ADA Dental Claim Form

Fill in ★ Boxes Thank you!

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services - OR - ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION ★Insurance Co★

3. 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	15. Subscriber Identifier (SSN or ID#)
	☐ M ☐ F	

16. Plan/Group Number	17. Employer Name

OTHER COVERAGE

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

5. Subscriber Name (Last, First, Middle Initial, Suffix)

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

9. Plan/Group Number	10. Relationship to Primary Subscriber (Check applicable box)
	☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

PATIENT INFORMATION

18. Relationship to Primary Subscriber (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	23. Patient ID/Account # (Assigned by Dentist)
	☐ M ☐ F	

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

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

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	

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other	

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

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

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

48. Address, City, State, Zip Code

57. Phone Number	58. Treating Provider Specialty