM|DD|CCYY)	Employer (Company) Name and Address	Group/Subgroup #	
	Is patent covered by another dental plan? ☐ Yes ☐ No If yes, complete Is patent covered by a medical plan? ☐ Yes ☐ No	Name and Address of Carrier(s)	Group/Subgroup Number(s)	Name and Address of other Employer(s)		
	Employee/Subscriber Name (if different than patient's)	Employee/Subscriber ID or Soc Sec #	Employee/Subscriber Birthdate (MM|DD|CCYY)	Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other _____		
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. ➔ _____ _____ Signed (Patient or Parent, if minor) Date			I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation. ➔ _____ _____ Signed (Insured Person) Date		

- For electronic claims submitted under the primary NYSDP policy by your provider, the same fields must be completed with secondary NYSDP policy information. Work with your provider to make sure these fields are completed in any electronic claim submissions. Anthem has provided educational materials with this information to provider offices.

*This change does not apply to members with other non-NYSDP policies.

If you or your provider have any questions, please call the dedicated Anthem New York State Dental Plan toll-free number at 1-833-821-1949.