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

DENTAL MEDICAID
PO BOX 30043
LANSING MI 48909

OTHER COVERAGE

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

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

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

7. Gender ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

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

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

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

Wigglytooth Jennifer A
100 Wobbly Lane
Shakey Ground MI 33333

13. Date of Birth (MM/DD/CCYY): 12062004

14. Gender: M X F

15. Policyholder/Subscriber ID (SSN or ID#): 2222222222

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): X1234

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	07022009	40				D1515	FIXED BILATERAL SPACE MAINTAINER	000
2								
3								
4								
5								
6								
7								
8								
9								
10								

SAMPLE OF VOID/CANCEL CLAIM

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)

33. Total Fee: 0 00

35. Remarks: CRN: 9189000110 Void/Cancel

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 Signature On File — 07302009
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 Signature On File — 07302009
Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: X Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99): Radiographs ☐ Oral Images(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, Zip Code

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 — 07302009
Signed (Treating Dentist) — Date

54. NPI: XXXXXXXXXX

55. License Number

56. Address, City, State, Zip Code
23 Full Of Smile 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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