

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
 Self Spouse Dependent Child

19. Relationship to Future

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

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

21. Policyholder/Subscriber 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. Diag. Code	31. 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

34a. Diagnosis Code(s)
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18

34. Dentist Qualifier (ICD-10 = AB)

A _____ C _____
 B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan, associated fees, and my responsibility for all charges for dental services and materials not covered by dental insurance. I understand that I am prohibited by law, or the treating dentist or dental practice from providing any financial plan prohibiting all or a portion of such charges. To the extent permitted by law, I hereby authorize you to use and disclosure of my protected health information to carry out your duties in connection with this claim.

X _____ Date _____
 Patient/Guardian

37. I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to the below named dentist.

X _____ Date _____
 Subscriber

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the policyholder/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number () -

52a. Additional Provider ID

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

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 (www.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's payment amount in the "Remarks" field (Item 35).

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. The diagnosis code is used to determine the diagnosis may affect claim adjudication when specific dental procedures may minimize the risk of complications with the condition between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedure codes by the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable to Item 34)
- 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 diagnosis code in the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Dental Services as standardized 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.

Description Code	Code
Dentist A dentist is a person who has a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practice within the scope of that license.	122300000X
General Practice	1223G0001X
Dentist 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>