DENTAL FAX REQUEST FORM

Visit MyDentalCoverage.com/dentists for 24/7 access to your patient's information!

Date: ____________________

To: **HMSA DENTAL SERVICES** Phone: (808) 948-6440 Fax: (808) 538-8966

From: ______________________________ Phone: ______________ Fax: ____________________

Provider's Name: ______________________________ Provider's Tax ID: ______________________________

Subscriber's ID Number: ______________________ Patient's Name: ______________________________

Subscriber's Name: ______________________ Patient's Date of Birth: ______________________________

Please indicate the information you require on your patient by marking the boxes on the left column. The information will be faxed to the number indicated above within one hour per request. Dental Fax Request Forms received after 3 pm will be faxed back the following business day.

Please note that the information provided is based on the data in our system as of the date/time research is done. Payments are based on plan benefits and eligibility of the member at the time services are rendered. This information does not guarantee payment for services.

Note: For patients with dual HMSA membership, please submit two forms for verification.

Date information completed by HMSA Dental Services*: ______________________ *[TO BE COMPLETED BY HMSA DENTAL]*

⬇	**GENERAL INFORMATION**	***TO BE COMPLETED BY HMSA DENTAL SERVICES:***
☐	Plan Coverage Code	
☐	Coverage Effective Date for subscriber ID listed above	
☐	Prior Continuous HMSA Coverage for Effective Date	
☐	Plan Maximum Per Year	
☐	YTD Benefits Used	
☐	Rollover Balance, if applicable	
☐	Dollar Amount of Plan Deductibles (if any)	
☐	Qualify for Enhanced Dental Benefits	☐ Yes ☐ No

	SERVICE HISTORY	***TO BE COMPLETED BY HMSA DENTAL SERVICES:***
☐	Date of last Exam(s) in current year	
☐	Date of last Prophylaxis in current year	
☐	Date of last FMX	
☐	Date of last Pano	
☐	Date of last Bitewing(s) in current year	
☐	Date of last Fluoride *(for patients under age 19)*	
☐	Date of last Crown - Tooth number:__________	
☐	Date of last Bridge - Tooth number:__________	
☐	Date of last Denture ☐ U ☐ L	
☐	Date of last Periodontic Procedure ☐ UR ☐ LR ☐ UL ☐ LL	

As of the date* listed above, our records indicate:

☐ Subscriber ID has been cancelled as of: ______________________

☐ Active coverage under subscriber ID: ______________________ Cov code: __________ Eff Date: ____________________

☐ No active HMSA dental coverage.

HMSA DENTAL SERVICES USE ONLY: **TIME IN:** ____________________ **TIME OUT:** ____________________

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