ADA American Dental Association[®] Dental Claim Form

- Pop

plot

HADEN PHORMATION Encode of the PORMATION Encode of the PORMATION Encode of the PORMATION		tai AS:	sociatioi	Denta			- -							1 0	d Comert			
Comparison of Ankare Strocks Comparison Comparin Comparison Comparison Comparison Comparison		licable box	(20					hm	75	Sa		A	·**					
A decima of a constrained of the Base Advances Advances Advances Advances Advances Advances Advances Advances Advances Advances Advan																		
								Herrichurg DA 17106 0426										
Partial ENGERT PLAN INFORMATION Company/Part Name, Address, CDy, Bass, Zp Color Partial ENGENT Name, Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State State (State), Address, CDy, Bass, Zp Color The Control Partial Ender State																		
	2. Predetermination/Preauthorization Number																	
							12	2. Policyholde	r/Subscr	iber Name	(Last	, ⊢ırst, M	iddle Ir	nitial, Suffix),	, Address,	City, Stat	ie, Zip Code	
OTHER COVERAGE Intel statistical is and complete times 2-11. If now, lower blank, if 10. Part Group Hunder 11. Condustment of the statistical is and complete times 2-11. If now lower blank, if 0. Nome of Participation Subscitter in at Late, Yinck Model Initial, Station 10. Part Group Hunder 11. Condustment of the statistication in at 12 Advoc 10. Recorded Conduction Cond	3. Company/Plan Name, Address, C	City, State, 2	Zip Code															
OTHER COVERAGE (Mar exclude board conglete time 3-11. If mays have ideal.) 10. PlancTex Minder (Mar exclude board conglete time 3-11. If mays have ideal.) 10. PlancTex Minder (Mar exclude board conglete time 3-11. If mays have ideal.) 10. Near of Planchade backster in a Lao., Vird, Made Index, Mitti 10. PlancTex Minder (Mar exclude backster) 11. Displayster in an additional (Mar exclude backster) 12. Displayster in an additional (Mar exclude backster) 13. Displayster in a additional (Mar exclude backster) 13. Displayster in a additional (Mar exclude backster) 13. Displayster in additional (Mar exclude backster) 11. Displayster in additional (Mar exclude backster) 13. Displayster in additional (Mar exclude backster) 13. Displayster <td></td>																		
OTHER COVERAGE (Mar exclude board conglete time 3-11. If mays have ideal.) 10. PlancTex Minder (Mar exclude board conglete time 3-11. If mays have ideal.) 10. PlancTex Minder (Mar exclude board conglete time 3-11. If mays have ideal.) 10. Near of Planchade backster in a Lao., Vird, Made Index, Mitti 10. PlancTex Minder (Mar exclude backster) 11. Displayster in an additional (Mar exclude backster) 12. Displayster in an additional (Mar exclude backster) 13. Displayster in a additional (Mar exclude backster) 13. Displayster in a additional (Mar exclude backster) 13. Displayster in additional (Mar exclude backster) 11. Displayster in additional (Mar exclude backster) 13. Displayster in additional (Mar exclude backster) 13. Displayster <td></td>																		
OTHER COVERAGE (Interception between them s-11 if it more, item bank) It dentar It de							13	Date of Birth	n (MM/D	D/CCYY)	14		_	15. Policyh	older/Subs	criber ID (Assigned by Pla	
4. Genery Michael Price (Prote complete 5:11 for domainary) Protect for domain of the domain of												MF_	U					
S Name of Poliginologic Bulaceber in P & Lass, Frist, Modele Initial, Edition B Data of Binn (MARDECCY) T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Cancer T Can	OTHER COVERAGE (Mark ap	plicable bo	x and complete	items 5-11. If no	one, leave blank	.)	16	6. Plan/Group	Number		17. E	mployer	Name					
	4. Dental? Medical?	(If both, comple	te 5-11 for dent	al only.)													
B. Date of Binn (BMXDDCCYY) 7. Gener 6. Microsofter Difference Conjugation 0. Binn 0. Binn </td <td>5. Name of Policyholder/Subscriber</td> <td>in #4 (Las</td> <td>t, First, Middle</td> <td>Initial, Suffix)</td> <td></td> <td></td> <td>P</td> <td>ATIENT IN</td> <td>FORM</td> <td>ATION</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	5. Name of Policyholder/Subscriber	in #4 (Las	t, First, Middle	Initial, Suffix)			P	ATIENT IN	FORM	ATION								
B. Basin of Rism (MADDCCYY) P. Olschweiselskeuteke ID (Paurgee to Prein) Bell Becode USA Other B. Rism (Mandbaccov) D. Patient Relationation to the Decominationation to December 10 Paurgee 1							18	8. Relationship	to Polic	yholder/Su	ubscri	ber in #12	2 Abov	e	19			
0 ParkGroup Number 20 Date of Barth (MAUDDCC/VY) 22 Gener 21 Date of Barth (MAUDDCC/VY) 22 Date of Barth (MAUDDCC/VY) 23 Date of Barth (MAUDDCC/VY) 23 Date of Barth (MAUDDCC/VY) 23 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDDCC/VY) 25 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDDCC/VY) 25 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDDCC/VY) 25 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDDCC/VY) 25 Date of Barth (MAUDDCC/VY) 25 Date of Barth (MAUDDCC/VY) 24 Date of Barth (MAUDCC/VY) 25 Da	6. Date of Birth (MM/DD/CCYY)	7. Gend	er 8. F	Policyholder/Subs	scriber ID (Assigr	ned by Plan)	Self	Sp	ouse	Dep	pendent (Child	Other		i uluie	036	
In other Insurance Company/Denial Benefit Plan Home, Address, Ciry, State, Zip Code 11. Other Insurance Company/Denial Benefit Plan Home, Address, Ciry, State, Zip Code 21. Date of Bish: (MMXDDCCCYY) 2. Earlier 21. Date of Bish: (MMXDDCCCYY) 2. Date of Bish: (MMXDDCCCYY) 2. Patient IDAccount # (Assigned by Centist) RECORD OF SERVICES PROVIDES 31. free 31. free 1 0. date 2. Date of Bish: (MMXDDCCCYY) 2. Carding 31. free 1 0. date 2. Date of Bish: (MMXDDCCCYY) 2. Carding 31. free 2 0. date 2. Date of Bish: (MMXDDCCCYY) 2. Carding 31. free 3 4 0. date 1. date 1. date 1. date 3 4 0. date 1. date 1. date 1. date 3 4 0. date 1. date 1. date 1. date 3 4 5 7. Samp 34. Daggeoda Code Lid Qualifier (ICC-10 - AB) 31. Gree 3 4 5 7. Samp 34. Daggeoda Code Lid Qualifier (ICC-10 - AB) 35. Daggeoda Code Lid Qualifier 12 3. date 7. date 5 7. date <		M	FU				20	0. Name (Last	, First, N	liddle Initial	l, Suff	ix), Addre	ess, Ci	ty, State, Zip	o Code			
11. Other Insurance Company/Denial Bendit Plan Name, Address, Diy, Site: Zp Code 21. Date of Bith (MADDCCY) 20. Patient (DiAccount # (Assigned by Dential)) RECORD OF SERVICES PROVIDED 31. Provider Date 20. Date of Bith (MADDCCY) 20. Date of Bith (MADDCCY) 20. Date of Bith (MADDCCY) 31. Provider Date 21. Date of Bith (MADDCCY) 20. Date of Bith (MADDCCY) 20. Date of Bith (MADDCCY) 21. Date of Bith (MADDCCY) 32. Address Date of Bith (MADDCCY) 20. Date of Bith (MADDCCY) 20. Date of Bith (MADDCCY) 21. Date of Bith (MADDCCY) 21. Date of Bith (MADDCCY) 32. Address Date of Bith (MADDCCY) 21. Date of Bith (MADDCCY) 21. Date of Bith (MADDCCY) 31. Reference 33. Meany Tesh Information. (Hold on MY on each means both) 34. Daspose Code List Quarker (ICD-10 - Ab) 31a. Other means 33. Meany Tesh Information. (Hold on MY on each means both) 34. Daspose Code List Quarker (ICD-10 - Ab) 31a. Other means 33. Meany Tesh Information. (Hold on MY on each means both) 34. Daspose Code List Quarker (ICD-10 - Ab) 23. Task Fee 33. Meany Tesh Information. (Hold on MY on each means both) 34. Daspose Code List Quarker (ICD-10 - Ab) 23. Task Fee 33. Meany Tesh Information. (Hold on MY on each means both) 34. Daspose Code List Quarker<	9. Plan/Group Number	10. Patie	ent's Relations	nip to Person na	imed in #5		1											
21. Date of Birth (MMCDCCCY) 22. Gender 23. Prierit IDAccount # (Assigned by Decide) 24. Decide of Birth (MMCDCCCY) 0. Decisiplen 31. Fee 24. Microbia 0. Decisiplen 31. Fee 31. Decide of Birth (MMCDCCCY) 0. Decisiplen 31. Fee 42. Microbia 0. Decisiplen 31. Fee 32. Microbia 0. Decisiplen 31. Fee 43. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 33. Microbia 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 34. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 35. Microbia 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 35. Microbia 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 36. Microbia 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 0. Decisiplen 37. Decisiplen 0. D		Sel	lf Spou	use Depe	endent O	ther												
RECORD OF SERVICES PROVIDED Difference	11. Other Insurance Company/Dent	al Benefit F	Plan Name, Ado	dress, City, State	e, Zip Code		1											
RECORD OF SERVICES PROVIDED Difference																		
RECORD OF SERVICES PROVIDED 2 1 21. Tooh, Tooh, 27. Tooh, Anneheng) 28. Touth 20. Description 31. Free 3 2 1 2 1 2 1 2 1 2 1 20. Description 31. Free 3 2 1 2 2 2							2'	1. Date of Birtl	n (MM/D	D/CCYY)	22	. Gender	r	23. Patient	t ID/Accour	nt # (Assi	gned by Dentist	
24 Processme Dram 0/4 Mark 0/4 Mark 27 Torph humanny 28 Torph 29 Decoder 20 Decopetor 31 Decoder 29 Decoder 20 Decopetor 31 Decoder 20 Decopetor 31 Decoder 29 Decoder 20 Decopetor 20 Decopetor 20 Decoder												M F	U					
Arrobaling Children	RECORD OF SERVICES PRO	VIDED												1				
UMMODECYY Code Porter Dy. St. Description St. The 1 Image: Code Image: Code Porter Dy. St. Description St. The 2 Image: Code Image: Cod			27. Tooth	Number(s)	28. Tooth	29. Proce	edure	29a. Diag.	29b.								04 F	
3 A B A A B A B A B A B A B A B													30. Des	cription			31. Fee	
3 A B A A B A B A B A B A B A B	1																	
4 A	2																	
6 1 2 1 2 1 2 1 2 1 2 1 2 1 2 31a. Other Fee(9)	3																	
a a	4																	
a a	5																	
7																		
B Image: Constraint of the state of t																		
a Image: Second Sec																		
1 2 34. Diagnosis Code List Qualifier 34. Diagnosis Code (S) A 34. Diagnosis Code (S) A 34. Diagnosis Code (S) A C Fee(s)																		
33. Missing Teeth Information (Place an 'X' or each missing tooth.) 34. Diagnosis Code List Qualifier (ICD-10 = AB) 31e. Other Fee(s) 1 2 3 4 5 6 7 8 9 10 11 12 13 44 15 16 34a. Diagnosis Code(s) A																		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34e. Diagnosis Code(s) A C Fee(s) 32. Todal Fee 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagnosis in 'A') B D D 32. Todal Fee 35. Remarks AUTHORIZATIONS ANCILLARY CLAIM/TREATMENT INFORMATION 38. Enclosures (Y or N) (Use "Place of Treatment (d.g. 11=office; 22=0/P Hospital) 39. Enclosures (Y or N) at a portion of the treatment plan and associated fees. Lagree to be responsible for all to a such charges. To the otwing permited by law Loader disclosure and materials not pad by my dental benefit plan, unless prohibited by law Loader disclosure and materials not pad by my dental benefit plan. Unless prohibited by law Loader disclosure and materials not pad by my dental benefit plan. Unless prohibited by law Loader disclosure and materials not pad by my dental benefit plan and associated fees. Lagree to be responsible for all to a such charges. The be dont permited by law Loader and disclosure and materials how pad permited by law Loader and disclosure and materials how pad permited by law Loader and disclosure and materials how pad permited by law Loader and disclosure and materials how pad permited by law Loader and material and pad permited by law Loader and material				(b.)		<u> </u>	0 1			(105.44					210.0	Other		
32 31 30 29 27 26 25 24 23 21 20 19 18 17 Primary diagnosis in "A") B D 32. Total Fee 35. Remarks AUTHORIZATIONS ANCILLARY CLAIMTREATMENT INFORMATION 32. Total Fee 33. Place of Treatment is particular based by dentals not paid by my dental benefit plan, unless prohibited by law, it consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. 39. Place of Treatment is particular to Otheodontics? 41. Date Appliance Placed (MM/DD/CCYY) W Patient/Guardian Signature Date 0 No (Skip 41-42) Yes (Complete 41-42) 44. Date of Prior Placement (MM/DD/CCYY) 37. I hereby subhorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. No (Skip 41-42) Yes (Complete 41-42) 44. Date of Prior Placement (MM/DD/CCYY) 37. I hereby subhorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.) Date 45. Treatment Resulting from 10. Coccupational illiness/injury Auto accident 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State BILLING DENTIST OR DENTAL ENTIFY (Leave blank if dentist or dental entity			-	-		-			, I	(ICD-10) = AB	,						
AUTHORIZATIONS ANCILLARY CLAIM/TREATMENT INFORMATION 36. Nave been informed of the treatment plan and associated fees. I agree to be responsible for all charads or dental services and materials not paid by my dental benefit plan, unless prohibiting all or a portion of such charges. To the extert permitted by law, consent to your use and discourse of Service Codes for Professional Claims*) 39. Enclosures (Y or N) 27. Indext been informed of the treatment plan and associated fees. I agree to be responsible for all of such charges. To the extert permitted by law, consent to your use and disclosure 39. Place of Treatment (1,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0						•		.,							- 32 To	tal Foo		
AUTHORIZATIONS ANCILLARY CLAIM/TREATMENT INFORMATION 36. Inave been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials and paids by my dental benefit plan, unless prohibiting all or a portion of such charges. To the extent permitted by law, crosment your use and discourse of my protected health information to carry out payment activities in connection with this claim. 39. Place of Treatment degree the extent degree the extent information to carry out payment activities in connection with this claim. 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY) V Patient/Guardian Signature Date 42. Months of Treatment 1 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY) 40. Date Appliance Placed (MM/DD/CCYY) Y		0 20 24	23 22 2	1 20 19 1	8 17 (F1	inary ulagi	10313 1	((A)	в			D			_ 52.10			
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, i consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. 38. Place of Treatment	35. Remarks																	
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, i consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. 38. Place of Treatment																		
charges for dental services and materials not paid by my dental benefit plan, unless prohibited gl 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.			and associated	lfoos Lagroo to	bo rosponsiblo	for all				_					nclosuros	(X or N)		
iaw, or the treating densits or dential practice has a contractual agreement with my plan prohoting air or a portion of such charges. To the extern permitted by law. consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY) Y Patient/Guardian Signature Date 42. Months of Treatment for Orthodontics? 44. Date of Prior Placement (MM/DD/CCYY) 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Nd Yes (Complete 41-42) 44. Date of Prior Placement (MM/DD/CCYY) 45. Treatment Resulting from Occupational illness/injury Auto 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 subnitting claim on behalf of the patient or insured/subscriber.) Treatment Resulting from S1. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. 49. NPI 50. License Number 51. SSN or TIN S2. Phone 55. Provider S8. Additional	charges for dental services and	materials n	ot paid by my d	ental benefit pla	an, unless prohit	pited by	30. г							39. L				
my protected health information to carry out payment activities in connection with this claim. 40. Is Treatment for Orthodorius? 41. Date Appliance Placed (MW/DD/CCYT) Patient/Guardian Signature Date 42. Months of Treatment of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY) 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. No (Skip 41-42) 42. Months of Treatment data Signature 44. Date of Prior Placement (MM/DD/CCYY) 45. Treatment Resulting from Occupational illness/injury Auto accident Other accident Subscriber Signature Date 45. Treatment Resulting from 0 Cocupational illness/injury Auto accident BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.) TREATING DENTIST AND TREATMENT LOCATION INFORMATION 48. Name, Address, City, State, Zip Code Signed (Treating Dentist) Date 49. NPI 50. License Number 51. SSN or TIN 55. License Number 56. Address, City, State, Zip Code 52. Phone 52. Additional 57. Phone 58. Additional	or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of						40.1											
Patient/Guardian Signature Date 42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY) 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Nd Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY) X Cocupational illness/injury Auto accident Other accident Subscriber Signature Date 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.) Solution of the patient or insured/subscriber.) 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 49. NPI 50. License Number 51. SSN or TIN 52. Phone 52a. Additional 57. Phone 58. Additional							40. 1				(0			41. Dat	e Applianc	e Placed		
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Nc Yes (Complete 44) 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Nc Yes (Complete 44) 37. I hereby authorize and direct payment of the dental entity. Auto accident Other accident X								,	. ,			•	,					
37.1 Intereby authorize and direct payment of the derital benefits otherwise payable to me, directly to the below named dentist or dental entity. 45. Treatment Resulting from X	Patient/Guardian Signature			Dat	ie		42. N	Nonths of Trea	itment						e of Prior F	Placemen	t (MM/DD/CCY	
X Date Occupational illess/injury Auto accident Other accident Subscriber Signature Date 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.) TREATING DENTIST AND TREATMENT LOCATION INFORMATION 48. Name, Address, City, State, Zip Code TREATING DENTIST OR DENTAL ENTITY Value 49. NPl 50. License Number 51. SSN or TIN 53. Phone 58. Additional				its otherwise pa	yable to me, dir	ectly				No	١	es (Com	plete 4	4)				
Subscriber Signature Date 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.) TREATING DENTIST AND TREATMENT LOCATION INFORMATION 48. Name, Address, City, State, Zip Code X Signed (Treating Dentist) Date 49. NPI 50. License Number 51. SSN or TIN 51. SSN or TIN 53. Phone 58. Additional	to the below named dentist or d	ental entity	<i>.</i>				45. T	reatment Res	ulting fro	m								
Notesticity (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.) TREATING DENTIST AND TREATMENT LOCATION INFORMATION 48. Name, Address, City, State, Zip Code 48. Name, Address, City, State, Zip Code 51. hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. 49. NPI 50. License Number 51. SSN or TIN 52. Phone 52. Additional 57. Phone 58. Additional	Χ							Occupa	tional illr	ness/injury		A	uto acc	ident	Othe	er acciden	nt	
submitting claim on behalf of the patient or insured/subscriber.) 48. Name, Address, City, State, Zip Code 48. Name, Address, City, State, Zip Code 48. Name, Address, City, State, Zip Code 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 55. Dicense Number 51. SSN or TIN 55. Phone 57. Phone 58. Additional	Subscriber Signature			Dat	ie		46. C	Date of Accide	nt (MM/[DD/CCYY)					47. Au	ito Accide	ent State	
48. Name, Address, City, State, Zip Code 53. Inereby Certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X					dental entity is r	not	TRE	ATING DE	NTIST	AND TRE	EATI		OCA	TION INFO	ORMATI	ON		
46. Name, Address, City, State, Zip Code 46. Name, Address, City, State, Zip Code X	submitting claim on behalf of the pa	atient or ins	ured/subscribe	er.)									by dat	e are in prog	gress (for p	rocedure	es that require	
Signed (Treating Dentist) Date 54. NPI 55. License Number 56. Address, City, State, Zip Code 56a. Provider Specialty Code 51. SSN or TIN 51. SSN or TIN 52. Phone 52. Additional	48. Name, Address, City, State, Zip	Code					n	nultiple visits)	or have	been comp	pletec	Ι.						
Signed (Treating Dentist) Date 54. NPI 55. License Number 56. Address, City, State, Zip Code 56a. Provider Specialty Code 59. NPI 50. License Number 51. SSN or TIN 57. Phone 52. Phone 57. Phone							х											
49. NPI 50. License Number 51. SSN or TIN 52. Phone 52a. Additional_ 57. Phone 57. Phone 58. Additional							<u>^</u> _											
49. NPI 50. License Number 51. SSN or TIN 52. Phone 52a. Additional 57. Phone 57. Phone 58. Additional							54. N	NPI					55. L	icense Num	ber			
49. NPI 50. License Number 51. SSN or TIN 52. Phone 52a. Additional 57. Phone 58. Additional							56. A	Address, City,	State, Zi	p Code			56a.	Provider ialty Code				
52. Phone 52a. Additional 57. Phone 58. Additional	49. NPI 5	0. License	Number	51. SSN	or TIN								Sher	any Ooue				
52. Phone 52a. Additional 57. Phone 58. Additional																		
	52. Phone		52a.	Additional Provider ID			57.	Phone										

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

- 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	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:

http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/