

**ADA Dental Claim Form**

HEADER INFORMATION																																																																																								
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services – OR – <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> 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? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																								
5. Subscriber Name (Last, First, Middle Initial, Suffix)																																																																																								
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Subscriber Identifier (SSN or ID#)																																																																																				
9. Plan/Group Number				10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																				
11. Other Carrier Name, Address, City, State, Zip Code																																																																																								
PRIMARY SUBSCRIBER INFORMATION																																																																																								
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																								
13. Date of Birth (MM/DD/CCYY)				14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Subscriber Identifier (SSN or ID#)																																																																																		
16. Plan/Group Number					17. Employer Name																																																																																			
PATIENT INFORMATION																																																																																								
18. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other						19. Student Status <input type="checkbox"/> FFS <input type="checkbox"/> PTS																																																																																		
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	30. Description			31. Fee																																																																														
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10																																																																																								
MISSING TEETH INFORMATION																																																																																								
34. (Place an 'X' on each missing tooth)																																																																																								
<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td colspan="15">Permanent</td> <td colspan="10">Primary</td> <td rowspan="2">32. Other Fee(S)</td> </tr> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td> <td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> <td>T</td><td>S</td><td>R</td><td>Q</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td> <td>33. Total Fee</td> </tr> </table>										Permanent															Primary										32. Other Fee(S)	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	33. Total Fee
Permanent															Primary										32. Other Fee(S)																																																															
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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.					38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other					39. Number of Enclosures (00 to 99) Radiographs <input type="checkbox"/> Oral Images <input type="checkbox"/> Models <input type="checkbox"/>																																																																														
X _____ Patient/Guardian 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)																																																																														
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.					42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)					44. Date Prior Placement (MM/DD/CCYY)																																																																									
X _____ Subscriber signature Date					45. Treatment Resulting from (Check applicable box) <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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.																																																																														
_____ Signed (Treating Dentist) Date										54. Provider ID										55. License Number																																																																				
49. Provider ID					50. License Number					51. SSN or TIN					56. Address, City, State, Zip Code																																																																									
52. Phone Number										57. Phone Number										58. Treating Provider Specialty																																																																				