

APR 02 2026

Ange Darnell

REGULATIONS COMPILER

1 PUBLIC PROTECTION CABINET

2 Department of Insurance

3 Division of Health, Life, Managed Care

4 (Amended After Comments)

5 806 KAR 17:595. Dental Benefits Assignment.

6 RELATES TO: KRS 14A.4-010, ~~[KRS]~~ 304.1-050, ~~[KRS]~~ 304.17C-130, ~~[KRS]~~ 304.17C-137

7 STATUTORY AUTHORITY: KRS 304.2-110(1), ~~[KRS]~~ 304.17C-137

8 NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the

9 commissioner to promulgate reasonable administrative regulations necessary for or as an aid to

10 the effectuation of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17C-

11 137(1)(a)1.b. requires insurers to accept dental benefit assignments made by covered persons in

12 writing on a form established by the commissioner in an administrative regulation. KRS

13 304.17C-137 requires the department to promulgate administrative regulations to implement and

14 enforce the provisions of 304.17C-137. This administrative regulation establishes the required

15 dental benefit assignment form.

16 Section 1. Definitions.

17 (1) "Benefit assignment" means written consent of a covered person choosing to allow ~~[for]~~ a
18 dental carrier to pay claim benefit payments directly to a non-participating dental service provider
19 in accordance with KRS 304.17C-137.

20 (2) "Covered person" is defined by KRS 304.17C-130(1).

21 (3) "Dental carrier" is defined by KRS 304.17C-130(3).

1 (4) “Dental services” is defined by KRS 304.17C-130(4).

2 (5) “Non-participating provider” means a dental services provider that has not entered into an
3 agreement with a dental carrier to provide dental services.

4 (6) “Provider” is defined by KRS 304.17C-130(7).

5 Section 2. Dental Benefit Assignment Form. A **provider shall comply with a** written
6 assignment[s] of benefits under a dental benefit plan made in accordance with KRS 304.17C-
7 137(1)(a)1.b. ~~[shall be made]~~ on the Dental Benefit Assignment Form. **Nothing in this**
8 **administrative regulation shall be construed to require a covered person to assign a dental**
9 **benefit. A provider shall not condition treatment on the execution of the Dental Benefit**
10 **Assignment Form.**

11 Section 3. Incorporation by Reference.

12 (1) “Dental Benefit Assignment[²²] Form,” **HL-DBA1 3/2026[7/2025]**, is incorporated by
13 reference.

14 (2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at
15 the Kentucky Department of Insurance, Mayo-Underwood Building, 500 Mero Street, Frankfort,
16 Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. This material is also available on
17 the Web site at: <http://insurance.ky.gov/ppc/CHAPTER.aspx>.

READ AND APPROVED:



Sharon P. Clark

Commissioner, Department of Insurance



Date



Ray A. Perry

Secretary, Public Protection Cabinet



Date

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

806 KAR 17:595

Contact Person: Shaun T. Orme
Phone: 502-782-1698
Email: shaun.orme@ky.gov

Subject Headings: Dentistry, Insurance, Health

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes a dental benefit assignment form, pursuant to 2025 Regular Session House Bill 210.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to provide the form proscribed by the new requirements of 2025 Regular Session House Bill 210.

(c) How this administrative regulation conforms to the content of the authorizing statutes: 2025 Regular Session House Bill 210 requires the regulation to provide for a new form for dental benefit assignments. This new regulation provides the form required by the new dental benefit assignment statute.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This amendment provides the form required by the new dental benefit assignment statute.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This amendment establishes a form required by the new dental benefit assignment statute.

(b) The necessity of the amendment to this administrative regulation: This amendment is required to implement 2025 Regular Session House Bill 210.

(c) How the amendment conforms to the content of the authorizing statutes: 2025 Regular Session House Bill 210 requires the regulation to create the new dental benefit assignment form.

(d) How the amendment will assist in the effective administration of the statutes: This amendment provides the new dental benefit assignment form.

(3) Does this administrative regulation or amendment implement legislation from the previous five years? Yes, 2025 Regular Session House Bill 210.

(4) List the type and number of individuals, businesses, organization, or state and local governments affected by this regulation: Over forty-four (44) insurance entities will be affected by this administrative regulation. In addition, individuals that have dental insurance plans will be affected.

(5) Provide an analysis of how the entities identified in question (4) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (4) will have to take to comply with this administrative regulation or amendment: Dental insurance providers will have to accept the new dental benefit assignment form. Individuals that have dental insurance will allowed to assign the rights to their dental insurance claims to their dental providers.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (4): The cost associated is expected to be *de minimus*.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (4): Insureds will be able to use a uniform form to assign their dental benefits to their dental providers. Additionally, dental insurers will have a universal form for accepting assignment of dental benefit claims.

(6) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: No cost is anticipated.

(b) On a continuing basis: No cost is anticipated.

(7) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Insurance's operational budget.

(8) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: None is anticipated.

(9) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: No fee is associated with this new form.

(10) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied as the provisions of this administrative regulation apply to all entities equally.

FISCAL IMPACT STATEMENT

806 KAR 17:595

Contact Person: Shaun T. Orme

Phone: 502-782-1698

Email: shaun.orme@ky.gov

(1) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 304.2-110(1) and 304.17C-137(1)(a)1.b.

(2) State whether this administrative regulation is expressly authorized by an act of the General Assembly, and if so, identify the act: Yes. 2025 Regular Session House Bill 210 requires the Kentucky Department of Insurance to establish a form for the assignment of dental benefits provided by dental benefit plan.

(3) (a) Identify the promulgating agency and any other affected state units, parts, or divisions: The Kentucky Department of Insurance as the implementer.

(b) Estimate the following for the first year:

1. Expenditures:

For the first year: \$0

For subsequent years: \$0

2. Revenues:

For the first year: \$0

For subsequent years: \$0

3. Cost Savings:

For the first year: \$0

For subsequent years: \$0

(4) (a) Identify affected local entities (for example: cities, counties, fire departments, school districts): No local entities affected.

(b) Estimate the following for the first year:

1. Expenditures:

For the first year: \$0

For subsequent years: \$0

2. Revenues:
For the first year: \$0
For subsequent years: \$0

3. Cost Savings:
For the first year: \$0
For subsequent years: \$0

(5) (a) Identify additional regulated entities not listed in (3)(a) or (4)(a): None.

(b) Estimate the following for the first year:

1. Expenditures:
For the first year: \$0
For subsequent years: \$0

2. Revenues:
For the first year: \$0
For subsequent years: \$0

3. Cost Savings:
For the first year: \$0
For subsequent years: \$0

(6) Provide a narrative to explain the following for each entity identified in (3)(a), (4)(a), and (5)(a):

(a) Fiscal Impact of this administrative regulation: This administrative regulation will not have a fiscal impact on those entities.

(b) Methodology and resources used to reach this conclusion. Not applicable.

(7) Explain, as it relates to the entities identified in (3)(a), (4)(a), and (5)(a):

(a) Whether this administrative regulation will have an overall negative or adverse “major economic impact”, as defined by KRS 13A.010(13). No, this administrative regulation will not have a major economic impact.

(b) The Methodology and resources used to reach this conclusion. Not applicable.

This administrative regulation will not have major impact in the aggregate for either the Department, insurers, dental providers, or insureds. HB 210 was enacted during the 2025 legislative session. HB 210 required the Department to provide a form for insureds to assign their dental benefits to providers.

SUMMARY OF MATERIAL INCORPORATED BY REFERENCE

806 KAR 17:595

The “Dental Benefit Assignment^[2] Form,” HL-DBA1 3/2026~~[7/2025]~~, is the new single page form that insureds may choose to use to assign their dental benefits to their providers.

STATEMENT OF CONSIDERATION
Relating to 806 KAR 17:595

Public Protection Cabinet, Department of Insurance
(Amended After Comments)

I. The public hearing on 806 KAR 17:595, scheduled for February 23, 2026, at the Kentucky Department of Insurance. There were no requests to attend the public hearing; Therefore, the hearing was canceled. Nonetheless, written comments were received during the public comment period.

II. The following people submitted written comments:

- | | |
|---|--|
| (1) <u>Name and Title</u>
Hope McLaughlin, JD
Senior Director Government Relations
for Kentucky | <u>Agency/Organization/Entity/Other</u>
Elevance Health |
| (2) <u>Name and Title</u>
Samantha Shaver, DMD, FAGD,
President
Stephen W. Robertson, DMD,
Executive Director | <u>Agency/Organization/Entity/Other</u>
Kentucky Dental Association |

III. The following people from the promulgating administrative body responded to the written comments:

Name and Title
Shaun T. Orme
Executive Advisor

IV. Summary of Comments and Responses

(1) Subject Matter: Adding additional identifying information to the material incorporated by reference.

(a) Comment: Hope McLaughlin, Elevance Health asked that the Department amend the material incorporated by reference, "Dental Benefit Assignment"

Form 7/2025 to include the Provider Taxpayer Identification number/National Provider Identifier and the provider's treating address.

- (b) Response: The Department is in agreement with the suggested changes and will amend the "Dental Benefit Assignment" Form 7/2025 to include the Provider Tax Payer Identification number/National Provider Identifier and the provider's treating address.

- (2) Subject Matter: Adding Disclosures that a covered person is not mandated to execute an assignment form.

- (a) Comment: The Kentucky Dental Association (Association) asked that the Department clarify in both the regulation and the "Dental Benefit Assignment" Form 7/2025 to language that makes it clear that the execution of an assignment of the dental benefits is optional and not mandatory.

- (b) Response: The Department is agreeable to inserting clarifying language in the regulation and the "Dental Benefit Assignment" Form 7/2025 making it clear that the execution of an assignment of the dental benefits is optional and not mandatory.

Summary of Statement of Consideration and Action Taken by Promulgating Administrative Body

The public hearing on this administrative regulation was canceled; however, one (1) entity submitted written comments. The Kentucky Department of Insurance responded to the comments and will be amending the material incorporated by reference, the "Dental Benefit Assignment" Form 7/2025, to include the Provider Taxpayer Identification number/National Provider Identifier and the provider's treating address. The Department will also be amending the regulation and "Dental Benefit Assignment" Form 7/2025 making it clear that the execution of an assignment of the dental benefits is optional and not mandatory.

Dental Benefit Assignment Form

Covered Person:

Last name	First name	DOB
Address		Member ID#

NOTICE: I, the covered person, acknowledge that I have been informed of and understand the following:

- This provider has not joined my dental carrier's network and therefore, is a non-participating provider.
- Non-participating providers may charge for non-covered dental services and may also charge for any part of the cost of a covered dental service that my dental carrier does not reimburse.
- **[This dental benefit assignment is optional.] I may choose to assign my dental benefits to my provider, but I do not have to assign my benefits to receive dental services or insurance benefits.**
- A photocopy of this benefit assignment is as valid as the original.
- This benefit assignment will remain in effect until I revoke it in writing and provide a copy to my dental carrier.
- If a credit occurs due to overpayment, my provider shall give me notice within thirty (30) days and if I request a refund, shall refund the credit within thirty (30) days of my request.
- If under this benefit assignment my provider first receives a payment from me and then receives a payment from my dental carrier, my provider shall refund me within thirty (30) days, unless I agree otherwise in writing.

RELEASE OF INFORMATION: On behalf of myself and my dependents, I authorize [**Provider**] to disclose and release to my dental carrier [**Dental Carrier Name**], as applicable, any medical and treatment information needed for payment purposes for dental services rendered. I authorize use of this form for the release of information needed to process claims to [**Insurer/Carrier Name**] and its authorized agents. I authorize my provider to act as my agent in helping obtain payment from my dental carrier.

ASSIGNMENT OF BENEFITS: I assign all payments, rights, and claims for all medical, dental, and surgical benefits or reimbursement of claims, costs, and expenses allowable under my dental carrier's plan(s) directly to my provider for services performed. I understand I will receive a statement for any balance due by me or my dependents and I agree to make full payment upon receipt of the statement after my dental carrier has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (my provider may also collect coinsurance and deductibles at the time of service). I understand I am financially responsible for charges not covered by my dental carrier. I also agree to pay any outstanding balance as well as attorney fees and costs to [**Provider Name**] if my provider must refer this matter to collection.

Covered Person's Signature	Print name	Date
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Provider:

Provider Signature	Provider TIN/NPI	Date
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Print Name	Treating Address
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Dental Benefit Assignment Form

Covered Person:

_____ Last name	_____ First name	_____ DOB
_____ Address		_____ Member ID#

NOTICE: I, the covered person, acknowledge that I have been informed of and understand the following:

- This provider has not joined my dental carrier's network and therefore, is a non-participating provider.
- Non-participating providers may charge for non-covered dental services and may also charge for any part of the cost of a covered dental service that my dental carrier does not reimburse.
- I may choose to assign my dental benefits to my provider, but I do not have to assign my benefits to receive dental services or insurance benefits.
- A photocopy of this benefit assignment is as valid as the original.
- This benefit assignment will remain in effect until I revoke it in writing and provide a copy to my dental carrier.
- If a credit occurs due to overpayment, my provider shall give me notice within thirty (30) days and if I request a refund, shall refund the credit within thirty (30) days of my request.
- If under this benefit assignment my provider first receives a payment from me and then receives a payment from my dental carrier, my provider shall refund me within thirty (30) days, unless I agree otherwise in writing.

RELEASE OF INFORMATION: On behalf of myself and my dependents, I authorize [**Provider**] to disclose and release to my dental carrier [**Dental Carrier Name**], as applicable, any medical and treatment information needed for payment purposes for dental services rendered. I authorize use of this form for the release of information needed to process claims to [**Insurer/Carrier Name**] and its authorized agents. I authorize my provider to act as my agent in helping obtain payment from my dental carrier.

ASSIGNMENT OF BENEFITS: I assign all payments, rights, and claims for all medical, dental, and surgical benefits or reimbursement of claims, costs, and expenses allowable under my dental carrier's plan(s) directly to my provider for services performed. I understand I will receive a statement for any balance due by me or my dependents and I agree to make full payment upon receipt of the statement after my dental carrier has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (my provider may also collect coinsurance and deductibles at the time of service). I understand I am financially responsible for charges not covered by my dental carrier. I also agree to pay any outstanding balance as well as attorney fees and costs to [**Provider Name**] if my provider must refer this matter to collection.

Covered Person's Signature

Print name

Date

Provider:

Provider Signature

Provider TIN/NPI

Date

Print Name

Treating Address

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