

ADA Dental Claim Form (2012 © American Dental Association) Completion Instructions

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Introduction

The ADA Dental Claim Form has been revised to incorporate key changes to the HIPAA standard electronic dental claim transaction. This version of the form, front and reverse sides, is illustrated on the next two pages.

Comprehensive completion instructions for this version (2012 © American Dental Association) follow the illustration. Please note that changes to the form and changes to the completion instructions are **highlighted**.

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX											
2. Predetermination/Preauthorization Number					POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)						
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION											
3. Company/Plan Name, Address, City, State, Zip Code											
13. Date of Birth (MM/DD/CCYY)					14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)				
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)					16. Plan/Group Number		17. Employer Name				
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)					PATIENT INFORMATION						
6. Date of Birth (MM/DD/CCYY)					7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)		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		
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											
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		23. Patient ID/Account # (Assigned by Dentist)				
RECORD OF SERVICES PROVIDED											
1	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	
33. Missing Teeth Information (Place an "X" on each missing tooth.)						34. Diagnosis Code List Qualifier		(ICD-9 = B, 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											
AUTHORIZATIONS						ANCILLARY CLAIM/TREATMENT INFORMATION					
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 _____ (e.g. 11-office, 22-OP Hospital) 39. Enclosures (Y or N) _____ (Use "Place of Service Codes for Professional Claims")					
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)			
						42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)			
						44. Date of Prior Placement (MM/DD/CCYY)					
						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			
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						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		54. NPI		55. License Number			
						56. Address, City, State, Zip Code		56a. Provider Specialty Code			
52. Phone Number () -			52a. Additional Provider ID			57. Phone Number () -			58. Additional Provider ID		

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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 printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

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 CDT manual's instructions.
- 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.

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). There are additional detailed completion instructions in the CDT manual.

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 (B for ICD-9-CM; 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 "www.cms.gov/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 "www.wpc-edi.com/codes/taxonomy"

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DATA ELEMENT SPECIFIC INSTRUCTIONS

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

Header Information

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

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

1. Type of Transaction: There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box marked "Request for Predetermination / Preauthorization". If the claim is through the **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment **P**rogram, mark the box marked 'EPSDT/Title XIX'.
2. Predetermination/Preauthorization Number: If you are submitting a claim for a procedure that has been pre-authorized by a third party payer, enter the preauthorization or predetermination number provided by the insurance company.

Insurance Company/Dental Benefit Plan Information

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

3. Company/Plan Name, Address, City, State, Zip Code: **This item is always completed.** Enter the information for the insurance company or dental benefit plan that is the third party payer receiving the claim.
 - If the patient is covered by more than one plan, enter the primary insurance company information here for the initial claim submission.

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

Other Coverage

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

- When the claim form is being prepared for submission to the primary carrier the information in "Other Coverage" applies to the secondary carrier.
- When the claim form is being prepared for submission to the secondary carrier the information in "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	8. Policyholder/Subscriber ID (SSN or ID#)
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		

4. **Other Dental or Medical Coverage?:** Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage.
 - Leave blank when the dentist is not aware of any other coverage(s).
 - When either box is marked, complete Items 5 through 11 in the "Other Coverage" section for the applicable benefit plan.
 - If both Dental and Medical are marked, enter information about the dental benefit plan in Items 5 through 11.
5. **Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix):** If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.

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6. Date of Birth (MM/DD/CCYY): Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.
7. Gender: Mark the gender of the person who is listed in Item #5. Mark "M" for Male or "F" for Female as applicable.
8. Policyholder/Subscriber Identifier (SSN or ID#): Enter the social security number or the identifier number of the person who is listed in Item #5. The identifier number is a number assigned by the payer/insurance company to this individual.
9. Plan/Group Number: Enter the group plan or policy number of the person identified in Item #5.
10. Patient's Relationship to Person Named in Item #5: Mark the patient's relationship to the other insured named in Item #5.
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code: Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

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

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

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

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company 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 <input type="checkbox"/> M <input type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Enter the complete name, address and zip code of the policyholder/subscriber with coverage from the company/plan named in #3.
13. Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year.

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14. Gender: This applies to the primary insured, who may or may not be the patient. Mark "M" for male or "F" for female.
15. Policyholder/Subscriber Identifier (SSN or ID#): Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in Item #12, which is on their identification card.
16. Plan/Group Number: Enter the policyholder/subscriber's group plan/policy number.
17. Employer Name: If applicable, enter the name of the policyholder/subscriber's employer.

Patient Information

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

18. Relationship to Policyholder/Subscriber in #12 Above: Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. **If the patient is also the primary insured, mark the box titled 'Self' and skip to item #23.**
19. Reserved For Future Use: Leave blank and skip to Item #20. (#19 was previously used to report "Student Status.")
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Enter the complete name, address and zip code of the patient.
21. Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.
22. Gender: This applies to the patient. Mark "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist): Enter if the dentist's office has assigned a number to identify the patient. This is not required to process claim.

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Record Of Services Provided

The 'Record Of Services Provided' contains information regarding the proposed treatment (predetermination/preauthorization), 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			(ICD-9 = B; 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	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A")	B	D		32. Total Fee
35. Remarks																				

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

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

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

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

- a. Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as **D4263 bone replacement graft – first site in quadrant**
- b. Do not report the applicable area of the oral cavity when the procedure either: 1) incorporates a specific area of the oral cavity in its nomenclature, such as **D5110 complete denture – maxillary**; or 2) does not relate to any portion of the oral cavity, such as **D9220 deep sedation/general anesthesia – first 30 minutes**.

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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

26. **Tooth System:** Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition). Enter "JO" when using the International Standards Organization System. Additional information regarding the tooth numbering systems can be found in Sections 3 (Tooth Numbering) and 6 (Glossary) of this manual.
27. **Tooth Number(s) or Letter(s):** Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank.

If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form.

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

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

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

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

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

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

Lower Arch

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

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

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

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

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

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

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

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

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

Statement on Reporting Fees on Dental Claims

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

(Note: Item 31 above is the last of the repeating 'service line' items.)

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

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

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

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

B = ICD-9-CM AB = ICD-10-CM (as of October 1, 2013)

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

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

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

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

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

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Authorizations

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

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

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.

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.

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

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.

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

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Ancillary Claim/Treatment Information

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

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment <input type="text"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) <input type="checkbox"/>
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 Remaining	43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)
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

38. Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard. Frequently used codes are:

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

All current codes are available online from the Centers for Medicare and Medicaid Services (search for CMS place of service codes downloads).

39. Number of Enclosures (00 to 99): Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).

40. Is Treatment for Orthodontics?: **If no, skip to Item #43.** If yes, answer Items 41 & 42.

41. Date Appliance Placed (MM/DD/CCYY): Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.

42. Months of Treatment: Enter the total number of months required to complete the orthodontic treatment. (Note: This is the total number of months from the beginning to the end of the treatment plan. Some versions of the paper claim form incorrectly include the word "Remaining" at the end of this data element's name)

43. Replacement of Prosthesis?: This Item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures).

Please review the following three situations in order to determine how to complete this Item.

a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to Item 45.

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- b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Item 45.
- c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete section 44.

44. Date of Prior Placement (MM/DD/CCYY): Complete if the answer to Item #43 was "YES."
45. Treatment Resulting From: If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to Items #46 and #47. **If the services you are providing are not the result of an accident, this Item does not apply; skip to Item #48.**
46. Date of Accident (MM/DD/CCYY): Enter the date on which the accident noted in Item #45 occurred. Otherwise, leave blank.
47. Auto Accident State: Enter the state in which the auto accident noted in Item #45 occurred. Otherwise, leave blank.

Billing Dentist Or Dental Entity

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

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	

48. Name, Address, City, State, Zip Code: Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).
49. NPI (National Provider Identifier): Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or

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similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.

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

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

Type 1 Individual Provider - All individual dentists are eligible to apply for Type 1 NPIs, regardless of whether they are covered by HIPAA.

Type 2 Organization Provider - A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.

On paper, there is no way to distinguish a type 1 from a type 2 in the absence of any associated data; they are identical in format. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site:
<http://www.ada.org/goto/npi>.

50. **License Number:** If the billing dentist is an individual, enter the dentist's license number. If a billing entity (e.g., corporation) is submitting the claim, leave blank.
51. **SSN or TIN:** Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.
52. **Phone Number:** Enter the business phone number of the billing dentist or dental entity.
- 52A. **Additional Provider ID:** This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

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

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Treating Dentist And Treatment Location Information

This section must be completed for all claims. Information that is specific to the dentist or practitioner 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	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number () -	58. Additional Provider ID

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

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

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

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

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

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

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Category / Description	Code
<p style="text-align: center;">Dentist /</p> <p>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.</p>	122300000X
<p style="text-align: center;">General Practice /</p> <p>Many dentists are general practitioners who handle a wide variety of dental needs.</p>	1223G0001X
<p style="text-align: center;">Dental Specialty /</p> <p>Other dentists practice in one of the nine specialty areas recognized by the American Dental Association.</p>	Various (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	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

"Provider specialty codes" (also known as provider taxonomy codes) come from the "Dental Service Providers" section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions. Provider taxonomy codes listed above are a subset of the full code set under dental providers, which includes codes in categories for dental assistants, dental hygienists, denturists, and dental lab technicians. The current full list is posted at <http://www.wpc-edi.com/codes/codes.asp>.

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

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

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