Claims Processing
Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu HI 96813-4196
808-529-9248; Toll-free 800-232-2533 ext 248
Fax 808-529-9366; Toll-free Fax 1-866-590-7988

PROVIDER SERVICE CHANGE AUTHORIZATION

Dentist Full Name:	Provider Number:
Patient's Name:	Subscriber ID:

Regarding Claim Number :

Requesting for a change to HDS records as indicated below:

TYPE OF CHANGE (check all that apply)	**FROM:**	**TO:**
☐ Date of Service (DOS)		
☐ Procedure Code		
☐ Submitted Fee		
☐ Tooth Code		
☐ Tooth Surface(s)		

I agree to allow an HDS representative to review the patient's dental records to confirm the requested change(s). I will submit the patient's treatment record to support this request.

DENTIST SIGNATURE*:	DATE:

*Required for approval of this request.

Please attach a copy of the remittance advice and return all related documents to Hawaii Dental Service, Attention: Claims Processing.