



CLEAR ALIGNER /  
COSMETIC BRACKET  
UPCHARGE

|  
*Free Guide*

THE WYRICK OUTLOOK, INC



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We often get asked how to “upcharge” for clear aligners and cosmetic brackets. The below will outline how to do just that.

1. Check in-network provider agreements. Most in network provider agreements will specifically lay out how to effectively upcharge for cosmetic appliances and/or if this is even allowed.

a. Note: As of January 1, 2020, MetLife and most Delta’s no longer allow for up charging for clear aligners and/or cosmetic brackets.

2. If allowed, the office will want to have this additional charge clearly outlined within the contract, as well as, on the initial claim for using D8999.

ADA American Dental Association® Dental Claim Form

**HEADER INFORMATION**

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

2. Prredetermination/Authorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

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

**POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

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

13. Date of Birth (MM/DD/YYYY) 14. Gender  M  F 15. Policyholder/Subscrber ID (SSN or ID#)

**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/Subscrber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YYYY) 7. Gender  M  F 8. Policyholder/Subscrber ID (SSN or ID#)

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

16. Plan/Group Number 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscrber 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/YYYY) 22. Gender  M  F 23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

24. Procedure Date (MM/DD/YYYY)	25. Area (Code)	26. Teeth (Code)	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Position	29b. Qty.	30. Description	31. Fee
001/01/2019					D8080			Comprehensive Orthodontic treatment of the adolescent dentition Initial Fee = \$1000 Monthly Fee of \$222.22 x 18 months	\$5000
					D8999			Optional Cosmetic Appliances	\$1000

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  I (CD-9 + B, ICD-10 + AB) 31a. Other Fees)

34a. Diagnosis Code(s) A \_\_\_\_\_ C \_\_\_\_\_  
 (Primary diagnosis in "A") B \_\_\_\_\_ D \_\_\_\_\_

32. Total Fee \$0.00

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 Subscrber Signature \_\_\_\_\_ Date \_\_\_\_\_

**BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or Insurance/Subscrber)**

48. Name, Address, City, State, Zip Code

49. NPI \_\_\_\_\_ 50. License Number \_\_\_\_\_ 51. SSN or TIN \_\_\_\_\_

52. Phone Number \_\_\_\_\_ 53. Additional Provider ID \_\_\_\_\_

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment \_\_\_\_\_ (eg. In-office, In-OP Hospital)  
 (See "Place of Service Codes for Professional Claims") 39. Enclosures (Y or N)

40. Is Treatment for Orthodontia?  No (Step 41-42)  Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/YYYY)

42. Months of Treatment \_\_\_\_\_ 43. Replacement of Prosthesis  No  Yes (Complete 44)

44. Date of Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from  
 Occupational Illness/Injury  Auto accident  Other accident

46. Date of Accident (MM/DD/YYYY) 47. Auto Accident State \_\_\_\_\_

**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 \_\_\_\_\_

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 AADA01 (Same as ADA Dental Claim Form - #20, #21, #432, #433, #434)

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