

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)													
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																			
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.)																			
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																			
16. Plan/Group Number				17. Employer Name															
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)													
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-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 _____ (Primary diagnosis in "A") B _____ D _____		32. Total Fee	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17				
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 <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")				39. Enclosures (Y or N) <input type="checkbox"/>							
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		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			
52. Phone Number () - - - - -								52a. Additional Provider ID				57. Phone Number () - - - - -				58. Additional Provider ID			
56. Address, City, State, Zip Code								56a. Provider Specialty Code											

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"