

# ADA Dental Claim Form

## HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

- Statement of Actual Services       Request for Predetermination/Preauthorization  
 EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

## PRIMARY PAYER INFORMATION

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

## OTHER COVERAGE

4. Other Dental or Medical Coverage?  No (Skip 5-11)       Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)      7. Gender  M  F      8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number      10. Patient's Relationship to Other Insured (Check applicable box)

- Self     Spouse     Dependent     Other

11. Other Carrier Name, Address, City, State, Zip Code

## PRIMARY INSURED INFORMATION

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

13. Date of Birth (MM/DD/CCYY)      14. Gender  M  F      15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number      17. Employer Name

## PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box)      19. Student Status

- Self     Spouse     Dependent Child     Other       FTS     PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)      22. Gender  M  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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

## MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

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 \_\_\_\_\_  
Subscriber signature      Date

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

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

49. Provider ID      50. License Number      51. SSN or TIN

52. Phone Number ( ) -

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)      39. Number of Enclosures (00 to 99)

- Provider's Office     Hospital     ECF     Other      Radiograph(s)    Oral Image(s)    Model(s)

40. Is Treatment for Orthodontics?      41. Date Appliance Placed (MM/DD/CCYY)

- No (Skip 41-42)     Yes (Complete 41-42)

42. Months of Treatment Remaining      43. Replacement of Prosthesis?      44. Date Prior Placement (MM/DD/CCYY)

- No     Yes (Complete 44)

45. Treatment Resulting from (Check applicable box)

- Occupational illness/injury     Auto accident     Other accident

46. Date of Accident (MM/DD/CCYY)      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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X \_\_\_\_\_  
Signed (Treating Dentist)      Date

54. Provider ID      55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) -      58. Treating Provider Specialty