ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFITS PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

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

5. Name of Policy Subscriber in #4 (Last, First, Middle Initial, Suf ix)

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

9. Plan/Group Number	10. Patient' s Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Subscriber/Policy Holder Name (Last, First, Middle Initial, Suf ix), Address, City, State, Zip Code

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

16. Plan/Group Number	17. Employer Name

PATIENT INFORMATION

18. Relationship to Policy Holder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suf ix), 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	
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

32. Other Fee(s)

33. Total Fee

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

X_____
Patient/G…e

37. I here… …ble to me, directly to the belo… dentist o…

X_____
Subscrib… …e

BILLING …al entity is not submitting claim on

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

49. NPI	50. License Number	51. SSN or TIN

( ) –	52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

…/DD/CCYY)

…DD/CCYY)

…tate

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.

X_____
Signed (Treating Dentist) Date

54. NPI	55. License Number

56. Address, City, State, Zip Code	56A. Provider Specialty Code

57. Phone Number ( ) –	58. Additional Provider ID

Referring Dentist could be the same as billing Dentist.

54. Referring Dentist NPI
56. Service Address
56A. Taxonomy Code

48: Name and Service Location of Provider submitting the bill. (If NPI is not a one to one match), system will look at Service Address as the match.

49: Billing NPI