DELTA DENTAL®

Please keep a photocopy of this form for your records and return original form to:
ATTN: Provider Services Dept.
Northeast Delta Dental
One Delta Drive, PO Box 2002
Concord, NH 03302-2002
Phone: 603-223-1100
Fax: 603-223-1033

IMPORTANT—Please Read: In the course of your practice, if you render (or may render) any of the listed procedures on the enclosed Fee Survey Form, it is necessary that you file a fee for such a procedure.

NOTE: All dentists in the office utilizing these fees must sign the form. Please copy this form for your records before returning it to Northeast Delta Dental. New fees are not effective until confirmed by Northeast Delta Dental.

Northeast Delta Dental Fee Survey Form
(Endodontists Only)

CONFIDENTIAL
Participating Dentist's Agreement

This fee profile represents my usual fees, as charged to my patients.

I will verify fees listed below by permitting inspection of my records upon request by a representative of Northeast Delta Dental. In the event Delta Dental finds that my fees listed below do not comply with the usual fees charged to my patients, I agree to adjust my filed fee.

I agree that I shall not charge a patient the amount of the Delta Dental withhold, if any, and that portion of my fee which may be in excess of the maximum fee allowed by Delta Dental.

I further agree that I will accept direct payment from Delta Dental and that I will not seek any additional compensation at the time of service from the covered subscriber/dependent other than appropriate co-payments or other stated obligations under the patient's group program, i.e., non-covered services and deductibles.

If I increase my fees to all of my patients, I understand that I may resubmit my listing of fees.

I understand that my participation and fee listing extend to subscribers/ dependents covered under Delta Dental's fee for service national account programs, including but not limited to, DeltaUSA and multi-state programs.

1. I continue to hold an active, valid license to practice in all states in which I provide services. Agree ____ Disagree ____
2. I continue to carry malpractice insurance. Agree ____ Disagree ____
3. I continue to have no state or local licensing board actions currently restricting or affecting my license. Agree ____ Disagree ____
4. My office continues to meet the infection control standards of the Centers for Disease Control and Prevention. Agree ____ Disagree ____
5. I have not been involved in any malpractice suits, claims, or settlements within the last ten years. Agree ____ Disagree ____

(If you disagree with any statements above, please provide complete details on a separate sheet.)

My signature below certifies my acceptance of these terms. My responses to the statements above are true to the best of my knowledge. **If I have not marked any responses above, my signature further certifies that my responses to all five statements are in agreement.**

X
DENTIST'S SIGNATURE (no signature stamps)

License Number Type 1 (Treating Dentist) National Provider ID #

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License Number Type 1 (Treating Dentist) National Provider ID #

Street Address City State Zip Code

Tax Identification Number Telephone Number E-Mail Address

Business Name *(please print)* : _____ Date: _____

Type 2 (Billing Entity) National Provider ID # : _____

DIAGNOSTIC D0100-D0999

D0120	Periodic oral evaluation	$ . . . . .
D0140	Limited oral evaluation-problem focused (not to be reported with treatment)	$ . . . . .
D0150	Comprehensive oral evaluation	$ . . . . .
D0160	Detailed and extensive oral evaluation - problem focused, by report	$ . . . . .
D0170	Re-evaluation-limited, problem-focused (established patient, not postoperative) visit	$ . . . . .
D0220	Intraoral-periapical first film	$ . . . . .
D0230	Intraoral-periapical each additional film	$ . . . . .
D0240	Intraoral-occlusal film	$ . . . . .
D0250	Extraoral-first film	$ . . . . .
D0260	Extraoral-each additional film	$ . . . . .
D0350	Oral/facial photographic images	$ . . . . .
D0360	Cone beam CT	$ . . . . .
D0362	Cone beam CT-two-dimensional	$ . . . . .
D0363	Cone beam CT-three-dimensional	$ . . . . .
D0415	Collection of microorganisms for culture and sensitivity	$ . . . . .
D0460	Pulp vitality tests	$ . . . . .
D0472	Accession of tissue, gross examination	$ . . . . .
D0473	Accession of tissue, gross and microscopic examination	$ . . . . .
D0474	Accession of tissue, assessment of surgical margins	$ . . . . .
D0477	Special stains not for micro-organisms	$ . . . . .
D0478	Immunohistochemical stains	$ . . . . .
D0484	Consultation on slides prepared elsewhere	$ . . . . .
D0486	Accession of transepithelial cytologic sample	$ . . . . .

RESTORATIVE D2000-D2999

D2952	Post and core in addition to crown, indirectly fabricated	$ . . . . .
D2953	Each additional indirectly fabricated post - same tooth	$ . . . . .
D2954	Prefabricated post and core in addition to crown	$ . . . . .
D2955	Post removal (not in conjunction with endodontic therapy)	$ . . . . .
D2957	Each additional prefabricated post - same tooth	$ . . . . .

ENDODONTICS D3000-D3999

D3110	Pulp cap-direct (excluding final restoration)	$ . . . . .
D3120	Pulp cap-indirect (excluding final restoration)	$ . . . . .
D3220	Therapeutic pulpotomy (excluding final restoration)	$ . . . . .
D3221	Pulpal debridement, primary and permanent teeth	$ . . . . .
D3222	Partial pulpotomy for apexogenesis - permanent tooth	$ . . . . .
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$ . . . . .
D3240	Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration)	$ . . . . .
D3310	Endodontic therapy - anterior (excluding final restoration)	$ . . . . .
D3320	Endodontic therapy - bicuspid (excluding final restoration)	$ . . . . .
D3330	Endodontic therapy - molar (excluding final restoration)	$ . . . . .
D3331	Treatment of root canal obstruction, non-surgical access	$ . . . . .
D3332	Incomplete endodontic therapy	$ . . . . .
D3333	Internal root repair of perforation defects	$ . . . . .
D3346	Retreatment of previous root canal therapy - anterior	$ . . . . .
D3347	Retreatment of previous root canal therapy - bicuspid	$ . . . . .
D3348	Retreatment of previous root canal therapy - molar	$ . . . . .
D3351	Apexification/recalcification/ pulpal regeneration - initial visit	$ . . . . .
D3352	Apexification/recalcification/ pulpal regeneration - interim medication replacement	$ . . . . .
D3353	Apexification/recalcification- final visit	$ . . . . .
D3410	Apicoectomy/periradicular surgery- anterior	$ . . . . .
D3421	Apicoectomy/periradicular surgery- bicuspid (first root)	$ . . . . .
D3425	Apicoectomy/periradicular surgery- molar (first root)	$ . . . . .
D3426	Apicoectomy/periradicular surgery (each additional root)	$ . . . . .
D3430	Retrograde filling-per root	$ . . . . .
D3450	Root amputation-per root	$ . . . . .
D3910	Surgical procedure for isolation of tooth with rubber dam	$ . . . . .

D3920 Hemisection (including any root removal), not including root canal therapy $ . . . . . .
D3950 Canal preparation and fitting of preformed dowel or post $ . . . . . .

PERIODONTICS D4000-D4999

D4230 Anatomical crown exposure, four or more teeth per quadrant $ . . . . . .
D4231 Anatomical crown exposure, one to three teeth per quadrant $ . . . . . .
D4320 Provisional splinting-intracoronal $ . . . . . .
D4321 Provisional splinting-extracoronal $ . . . . . .

PROSTHODONTICS, FIXED D6200-D6999

D6970 Post and core in addition to fixed partial denture, indirectly fabricated $ . . . . . .
D6972 Prefabricated post and core in addition to fixed partial denture $ . . . . . .
D6976 Each additional indirectly fabricated post $ . . . . . .
D6977 Each additional prefabricated post $ . . . . . .

ORAL AND MAXILLOFACIAL SURGERY D7000-D7999

D7288 Brush biopsy - transepithelial sample collection $ . . . . . .
D7410 Excision of benign lesion up to 1.25 cm $ . . . . . .
D7450 Removal of odontogenic cyst or tumor up to 1.25 cm $ . . . . . .
D7460 Removal of nonodontogenic cyst or tumor up to 1.25 cm $ . . . . . .
D7510 Incision and drainage of abscess-intraoral soft tissue $ . . . . . .
D7511 Incision and drainage of abscess-intraoral soft tissue - complicated $ . . . . . .
D7520 Incision and drainage of abscess-extraoral soft tissue $ . . . . . .
D7521 Incision and drainage of abscess-extraoral soft tissue - complicated $ . . . . . .
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue $ . . . . . .
D7540 Removal of reaction producing foreign bodies, musculoskeletal system $ . . . . . .
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body $ . . . . . .
D7910 Suture of recent small wounds up to 5 cm $ . . . . . .
D7911 Complicated suture up to 5 cm $ . . . . . .
D7912 Complicated suture greater than 5 cm $ . . . . . .
D7998 Placement of fixation device not in conjunction with a fracture $ . . . . . .

ADJUNCTIVE GENERAL SERVICES D9000-D9999

D9110 Palliative (emergency) treatment of dental pain-minor procedure $ . . . . . .
D9210 Local anesthesia not in conjunction with operative or surgical procedures $ . . . . . .
D9230 Inhalation of nitrous oxide/ analgesia, anxiolysis $ . . . . . .
D9241 Intravenous sedation/analgesia-first 30 minutes $ . . . . . .
D9242 Intravenous sedation/analgesia-each additional 15 minutes $ . . . . . .
D9248 Non-intravenous conscious sedation $ . . . . . .
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician $ . . . . . .
D9420 Hospital or ambulatory surgical center call $ . . . . . .
D9430 Office visit for observation (during regularly scheduled hours)-no other services performed $ . . . . . .
D9440 Office visit-after regularly scheduled hours $ . . . . . .
D9450 Case presentation $ . . . . . .
D9610 Therapeutic parenteral drug, single administration $ . . . . . .
D9612 Therapeutic parenteral drug, two or more administrations $ . . . . . .
D9920 Behavior management, by report $ . . . . . .
D9930 Treatment of complications (post-surgical)-unusual circumstances, by report $ . . . . . .
D9951 Occlusal adjustment-limited $ . . . . . .
D9974 Internal bleaching-per tooth $ . . . . . .

CURRENT ADA CODES FOR PROCEDURES PERFORMED BUT NOT LISTED

Code	Description	Fee
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____

NORTHEAST DELTA DENTAL FEE SURVEY POLICY

Do not list a range of fees when completing the fee survey; **list only one fee.** The fee listed should be your usual fee charged to all your patients. It should **not** be the highest fee you might charge for that particular procedure. If you should charge a Northeast Delta Dental patient a higher fee than filed, due to special circumstances, individual consideration must be requested.

It is not necessary to complete the entire form unless all fees are being changed. You need only fill in those fees that are being updated. For all procedures left blank, Northeast Delta Dental will continue to use your last filed fee as your usual fee for that procedure. **DO NOT** leave any procedures blank unless your last fee on file represents your current fee.

If you no longer perform a procedure for which you have previously filed a fee, and you no longer wish that fee to remain on file, please mark **"DELETE"** on the fee survey for that procedure.

Current Dental Terminology CDT-2011/2012 Compiled and Edited by the American Dental Association's Council on Dental Benefit Programs.

NOTE: The procedures listed are not necessarily covered benefits for all Northeast Delta Dental patients. Please contact our Customer Service department or call Northeast Delta Dental's automated information system, DentalLink, for benefit information. Predetermination is also strongly recommended. Thank you.