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BULLETIN
2025-05

The following Bulletin is to inform the reader of the current position of the Kentucky Department of Insurance on the specified issue. The Bulletin is not legally binding on either the Department or the reader.

TO: ALL INSURERS TRANSACTING DENTAL INSURANCE BUSINESS WITHIN THE COMMONWEALTH OF KENTUCKY

FROM: SHARON P. CLARK, COMMISSIONER
KENTUCKY DEPARTMENT OF INSURANCE

RE: DENTAL BENEFIT ASSIGNMENTS

DATE: December 15, 2025

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Effective Date
This bulletin is effective December 15, 2025.

Purpose
This Bulletin offers guidance with respect to 2025 Regular Session House Bill 210 (2025 HB 210), which requires the Kentucky Department of Insurance to file a regulation that creates a new, uniform dental benefit assignment form for covered persons to use to direct insurance payments to their dental providers. The effective date of the dental benefit assignment provisions is January 1, 2026.

Implementation
As charged by 2025 HB 210, the Department has created the attached form which covered persons may use to assign their dental insurance benefit payments directly to their providers. 2025 HB 210 was codified as Kentucky Revised Statute (KRS) 304.17C-137. The Department is providing the following information and the attached dental benefits assignment form until further details and guidance can be created through the promulgation of a new regulation formally adopting the form.

The new dental benefit assignment form includes a notice informing the covered person of the following information, pursuant to KRS 304.17C-137:

(a) The provider, as applicable:

1. Is an out-of-network provider;
2. May charge the covered person for noncovered services; and
3. May charge the covered person for any portion of the cost of a covered service that is not reimbursed under the dental benefit plan;

(b) Any assignment of benefits is optional; and

(c) If the covered person has accrued a credit balance on his or her account, the provider shall:

1. Notify the covered person of the credit balance with the provider within thirty (30) days; and
2. a. Except as provided in subdivision b. of this subparagraph, refund any credit balance that has accrued on the covered person's account with the provider within thirty (30) days of receiving a request for refund from the covered person; and

b. If, under the assignment, the provider collects payment from the covered person and subsequently receives payment from the insurer, refund the covered person within thirty (30) days of receiving the payment from the insurer unless the provider and covered person agree otherwise in writing.

In addition, both the covered person and the dental services provider shall sign the form.

Finally, the provisions of KRS 304.17C-137 shall not be construed to limit an insurer's ability to:

(a) Determine the scope of a dental benefit plan's benefits, services, or other terms that are not in conflict with this section; or

(b) Negotiate any contract with a health care provider regarding reimbursement rates or any other lawful provisions that are not in conflict with this section.

A. Covered Person/Patient/Insured/Consumer

Assignment of Benefits: Covered persons (also referred to as a 'patients,' 'insureds,' or 'consumers') may assign, or instruct their dental carrier to pay, their insurance benefits directly to their out-of-network (also called 'non-network' or 'non-participating') service provider. The assignment of dental benefits means the covered person authorizes their dental carrier to pay their insurance benefits directly to their provider or dentist.

Out-of-Network: This form is to be used for out-of-network dental service providers. It is common for dentists who have joined a dental carrier's network to automatically include dental benefit assignment in their agreements. Covered persons may choose to use the new dental benefit assignment form to direct assigned insurance benefits to their dental service provider who are not part of the dental carrier's network. This will allow the dental carrier to pay the service provider directly, rather than the covered person having to seek reimbursement from the carrier after the patient has paid in advance for the service. The intent of the form is to simplify the payment process for both covered persons and providers.

Balance-Billing: The use of this form will not guarantee payment or payment in full by the dental carrier. The dental carrier will only pay those benefits that its policy allows for an out-of-network service. Therefore, the service provider may still balance-bill the covered party. Balance billing (also

referred to as "surprise billing") occurs when a provider requires the payment of the difference between the total cost of services the provider charged and the amount the carrier has paid.

Optional Use: Covered persons may voluntarily choose to sign a dental benefit assignment form and do not have to assign their out-of-network dental benefits directly to their providers. The provider must inform covered persons that the assignment of out-of-network dental benefits is optional and that added payments may be required if the insurance benefit is not enough to cover the entire billed service charges.

Over Payment: If there is a credit to the covered person's account, the dental provider shall give notice to the covered person within thirty (30) days of the credit accruing. If the covered person requests a refund, then the provider shall issue the refund within thirty (30) days of the request. If the provider first collects a payment from the covered person and then receives a payment from the dental carrier under the assignment of benefits, then the provider shall refund the over-payment to the covered person within thirty (30) days of receiving the carrier's payment.

Revocation: Covered persons may revoke their dental benefit assignment for an out-of-network provider at any time by sending a written request to cancel or rescind the assignment to their dental carrier. A covered person may revoke an assignment with or without the consent of the provider. The revocation is effective when the dental carrier receives it and does not apply to charges incurred on or before the effective date.

B. Dental Service Providers/Dentists

2025 Regular Session House Bill 210 requires dental carriers and providers to honor a covered person's out-of-network dental benefit assignment. The dental benefit assignment form does not create a contractual relationship between the dental carrier and the service provider or dentist.

C. Dental Carriers/Insurance Companies/Insurers

The new law requires dental carriers (also referred to as 'insurance companies' or 'insurers') to pay out-of-network dental providers directly when covered persons instruct them to do so. Under KRS 304.17C-137, dental carriers are required to accept the new dental benefit assignment form created by the Department, regardless of the dental providers network status. After receiving a revocation of an assignment from a patient, the dental carrier shall promptly send a copy to the dental provider of the revocation marked with the effective date.

Insurers, licensees, and registered entities are charged with notifying their agents and employees of the provisions of the dental benefit assignment law and the use of the new form in accordance with this opinion and KRS 304.17C-137. The Department does not provide legal advice to insurers or entities. The information provided herein has been offered for the sole purpose of clarifying the Department's regulatory authority pursuant to KRS 304.17C-137.

If you have any questions about this Bulletin, please contact Health and Life and Managed Care Division at (502) 564-6088 or DOI.HealthMail@ky.gov.

Sharon P. Clark

Sharon P. Clark, *Commissioner*
Kentucky Department of Insurance
On this 15 day of December 2025.

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.
- 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 signature	**Print name**	**Date**