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

INSU…Y/DENTAL BENE…AN INFORMAT…

3. C…any/Plan Name, …ss, City, State, Z…

O…R COVERAGE

4. O…ntal or Medi…verage ☐ No (Skip 5-11) ☐ …Complete…

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

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/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

OI-P M-8

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

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

Member, Im A.

13. Date …	14. …er ☐ M ☐ F	15. Policyhold… …ID (SSN or ID#)
MM/DD/CCYY		1234567890
16. Plan…p Number	17. Em…r Name	

PATIENT INFORMATION

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

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), 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	MM/DD/CCYY					D0120	Exam - oral evaluation	XXX XX
2	MM/DD/CCYY					D1120	Prophylaxis	XX XX
3								
4								
5								
6								
7								
8								
9								
10								

MISSI…ORMATION

34. (Place an 'X' on each m… tooth)

Perm…nt																Pr…																
1	2	3	…	5	6	…	8	…	10	…	12	…	14	1…	…	A	B	C	D	E	…	G	H	I	J	…						
…	…	…	28	27	…	25	2…	23	…	21	…	19	1…	17	…	T	S	R	Q	P	…	N	M	L	K	…						

…Fee(s) XX XX

…tal Fee XXX XX

35. R…rks

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 ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

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

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

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

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date 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

Dental Group
1 W. Williams St.
Anytown, WI 55555-1234

49. NPI	50. License Number	51. SSN or TIN
0111111110		

52. Phone Number ( ) – 52A. Additional Provider ID 123456789X

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 *I.M. Provider* MM/DD/CCYY
Signed (Treating Dentist) Date

54. NPI 0222222220	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code 123456789X

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

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

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