ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[X] Statement of Actual Services [X] Request for Predetermination/Preauthorization

[X] EPSDT/Title XIX

2. Predetermination/Preauthorization Number

XXXXXXXXXX

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XX XXXXXXXXXX

OTHER COVERAGE

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

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

6. Date of Birth (MM/DD/CCYY): XXXXXXXXXX

7. Gender: [X] M [X] F

8. Policyholder/Subscriber ID (SSN or ID#): XXXXXXXXXXX

9. Plan/Group Number: XXXXXXXXXXX

10. Patient's Relationship to Person Named in #5: [X] Self [X] Spouse [X] Dependent [X] Other

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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XX XXXXXXXXXX

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

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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XX XXXXXXXXXX

13. Date of Birth (MM/DD/CCYY): XXXXXXXXXX

14. Gender: [X] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): XXXXXXXXXXX

16. Plan/Group Number: XXXXXXXXXXX

17. Employer Name: XXXXXXXXXXXXXXXXXXXXXXXXXX

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [X] Self [X] Spouse [X] Dependent Child [X] Other

19. Student Status: [X] FTS [X] PTS

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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XX XXXXXXXXXX

21. Date of Birth (MM/DD/CCYY): XXXXXXXXXX

22. Gender: [X] M [X] F

23. Patient ID/Account # (Assigned by Dentist): XXXXXXXXXXX

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	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
2	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
3	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
4	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
5	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
6	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
7	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
8	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
9	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX
10	XXXXXXXXXX	XX	XX	XXXXXXXXXXX	XXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX

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): XXXXXX XXXXXX

33. Total Fee: XXXXXXX

35. Remarks XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

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 XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXX

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 XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXX

Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: [X] Provider's Office [X] Hospital [X] ECF [X] Other

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

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [X] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY): XXXXXXXXXX

42. Months of Treatment Remaining: XX

43. Replacement of Prosthesis? [X] No [X] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY): XXXXXXXXXX

45. Treatment Resulting from: [X] Occupational illness/injury [X] Auto accident [X] Other accident

46. Date of Accident (MM/DD/CCYY): XXXXXXXXXX

47. Auto Accident State: XX

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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XX XXXXXXXXXX

49. NPI: XXXXXXXXXX

50. License Number: XXXXXXXXXX

51. SSN or TIN: XXXXXXXXXX

52. Phone Number: (XXX) XXX-XXXX

52A. Additional Provider ID: XXXXXXXXXX

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 XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXX

Signed (Treating Dentist) — Date

54. NPI: XXXXXXXXXX

55. License Number: XXXXXXXXXX

56. Address, City, State, Zip Code

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX XX XXXXXXXXXX

56A. Provider Specialty Code: XXXXXXXXXX

57. Phone Number: (XXX) XXX-XXXX

58. Additional Provider ID: XXXXXXXXXX

Sample

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J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

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