ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
X Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

EveryOther Tooth Covered Insurance Company
333 Enamel Highway
Toothytown MI 11111

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) X Yes (Complete 5-11)

5. Name of Policyholder/Subscriber: Looseteeth Tom R

6. Date of Birth (MM/DD/CCYY): 02161965
7. Gender: X M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#): 2323232323
9. Plan/Group Number: ABC1212
10. Patient's Relationship to Person Named in #5: ☐ Self ☐ Spouse X Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

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

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

Looseteeth Adam M
111 Maple Street
Anywhere MI 11111

Medicaid Beneficiary ID

13. Date of Birth (MM/DD/CCYY): 05052002
14. Gender: X M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#): 1111111111
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: X 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): 90210

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	07012009					D0120	Periodic oral exam	4500
2	07012009	20				D1515	Fixed Bilateral Band Type	27500
3								
4								
5								
6								
7								
8								
9								
10								

Example of Other Insurance

Other insurance paid this amount. Deduct this amount from total combined fees in Field 31 to obtain total for Field 33

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s): 15000
33. Total Fee: 17000

35. Remarks

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

X SIGNATURE ON FILE — Patient/Guardian Signature
07302009 — 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.

SIGNATURE ON FILE — Subscriber Signature
07302009 — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: X Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99): Radiographs ☐ Dental Image(s) ☐ Models ☐
40. Is Treatment for Orthodontics? X No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? X 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,

Brightest Dentist Practice Inc
23 Full Of Smiles Drive
Best City Ever MI 22222

49. NPI: AAAAAAAAAA
50. License Number: XXXXXX
51. SSN or TIN: BBBBBBBBB
52. Phone Number: 555 555 5555
52A. Additional Provider ID

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 SIGNATURE ON FILE — Signed (Treating Dentist)
07302009 — Date

54. NPI: XXXXXXXXXX
55. License Number
56. Address, City, State, Zip Code

23 Full Of Smiles Drive
Best City Ever MI 22222

56A. Provider Specialty Code: 1223G0001X
57. Phone Number: 555 555 5555
58. Additional Provider ID

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

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