

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) Request for Predetermination/Preauthorization

Statement of Actual Services EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

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

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

7. Gender
 M F U

8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

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

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

14. Gender
 M F U

15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

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

19. Reserved For Future Use

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

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

22. Gender
 M F U

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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. 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 _____ Date
Patient/Guardian Signature

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 _____ Date
Subscriber Signature

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital)
(Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

39a. Date Last SRP

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

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

42. Months of Treatment 43. Replacement of Prosthesis
 No Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
 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. NPI

50. License Number

51. SSN or TIN

52. Phone Number () -

52a. Additional Provider ID

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 _____ Date
Signed (Treating Dentist)

53a. Locum Tenens Treating Dentist?

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number () -

58. Additional Provider ID

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (<https://www.ADA.org/en/publications/cdt/ada-dental-claim-form>).

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.
- F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35).

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf>

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223X0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at: <https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40>

ADA Dental Claim Form Completion Instructions

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1 Introduction

2 The ADA's Council on Dental Benefit Programs has responsibility for electronic and paper dental claim
3 content and completion instructions. Staff from the Center for Dental Benefits, Coding and Quality
4 within the ADA's Practice Institute maintain the paper ADA Dental Claim Form and its completion
5 instructions. According to ADA policy the paper form's data content must be in harmony with the
6 HIPAA standard electronic dental claim transaction.

7 The 2024 ADA Dental Claim Form has been structurally revised to incorporate data content changes
8 that enable reporting: a) services delivered by a dentist in a locum tenens (i.e., temporary substitute)
9 status; b) date of the patient's last scaling and root planing procedure; and c) benefit plan Payer ID
10 codes.

11 Summary of Form Version 2024 Completion Instruction Changes

Change Description	Affected Form	
	#	Field Name
Completion instructions for new field to report Dental Benefit Plan Payer ID.	3.a.	Payer ID
Completion instructions for new field to report <u>Other Insurance Company/Dental Benefit Plan Payer ID</u> .	11.b.	Other Payer ID
Completion instructions for new field to report date of patient's last Scaling and Root Planing procedure (MM/DD/CCYY format).	39.a.	Date Last SRP
Completion instructions for new field to indicate whether the treating dentist is Locum Tenens.	53.a.	Locum Tenens Dentist
Amended instructions applicable when treatment is delivered by a Locum Tenens Dentist	54 55 56a 57 58	National Provider Identifier License Number Provider Specialty Code Phone Number Additional Provider ID
Correction to Provider Specialty Code list (for Oral and Maxillofacial Radiology) and instructions.	56.a.	Provider Specialty Code
Addition of clarifying NOTE that addresses surface identification when restoration involves anterior tooth's incisal angle (aka incisal edge).	28.	Tooth Surface

12 The current version of the paper form (2024 © American Dental Association), front and reverse sides, is
13 illustrated on the next two pages. The illustrations are then followed by comprehensive form completion
14 instructions.

ADA Dental Claim Form Completion Instructions

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ADA American Dental Association® Dental Claim Form										
HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> EPSDT / Title XIX										
2. Predetermination/Preauthorization Number										
DENTAL BENEFIT PLAN INFORMATION					POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named In #3)					
3. Company/Plan Name, Address, City, State, Zip Code					12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code					
3a. Payer ID					13. Date of Birth (MM/DD/CCYY)		14. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U		15. Policyholder/Subscriber ID (Assigned by Plan)	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)										
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)										
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)										
6. Date of Birth (MM/DD/CCYY)			7. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U		8. Policyholder/Subscriber ID (Assigned by Plan)			16. Plan/Group Number		17. Employer Name
PATIENT INFORMATION										
9. Plan/Group Number					10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Reserved For Future Use
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										
11a. Other Payer ID					21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U		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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)						34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-10 - AB)			31a. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11
32	31	30	29	28	27	26	25	24	23	22
						34a. Diagnosis Code(s)		A _____	C _____	
						(Primary diagnosis in "A")		B _____	D _____	32. Total Fee
35. Remarks										
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)					
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					38. Place of Treatment <input type="checkbox"/> (e.g. 11-office; 22-O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N)			39a. Date Last SRP
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					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)			44. Date of Prior Placement (MM/DD/CCYY)
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)					42. Months of Treatment		43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		47. Auto Accident State	
48. Name, Address, City, State, Zip Code					TREATING DENTIST AND TREATMENT LOCATION INFORMATION					
49. NPI					50. License Number		51. SSN or TIN			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
52. Phone Number () -					52a. Additional Provider ID		57. Phone Number () -			58. Additional Provider ID
53a. Locum Tenens Treating Dentist? <input type="checkbox"/>					54. NPI		55. License Number			56a. Provider Specialty Code
56. Address, City, State, Zip Code										

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ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (<https://www.ADA.org/en/publications/cdt/ada-dental-claim-form>).

GENERAL INSTRUCTIONS

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- B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.
- F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35).

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

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PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf>

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223X0008X
Oral & Maxillofacial Surgery	1223S0112X

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1 DATA ELEMENT SPECIFIC INSTRUCTIONS

2 Form completion instructions are provided for each data item, which is indicated by a number. Please
3 note that data items are in groups of related information. These instructions explain the reasons for
4 such groupings, and the relationships (if any) between groups.

5 Header Information

6 The 'header' provides information about the type of submission being made. This information applies
7 to the entire transaction.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION	
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Request for Predetermination/Preauthorization	
<input type="checkbox"/> Statement of Actual Services	<input type="checkbox"/> EPSDT / Title XIX
2. Predetermination/Preauthorization Number	

8

9 1. Type of Transaction: There are three boxes that may apply to this submission. If services have
10 been performed, mark the "Statement of Actual Services" box. If there are no dates of service,
11 mark the box marked "Request for Predetermination / Preauthorization". If the claim is through
12 the **Early and Periodic Screening, Diagnosis and Treatment Program**, mark the box marked
13 'EPSDT/Title XIX'.

14 2. Predetermination/Preauthorization Number: If you are submitting a claim for a procedure that has
15 been pre-authorized by a third party payer, enter the preauthorization or predetermination number
16 provided by the insurance company.

17 Insurance Company/Dental Benefit Plan Information

DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code
3a. Payer ID

18

19 3. Company/Plan Name, Address, City, State, Zip Code: **This item is always completed.** Enter the
20 information for the insurance company or dental benefit plan that is the third party payer receiving
21 the claim.

22 • If the patient is covered by more than one plan, enter the primary insurance company
23 information here for the initial claim submission.

24 • When submitting a separate claim to the secondary carrier, place the secondary carrier's
25 company/plan name and address information here.

26 3a. Payer ID: Enter the Payer Identification Number for the Company/Plan specified in "3." above.
27 (Leave blank if not known.)

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1 **Other Coverage**

2 This area of the claim form provides information on the existence of additional dental or medical
3 insurance policies. This is necessary to determine if multiple coverages are in effect, and the possibility of
4 coordination of benefits.

- 5 • When the claim form is being prepared for submission to the primary carrier the information in
6 “Other Coverage” applies to the secondary carrier.
- 7 • When the claim form is being prepared for submission to the secondary carrier the information in
8 “Other Coverage” applies to the primary carrier.

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		
11a. Other Payer ID		

- 9
- 10 4. Other Dental or Medical Coverage?: Mark the box after “Dental?” or “Medical?” whenever a
11 patient has coverage under any other dental or medical plan, without regard to whether the
12 dentist or the patient will be submitting a claim to collect benefits under the other coverage.
- 13 • Leave blank when the dentist is not aware of any other coverage(s).
 - 14 • When either box is marked, complete Items 5 through 11 in the “Other Coverage” section
15 for the applicable benefit plan.
 - 16 • If both Dental and Medical are marked, enter information about the dental benefit plan in
17 Items 5 through 11.

18 5. Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial,
19 Suffix): If the patient has other coverage through a spouse, domestic partner or, if a child, through
20 both parents, the name of the person who has the other coverage is reported here.

21 6. Date of Birth (MM/DD/CCYY): Enter the date of birth of the person listed in Item #5. The date
22 must be entered with two digits each for the month and day, and four digits for the year of birth.

23 7. Gender: Mark the gender of the person who is listed in Item #5. Mark “M” for Male, “F” for
24 Female, or “U” for Unknown as applicable.

25 8. Policyholder/Subscriber Identifier (Assigned by Plan): Enter the unique identifying number
26 assigned by the third-party payer (e.g., insurance company) to the person named in Item #5,
27 which is on their identification card.

28 9. Plan/Group Number: Enter the group plan or policy number of the person identified in Item #5.

29 10. Patient's Relationship to Person Named in Item #5: Mark the patient's relationship to the other
30 insured named in Item #5.

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1 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code: Enter the
2 complete information of the additional payer, benefit plan or entity for the insured named in Item
3 #5.

4 11a. Payer ID: Enter the Payer Identification Number for the Other Insurance Company/Dental Benefit
5 Plan specified in "11." above. (Leave blank if not known.)

6 **Policyholder/Subscriber Information** (For Insurance Company Named in Item #3)

7 This section documents information about the insured person who may or may not be the patient.

- 8 • When the claim form is being prepared for submission to the primary carrier the information
9 supplied applies to the person insured by the primary carrier.
- 10 • When the claim form is being prepared for submission to the secondary carrier the information
11 entered applies to the person insured by secondary carrier.

12 POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)		
13 12. <u>Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code</u>		
14 13. <u>Date of Birth (MM/DD/CCYY)</u>	14. <u>Gender</u> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	15. <u>Policyholder/Subscriber ID (Assigned by Plan)</u>
16. <u>Plan/Group Number</u>	17. <u>Employer Name</u>	

13 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:
14 Enter the complete name, address and zip code of the policyholder/subscriber with coverage
15 from the company/plan named in #3.

16 13. Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month,
17 two for the day of the month, and four for the year.

18 14. Gender: This applies to the primary insured, who may or may not be the patient. Mark "M" for
19 Male, "F" for Female, or "U" for Unknown as applicable.

20 15. Policyholder/Subscriber Identifier (Assigned by Plan): Enter the unique identifying number
21 assigned by the third-party payer (e.g., insurance company) to the person named in Item #12,
22 which is on their identification card.

23 16. Plan/Group Number: Enter the policyholder/subscriber's group plan/policy number.

24 17. Employer Name: If applicable, enter the name of the policyholder/subscriber's employer.

25

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1 Patient Information

2 The information in this section of the claim form pertains to the patient.

PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Reserved For Future Use
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 <input type="checkbox"/> U	23. Patient ID/Account # (Assigned by Dentist)

3

4 18. Relationship to Policyholder/Subscriber in #12 Above: Mark the relationship of the patient to the
5 person identified in Item #12 who has the primary insurance coverage. The relationship between
6 the insured and the patient may affect the patient's eligibility or benefits available. **If the patient
7 is also the primary insured, mark the box titled 'Self' and skip to item #23.**

8 19. Reserved For Future Use: Leave blank and skip to Item #20. (#19 was previously used to report
9 "Student Status.")

10 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Enter the complete name,
11 address and zip code of the patient.

12 21. Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month,
13 two for the day of the month, and four for the year of birth of the patient.

14 22. Gender: This applies to the patient. Mark "M" for Male, "F" for Female, or "U" for Unknown as
15 applicable.

16 23. Patient ID/Account # (Assigned by Dentist): Enter if the dentist's office has assigned a number to
17 identify the patient. This is not required to process claim.

18 Record Of Services Provided

19 This section contains information regarding the proposed treatment (predetermination/preauthorization),
20 or treatment performed (actual services).

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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee										
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
33. Missing Teeth Information (Place an "X" on each missing tooth.)					34. Diagnosis Code List Qualifier <input type="checkbox"/> <input type="checkbox"/> (ICD-10 = AB)			31a. Other Fee(s)											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)		A _____ C _____	32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A")		B _____ D _____	
35. Remarks																			

21

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1 **NOTE:** Items 24 through 31, following, apply to each of the 10 available lines on the claim form for
2 reporting dental procedures provided to the patient. **The remaining items in this section of the form**
3 **(33-35) do not repeat.**

4 24. Procedure Date (MM/DD/CCYY): Enter procedure date for actual services performed or leave
5 blank if the claim is for preauthorization/predetermination. The date, if included, must have two
6 digits for the month, two for the day, and four for the year.

7 **NOTE:** The presence or absence of a Procedure Date should be consistent with the type of
8 transaction(s) marked in Item #1 (e.g., actual services; predetermination /
9 preauthorization).

10 25. Area of Oral Cavity: **Use of this field is conditional.** Always report the area of the oral cavity
11 when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the
12 area of the oral cavity is not uniquely defined by the procedure's nomenclature. For example:

- 13 a. Report the applicable area of the oral cavity when the procedure code nomenclature
14 includes a general reference to an arch or quadrant, such as **D4263 bone replacement**
15 **graft – first site in quadrant**
- 16 b. Do not report the applicable area of the oral cavity when the procedure either: 1)
17 incorporates a specific area of the oral cavity in its nomenclature, such as **D5110 complete**
18 **denture – maxillary**; or 2) does not relate to any portion of the oral cavity, such as **D9222**
19 **deep sedation/general anesthesia – first 15 minutes.**

20 **NOTE:** Detailed guidance on reporting Area of the Oral Cavity, Tooth Numbers and
21 Tooth Surfaces by CDT code is posted on the ADA Dental Claim Form web
22 page.

23 [ADA Dental Claim Form](#)

24 Area of the oral cavity is designated by a two-digit code, selected from the following code list:

Code	Area
00	entire oral cavity
01	maxillary arch
02	mandibular arch
10	upper right quadrant
20	upper left quadrant
30	lower left quadrant
40	lower right quadrant

25 26. Tooth System: Enter "JP" to indicate that teeth are being designated using the ADA's
26 Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary
27 dentition).

28 27. Tooth Number(s) or Letter(s): **Enter the appropriate tooth number or letter when the**
29 **procedure directly involves a tooth or range of teeth. Otherwise, leave blank.**

30 **NOTE:** Numbers or letters reported are based on tooth morphology, not anatomic
31 position. This is the traditional and important concept to understand for
32 accurate documentation and reporting. For instance, a tooth may migrate
33 into an edentulous space, but that movement does not change its
34 morphology. Similarly, placement of an implant body need not be in an
35 anatomic tooth position, but the prosthesis placed is the morphological
36 equivalent of a missing tooth or range of teeth.

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1 If the same procedure is performed on more than a single tooth on the same date of service there
2 are two options for reporting –

- 3 • Report each procedure, the tooth involved, and the fee on separate service lines
- 4 • Report the procedure on a single service line with the teeth involved in #27, the number
5 of times the procedure was delivered in the #29b (Quantity), and the total fee for all in
6 #31 (Fee)

7 When a procedure involves a range of teeth, the range is reported in this field. This is done either
8 with a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the
9 use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10; 3-5, 22-27).

10 Supernumerary teeth in the **permanent** dentition are identified in the ADA's Universal/National
11 Tooth Designation System ("JP") by the numbers 51 through 82, beginning with the area of the
12 upper right third molar, following around the upper arch and continuing on the lower arch to the
13 area of the lower right third molar (for example, supernumerary number 51 is adjacent to the
14 upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar
15 number 32). This enumeration is illustrated in the following chart:

16 Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
'Super' #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

17 Lower Arch

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
'Super' #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

18 Supernumerary teeth in the **primary** dentition are identified by the placement of the letter "S"
19 following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is
20 adjacent to "A"; supernumerary "TS" is adjacent to "T"). This enumeration is illustrated in the
21 following chart:

22 Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	A	B	C	D	E	F	G	H	I	J
'Super' #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

23 Lower Arch

Tooth "#"	T	S	R	Q	P	O	N	M	L	K
Super "#"	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

24 28. Tooth Surface: This Item is necessary when the procedure performed by tooth involves one or
25 more tooth surfaces. Otherwise leave blank. The following single letter codes are used to identify
26 surfaces:

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Surface	Code
Buccal	B
Distal	D
Facial (or labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

1 Do not leave any spaces between surface designations in multiple surface restorations (e.g.,
2 MOD).

3 **NOTE:** The Incisal (“I”) surface of an anterior tooth (analogous to the Occlusal surface of
4 posterior teeth for reporting purposes) may incorporate the Incisal Angle. A
5 restoration involving the incisal angle will include multiple surfaces. The size of the
6 affected area and the anatomy of the tooth will dictate the number of surfaces
7 involved in this restoration.

8 For example, a small fracture involving the angle could be perceived clinically as two
9 surface restoration (e.g., M-I; D-I). A larger fracture involving the angle that requires
10 restoring a greater portion of the tooth would require a multi-surface restoration (e.g.,
11 M-I-F-L; D-I-F-L). The clinician determines what type of restoration was placed, and
12 the code to report the procedure delivered to the patient.

13 29. Procedure Code: Enter the appropriate procedure code found in the version of the *Code on*
14 *Dental Procedures and Nomenclature* in effect on the “Procedure Date” (Item #24).

15 **NOTE:** Additional guidance concerning reporting select CDT codes (e.g.,
16 Teledentistry; Sales Tax) are in Coding Education and the ADA Claim Form
17 content linked to the CDT Code Portal web page –

18 www.ada.org/cdt

19 29a Diagnosis Code Pointer: Enter the letter(s) from Item 34 that identify the diagnosis code(s)
20 applicable to the dental procedure. List the primary diagnosis pointer first.

21 29b Quantity: Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the
22 patient on the date of service shown in Item 24. The default value is “01.”

23 30. Description: Provide a brief description of the service provided (e.g., abbreviation of the
24 procedure code’s nomenclature).

25 31. Fee: Report the dentist’s full fee for the procedure. Resolution 44-2009 Statement on Reporting
26 Fees on Dental Claims adopted by the ADA House of Delegates, as follows, provides guidance
27 on the appropriate entry for this item.

28 Statement on Reporting Fees on Dental Claims

- 29 1) A full fee is the fee for a service that is set by the dentist, which reflects the costs of
30 providing the procedure and the value of the dentist’s professional judgment.
- 31 2) A contractual relationship does not change the dentist’s full fee.
- 32 3) It is always appropriate to report the full fee for each service reported to a third-party
33 payer.

34 **(Note: Item 31 above is the last of the repeating ‘service line’ items.)**

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1 31a Other Fee(s): When other charges applicable to dental services provided must be reported, enter
2 the amount here. Charges may include state tax and other charges imposed by regulatory
3 bodies.

4 32. Total Fee: The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a

5 33. Missing Teeth Information: Mark an "X" on the number of the missing tooth – for identifying
6 missing permanent dentition only. Report missing teeth when pertinent to Periodontal,
7 Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim

8 **NOTE:** Numbers marked are based on tooth morphology, not anatomic position.

9 34. Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source:

10 **AB** = ICD-10-CM

11 34a Diagnosis Code(s): Enter up to four applicable diagnosis codes after each letter (A. – D.). The
12 primary diagnosis code is entered adjacent to the letter "A."

13 **NOTE:** #34 and #34a are required when a) the diagnosis may have an impact on the
14 adjudication of the claim in cases where specific dental procedures may
15 minimize the risks associated with the connection between the patient's oral
16 and systemic health conditions; or b) when required by state regulation (e.g.,
17 Medicaid) or third-party payer contract provisions.

18 Detailed guidance on reporting ICD-10-CM diagnosis codes is posted on the
19 ADA CDT Code web page –

20 [ICD Reporting on ADA Dental Claim Form](#)

21 35. Remarks: This space may be used to convey additional information for a procedure code that
22 requires a report, or for multiple supernumerary teeth. It can also be used to convey additional
23 information you believe is necessary for the payer to process the claim (e.g., for a secondary
24 claim, the amount the primary carrier paid).

25 Remarks should be concise and pertinent to the claim submission. Claimants should note that an
26 entry in "Remarks" may prompt review by a person as part of claim adjudication, which may affect
27 overall time required to process the claim.

28 **NOTE:** When the claim is for a multi-unit implant supported prosthesis the supporting
29 implant body locations may not correlate to the anatomic location of a natural
30 tooth. An appropriate notation in "Remarks" may avoid a misunderstanding
31 when the claim is submitted to a third-party payer.

32 **Authorizations**

33 This section provides consent for treatment as well as permission for the payer to send any patient
34 benefit available for procedures performed directly to the dentist or the dental business entity.

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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

1

2
3
4
5

36. **Patient Consent:** The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient’s parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.

6
7
8
9

By signing (or “Signature on File” notice) in this location of the claim form, the patient or patient’s representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.

10
11

Claim forms prepared by the dentist’s practice management software may insert “Signature on File” when applicable in this Item.

12
13
14
15

37. **Authorize Direct Payment:** The signature and date (or “Signature on File” notice) are required when the Policyholder/Subscriber named in Item #12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company.

16
17

Claim forms prepared by the dentist’s practice management software may insert “Signature on File” when applicable in this Item.

18 **Ancillary Claim/Treatment Information**

19 This section of the claim form provides additional information to the third-party payer regarding the claim.

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)	
38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use “Place of Service Codes for Professional Claims”)	39. Enclosures (Y or N) 39a. Date Last SRP
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)
42. Months of Treatment	43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)
45. Treatment Resulting from <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

20

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- 1 38. Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims, a
2 HIPAA standard. Frequently used codes are:
- 3 **11** = Office; **12** = Home; **21** = Inpatient Hospital; **22** = Outpatient Hospital; **31** =
4 Skilled Nursing Facility; **32** = Nursing Facility; **02** = Telehealth (aka Teledentistry)
- 5 All current codes are available online from the Centers for Medicare and Medicaid Services in
6 PDF format for download –
- 7 [CMS Place of Service Code Set](#)
- 8 39. Number of Enclosures (00 to 99): Enter a “Y” or “N” to indicate whether or not there are
9 enclosures of any type included with the claim submission (e.g., radiographs, oral
10 images, models).
- 11 39a. Date Last SRP: Enter the date of service for the last Scaling and Root Planing procedure (e.g.,
12 D4341) delivered to the patient in the space immediately to the right of this data element caption;
13 date format is MM/DD/CCYY. (Leave blank if not applicable to claim or if not known.).
- 14 40. Is Treatment for Orthodontics?: **If no, skip to Item #43.** If yes, answer Items 41 & 42.
- 15 41. Date Appliance Placed (MM/DD/CCYY): Indicate the date an orthodontic appliance was placed.
16 This information should also be reported in this section for subsequent orthodontic visits.
- 17 42. Months of Treatment: Enter the total number of months required to complete the orthodontic
18 treatment, from the beginning to the end of the treatment plan.
- 19 43. Replacement of Prosthesis?: This Item applies to Crowns and all Fixed or Removable Prostheses
20 (e.g., bridges and dentures).
- 21 Please review the following three situations in order to determine how to complete this Item.
- 22 a) If the claim does not involve a prosthetic restoration mark “NO” and proceed to Item
23 45.
- 24 b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis,
25 mark “NO” and proceed to Item 45.
- 26 c) If the patient has previously had these teeth replaced by a crown, or a fixed or
27 removable prosthesis, or the claim is to replace an existing crown, mark the “YES”
28 field and complete section 44.
- 29 44. Date of Prior Placement (MM/DD/CCYY): Complete if the answer to Item #43 was “YES.”
- 30 45. Treatment Resulting From: If the dental treatment listed on the claim was provided as a result of
31 an accident or injury, mark the appropriate box in this item, and proceed to Items #46 and #47. **If**
32 **the services you are providing are not the result of an accident, this Item does not apply;**
33 **skip to Item #48.**
- 34 46. Date of Accident (MM/DD/CCYY): Enter the date on which the accident noted in Item #45
35 occurred. Otherwise, leave blank.
- 36 47. Auto Accident State: Enter the state in which the auto accident noted in Item #45 occurred.
37 Otherwise, leave blank.

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1 **Billing Dentist Or Dental Entity**

2 The 'Billing Dentist' or 'Dental Entity' section provides information on the individual dentist's name, the
3 name of the practitioner providing care within the scope of their state licensure, or the name of the group
4 practice/corporation that is responsible for billing and other pertinent information. Depending on the
5 business relationship of the practice and the treating dentist, the information provided in this section may
6 not be the treating dentist. **If the patient is submitting the claim directly, do not complete Items 48-**
7 **52a.**

48. Name, Address, City, State, Zip Code			
49. NPI		50. License Number	51. SSN or TIN
52. Phone Number	() -	52a. Additional Provider ID	

8

9 48. Name, Address, City, State, Zip Code: Enter the name and complete address of a dentist or the
10 dental entity (corporation, group, etc.).

11 49. NPI (National Provider Identifier): Enter the appropriate NPI type for the billing entity. A Type 2
12 NPI is entered when the claim is being submitted by an incorporated individual, group practice or
13 similar legally recognized entity. Unincorporated practices may enter the individual practitioners
14 Type 1 NPI.

15 **NOTE:** The NPI is an identifier assigned by the Federal government to all providers
16 considered to be HIPAA covered entities. Dentists who are not covered entities may
17 elect to obtain an NPI at their discretion, or may be enumerated if required by a
18 participating provider agreement with a third-party payer, or applicable state
19 law/regulation.

20 An NPI is unique to an individual dentist or dental entity, and has no intrinsic meaning. There
21 are two types of NPI available to dentists and dental practices:

- 22 • Type 1 Individual Provider - All individual dentists are eligible to apply for Type 1
23 NPIs, regardless of whether they are covered by HIPAA.
- 24 • Type 2 Organization Provider - A health care provider that is an organization, such
25 as a group practice or corporation. Individual dentists who are incorporated may
26 enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All
27 incorporated dental practices and group practices are eligible for enumeration as
28 Type 2 providers.

29 On paper, there is no way to distinguish a type 1 from a type 2 in the absence of any
30 associated data; they are identical in format. Additional information on NPI and enumeration
31 can be obtained from the CMS' Internet Web Site – [National Provider Identifier \(NPI\)](#)

32 50. License Number: If the billing dentist is an individual, enter the dentist's license number. If a
33 billing entity (e.g., corporation) is submitting the claim, leave blank.

34 51. SSN or TIN: Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of
35 the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing
36 entity is a group practice or clinic.

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1 52. Phone Number: Enter the business phone number of the billing dentist or dental entity.

2 52a. Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other
3 than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's
4 NPI.

5 The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be
6 unique as they are assigned by different entities (e.g., third-party payer; federal government).
7 Some Legacy IDs have an intrinsic meaning.

8 **Treating Dentist And Treatment Location Information**

9 **This section must be completed for all claims.** Information that is specific to the dentist or practitioner
10 acting within the scope of their state licensure who has provided treatment is entered in this section.

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	
53a. Locum Tenens Treating Dentist? <input type="checkbox"/>	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number () -	58. Additional Provider ID

11
12 53. Certification: Signature of the treating or rendering dentist and the date the form is signed. This is
13 the dentist who performed, or is in the process of performing, procedures, indicated by date, for
14 the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not
15 necessary for the dentist to sign the form.

16 Claim forms prepared by the dentist's practice management software may insert the treating
17 dentist's printed name in this item.

18 53a. Locum Tenens Dentist: Enter a "Y" immediately after this data element's caption to indicate
19 whether or not the treating dentist is providing services is a locum tenens capacity. (Leave blank if
20 not applicable.)

21 54. NPI (National Provider Identifier): Enter the treating dentist's Type 1 – Individual Provider NPI in
22 Item # 54. (See Item #49 for more NPI information.)

23 **NOTE**: This will be the "locum tenens" dentist's NPI when applicable.

24 55. License Number: Enter the license number of the treating dentist. This may vary from the billing
25 dentist.

26 **NOTE**: This will be the "locum tenens" dentist's license number when applicable.

27 56. Address, City, State, Zip Code: Enter the physical location where the treatment was rendered.
28 Must be a street address, not a Post Office Box.

29 **NOTE**: For teledentistry encounters the treatment location is the dentist's practice location,
30 not the patient's location.

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- 1 56a. Provider Specialty Code: Enter the code that indicates the type of dental professional who
2 delivered the treatment. Available codes describing treating dentists follow. The general code
3 listed as “Dentist” may be used instead of any other dental practitioner codes.

4 **NOTE:** This will be the “locum tenens” dentist’s specialty when applicable.

Category / Description	Code
Dentist / a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice / a dentist who provides a variety of dental services to address patient needs.	1223G0001X
Dental Specialty / a practitioner in one of the nine specialty areas recognized by the ADA.	See following list
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223x0008X
Oral & Maxillofacial Surgery	1223S0112X

- 5 These codes are from the “Dental Service Providers” section of the Healthcare Providers
6 Taxonomy code list, a HIPAA standard, and are a subset of the full list that includes codes for
7 other types of practitioners including dental assistants, dental hygienists, denturists, and dental
8 lab technicians. The current full list is posted online –

9 [Health Care Provider Taxonomy Code Set](#)

- 10 57. Phone Number: Enter the business telephone number of the treating dentist.

11 **NOTE:** This will be the “locum tenens” dentist telephone number, when applicable.

- 12 58. Additional Provider ID: This is an identifier assigned to the treating dentist other than a Social
13 Security Number (SSN) or Tax Identification Number (TIN). It is not the provider’s NPI.

14 The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be
15 unique as they are assigned by different entities (e.g., third-party payer; Federal government).
16 Some Legacy IDs have an intrinsic meaning.

17 **NOTE:** This will be the “locum tenens” dentist’s Additional Provider ID when applicable.