ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ 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

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ 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

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

14. Gender ☐ M ☐ F

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

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ 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)

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								
2								
3								
4								
5								
6								
7								
8								
9								
10								

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

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 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

ANCILLARY CLAIM/TREATMENT INFORMATION

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

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ 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

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number ( ) –

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

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

Sample

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

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

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 #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

Coordination of Benefits (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

National Provider Identifier (NPI)

49 and 54 NPI (National Provider Indentifier): This 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 (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: **www.ada.org/goto/npi**

Additional Provider Identifier

52A and 58 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.

Provider Specialty Codes

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

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

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at: **www.wpc-edi.com/codes/taxonomy**

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at: **www.ada.org/goto/dentalcode**

Sample

HealthChoice
www.healthchoiceok.com

Blk No.	Block Description:
1	**Type of Transaction** R Check the Request for Predetermination/Preauthorization box if this is a prior authorization or post-operative review request. Check the Statement of Actual Services box if this is a claim for completed services.
2	**Predetermination/Preauthorization Number** A If the Statement of Service box is checked in Block 1 (Type of Transaction) and the service was identified in a Predetermination of Benefits submitted to and reported by OSEEGIB, enter the OSEEGIB Predetermination of Benefits ID.
3	**Name, Address, City, State, Zip Code** R Enter the full name and address of the Insurance Company or Dental Benefit Plan. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246).
4	**Other Dental or Medical Coverage** A If there is other dental coverage, check the Yes Box and complete items 5–11 below.
5	**Name of Policyholder/ Subscriber in #4 Name (Last, First, Middle Initial, Suffix)** A If Block 4 completed, enter name of Policyholder/Subscriber. Name must be entered in the following order Last, First, Middle Initial, and Suffix if applicable.
6	**Date of Birth (MM/DD/CCYY)** A If Block 4 completed, enter the Policyholder/Subscriber's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
7	**Gender** A If Block 4 completed, put an "X" in the appropriate box of the person named in Block 5. Only one box can be selected.
8	**Policyholder/ Subscriber ID # (SSN or ID#)** A If Block 4 completed, enter the Social Security Number or Identification Number of the Policyholder/Subscriber.
9	**Plan/Group Number** A If Block 4 completed, enter the Plan/Group number if applicable.
10	**Patient's Relationship to Person Named in #5** A If Block 4 completed, enter the Patient's Relationship to person named in Block 5.
11	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code** A If Block 4 completed, enter the full name and address of the Other Insurance or Dental Plan. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246).
12	**Policyholder/ Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code** R Enter full name and address of Member. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246).
13	**Date of Birth (MM/DD/CCYY)** R Enter the date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) of the person named in Block 12.
14	**Gender** R Enter an "X" in the appropriate box of the named person in Block 12. Only one box can be selected.
15	**Policyholder/ Subscriber ID# (SSN or ID#)** R Enter the Member's ID, Must 9 Characters.
16	**Plan/Group Number** R Enter the Plan/Group number.
17	**Employer Name** R Enter the Employer name of the person named in Block 12.
18	**Relationship to Policyholder/ Subscriber in #12 above** R Put an "X" in the appropriate box. Only one box can be selected.
19	**Student Status** LB Do not complete this block.
20	**Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code** R Patient Last Name and First name (e.g., Doe, John)
21	**Date of Birth (MM/DD/CCYY)** R Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
22	**Gender** R Indicate the patient's gender by placing an X in the appropriate box.
23	**Patient ID/Account Number** O If entered, must be less than 20 characters
24. (1-10)	**Procedure Date** R Enter the procedure date in an eight-digit format (MMDDCCYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 03012007) or in six-digit format (MMDDYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 030107). When box 1, request for predetermination is checked, do not enter procedure date.
25	**Area of Oral Cavity** A Enter area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'
26	**Tooth System** LB Do not complete this block.
27 (1-10)	**Tooth Number(s) or Letter(s)** R Enter only one tooth number or, letter per claim line. This item must be no longer than 2 characters.
28 (1-10)	**Tooth Surface** R Values: M—Mesial, D—Distal, O—Occlusal, L—Lingual, F—Facial, B—Buccal, I—Incisal
29 (1-10)	**Procedure Code** R Enter the code for the procedure performed. The "D" must be entered as the first part of the procedure code.
30	**Description** R Enter the terminology to describe the service provided.
31 (1-10)	**Fee** R Enter your usual and customary charge to the general public for the service(s) provided in dollars and cents. Example: $25.00, $150.00 If you are billing for multiple units of service, be sure to multiply your usual charge by the number of units billed and enter that amount.
32	**Other Fee(s)** LB Do not complete this block.
33	**Total Fee** O Enter total fee. Amount should be the sum of Box 31 (1-10). Amount should be provided in dollars and cents. Example: $25.00, $150.00. Multiple page claims are not allowed. If detail requires more than one claim, each claim must be considered a separate claim with its own total charge. $0 are allowed when box 1, request for predetermination is checked.
34	**(Place an 'X' on each missing tooth)** R Draw an X through the number or letter of each missing permanent and primary tooth.
35	**Remarks** O Complete if applicable
36	**Patient/Guardian signature and Date** O If entered, can enter "Signature on file".
37	**Subscriber signature and Date** O If entered, can enter "Signature on file".

Blk No.	Block Description:
38	**Place of Treatment** R Place an "X" in one box only.
39	**Number of Enclosures** LB Do not complete this block.
40	**Is Treatment for Orthodontics?** R Place an "X" in one box only. If No, skip items 41 and 42.
41	**Date Appliance Placed (MM/DD/CCYY)** A Enter the Date Appliance Placed using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
42	**Months of Treatment Remaining** A Enter months of orthodontic treatment remaining.
43	**Replacement of Prosthesis?** R Place an "X" in one box only. If Yes, complete Block 44.
44	**Date Prior Placement (MM/DD/CCYY)** A Enter the date of prior placement of the prosthesis using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
45	**Treatment Resulting from** A Mark the Occupational Illness/injury if applicable. Mark the Auto accident box to indicate that the treatment is the result of an automobile accident. Mark the Other accident box to indicate that the treatment is the result of non-auto accident. If the treatment is not the result of occupational illness/injury, auto or other type of accident, leave blank.
46	**Date of Accident (MM/DD/CCYY)** A Enter the date of the accident if the treatment is the result of an accident. Enter date in an eight-digit format (MMDDCCYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 03012007) or in six-digit format (MMDDYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 030107).
47	**Auto Accident State** A Enter two-letter abbreviation for state in which auto accident occurred.
48	**Name, Address, City, State, Zip Code** R Enter name and address where service was performed. Zip code must be nine digits (e.g. 770513246).
49	**NPI Number** R Enter the ten-digit NPI number of the billing provider. *NOTE * The treating/servicing NPI number (block 54) is the designated provider to receive payment for the service(s) provided.
50	**License Number** LB Do not complete this block.
51	**SSN or TIN** R Enter Provider Tax-ID or SSN# that corresponds to the NPI number entered in block 49.
52	**Phone Number** R Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code
52A	**Additional Provider ID** R Enter the 2-6 service Member PIN# of the provider designated to receive payment for the service provided.
53	**Signature (Treating Dentist) and Date (MMDDYYYY)** R The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. Enter the date using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978)
54	**NPI Provider ID** R Enter the ten-digit NPI number of the treating/servicing provider.
55	**License Number** LB Do not complete this block.
56	**Address, City, State, Zip Code Provider Specialty Code** R Enter the address (Street Address, City, State, and ZIP Code) where the service was performed.
56A	**Provider Specialty Code** LB Do not complete this block.
57	**Phone Number** O Enter the telephone number of the rendering/treating dentist that provided the service.
58	**Additional Provider ID** LB Do not complete this block.

LEGEND: R – Required A – Applicable O – Optional LB – Leave Blank