

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																		
2. Predetermination/Preauthorization Number					POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)													
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																		
3. Company/Plan Name, Address, City, State, Zip Code																		
13. Date of Birth (MM/DD/CCYY)					14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)											
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)					16. Plan/Group Number		17. Employer Name											
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																		
PATIENT INFORMATION																		
6. Date of Birth (MM/DD/CCYY)					7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)		18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other	19. Reserved For Future Use								
9. Plan/Group Number					10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other													
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																		
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code					21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)									
RECORD OF SERVICES PROVIDED																		
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. Qty	30. Description	31. Fee									
33. Missing Teeth Information (Place an "X" on each missing tooth)					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)					31a. Other Fee(s)								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____		32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A") B _____ D _____		
35. Remarks																		
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION													
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 _____					38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N) <input type="checkbox"/> (Use "Place of Service Codes for Professional Claims")													
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 Subscriber Signature _____ Date _____					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)											
					42. Months of Treatment Remaining		43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)									
					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident													
					46. Date of Accident (MM/DD/CCYY)			47. Auto Accident State										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)					TREATING DENTIST AND TREATMENT LOCATION INFORMATION													
48. Name, Address, City, State, Zip Code					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 _____													
49. NPI		50. License Number		51. SSN or TIN		54. NPI		55. License Number										
					56. Address, City, State, Zip Code		56a. Provider Specialty Code											
52. Phone Number			52a. Additional Provider ID		57. Phone Number		58. Additional Provider ID											