ADA American Dental Association[®] Dental Claim Form

| | HEADER INFORMATION | | | _ | | | | | |
|--|---|--|------------------------------|--------------------|---|-----------------------|---------------------------------------|-------------------|--|
| | | | 1: | | | | | | |
| | | Request for Predetermina | ition/Preauthorization | | | | | | |
| Company/Plant have: Address: City: State: Zip Coce Company Plant have: City: C | | | | | | | | | |
| NUMBER Companyment Name, Assisse, City, State, Zp Code 13. Date of Sint (MMDDCCYY) 14. Genet 14. Date of Sint (MMDDCCYY) 15. Folloyed with Source to Sint (MMDDCCYY) 15. Date of Sint (MMDDCCYY) 16. Folloyed with Source to Sint (MMDDCCYY) 16. Date of Sint (MMDDCCYY) 17. Cardy Marce 16. Date of Sint (MMDDCCYY) 17. Cardy Marce 17. Date of Sint (MMDDCCYY) 17. Cardy Marce 18. Date of Sint (MMDDCCYY) 17. Cardy Marce 19. Date of Sint (MMDDCCYY) 17. Cardy Marce 10. Date of Sint (MMDDCCYY) 18. Relations Sinth, Address, Lity, State, Zp Costs 10. Date of Sinth (MMDDCCYY) 19. Relations Sinth, Address, Lity, State, Zp Costs 10. Date of Sinth (MMDDCCYY) 10. Cardy Marce 10. Date of Sin | | | | | | | | | |
| | INSURANCE COMPANY/DENT | | | | | | , can <i>x</i> , , , aarooo, city, ca | , <u>Lip</u> 0000 | |
| THERE COVERAGE (Mok applicable loss and complete larms 5, 11, if rome, lawer blank.) 10, Particles Number 11, Employer Number 1, Dentil? Machae? (If back, complete 5 fm of dentil only) 10, Particles Number 11, Employer Number 1, Dentil? Machae? (If back, complete 5 fm of dentil only) Particles Number 11, Employer Number 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil only) Particles Number 10, Particles Number 11, Employer Number 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDE | | | | | | | | | |
| THERE COVERAGE (Mok applicable loss and complete larms 5, 11, if rome, lawer blank.) 10, Particles Number 11, Employer Number 1, Dentil? Machae? (If back, complete 5 fm of dentil only) 10, Particles Number 11, Employer Number 1, Dentil? Machae? (If back, complete 5 fm of dentil only) Particles Number 11, Employer Number 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil only) Particles Number 10, Particles Number 11, Employer Number 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDECCY?) 1, Dentil (MADDECCY?) (If back, complete 5 fm of dentil Number) 10, Dentil (MADDE | | | | | | | | | |
| L Denzin (Hohi, complete 5-11 for denal only) Parteret TINFORMATION 1. Denzing OP Policyholder/Gubecher III P4 (Last, Frist, Middle Ilinka, Sufts). Parteret TINFORMATION 1. Denzing OP Policyholder/Gubecher III P4 (Last, Frist, Middle Ilinka, Sufts). Parteret TINFORMATION 1. Denzing OP Policyholder/Gubecher III P1 (Last) In Parteret Recompton III (Last) Parteret TINFORMATION 1. Denzing OP Policyholder/Gubecher III P1 (Last) In Parteret Recompton III (Last) Parteret TINFORMATION 1. Denzing OP Parteret Recompton III (Last) In Parteret Recompton IIII (Last) Parteret TINFORMATION 1. Denzing OP Parteret Recompton IIII (Last) In Parteret Recompton IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII | | | | 13. Date of Birt | h (MM/E | , | 5. Policyholder/Subscriber I | D (SSN or ID#) | |
| | OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.) | | | | 16. Plan/Group Number 17. Employer Name | | | | |
| 18 Read-company Dimensional Processional Processint Proceesinternal Processional Processinternal Processional Proce | | | | | | | | | |
| 3. Date of Birth (MMEDDECYY) ? Center 8. Inteleptionent/Subscripter 10 (SSN et (Up) 2. Park/Guo Murrier 10. Brainford Relationship to Person named in 85 | 5. Name of Policyholder/Subscriber in a | #4 (Last, First, Middle Initial, Suffix) | | | - | - | 10 Decen | ad For Futuro | |
| Participa Number | 6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#) | | | | | | | | |
| | | | | | · · · | | State, Zip Code | | |
| 11. Other Insurance Company/Detail Benefit Plan Name, Address, Cip, State, Jp Code 21. Date of Bitts (MMDD/CCYY) 22. Gender 23. Potent (DAccount # /Assigned by Dentify (MMDD/CCYY)) 21. Date of SERV/CES PROVIDED 24. Procedure Date 20. Date of Bitts (MMDD/CCYY) 22. Gender 29. Date of Distance Date 24. Procedure Date 24. Procedure Date 20. Date of Distance Date 30. Discription 31 Rei 2 2 2 2 20. Date of Distance Date 20. Date of Distance Date 31. Discription 31 Rei 2 </td <td>9. Plan/Group Number 1</td> <td>10. Patient's Relationship to Person</td> <td>named in #5</td> <td>_</td> <td></td> <td></td> <td></td> <td></td> | 9. Plan/Group Number 1 | 10. Patient's Relationship to Person | named in #5 | _ | | | | | |
| 21. Date of Bith (MMDDCCCY) 22. Ender 23. Patient Bukkesourt # (Assigned by Denti Assigned by D | | Self Spouse De | ependent Other | | | | | | |
| Bit Processes Bit Processes< | 11. Other Insurance Company/Dental E | Benefit Plan Name, Address, City, St | tate, Zip Code | | | | | | |
| Bit Processes Bit Processes< | | | | | | | | | |
| 24. Procedure Deter 26. Monol (MMDDCCVY) 27. Tools Number(1) or Letters) 28. Tools Suffee 22. Procedure Source 22. Book Patter 20. Doc Source 20. Doc Source 20. Doc Source 20. Doc Source 20. Doc Source 30. Description 31. Fee 2 2 2 2 2 20. Doc Source 20. Doc Source 20. Doc Source 20. Doc Source 30. Description 31. Fee 2 2 2 2 2 2 20. Doc Source | | | | 21. Date of Birt | h (MM/E | | 3. Patient ID/Account # (Ass | igned by Dentist | |
| | | | | | | | | | |
| Image of particle Im | (MM/DD/CCXX) of Oral | Tooth 27. Tooth Number(s) | | | | 30. Descrip | tion | 31. Fee | |
| S A I <thi< th=""> I <thi< th=""> <thi< th=""></thi<></thi<></thi<> | 1 Cavity | System | | | | | | | |
| 4 Image: Section of the section of the section with the section of the section with the section of the section with the sectin the sectin the section with the section with the secti | 2 | | | | | | | | |
| S | 3 | | | | | | | | |
| a | 4 | | | | | | | | |
| r | 5 | | | | | | | | |
| B Image: Control of Subscription Subscription of Subscription of Subscription of Subsc | 6 | | | | | | | | |
| 9 | 7 | | | | | | | | |
| 0 33. Massing Teeth Information (Piace an 'X' on each missing tooth.) 34. Diagnosis Code List Qualifier (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 32 31 30 29 28 27 26 24 23 22 21 20 19 18 17 Prec(s) 24 Diagnosis Code(s) A C 22 Total Fee 22 Total Fee 22 Total Fee 22 Total Fee 23 Total Fee 24 Diagnosis Code(s) A C 23 Total Fee 23 Total Fee 24 Diagnosis Code(s) A C 24 Total Fee 24 Diagnosis Code(s) A C 24 Diagnosis Code(s) A Diagnosis Code(s) A Diagnosis Code(s) | 8 | | | | | | | | |
| 33. Missing Teeth Information (Place an 'X' on each missing tooth.) 34. Diagnosis Code List Qualifier (1CD-9 = B; ICD-10 = AB) 31a. Other 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 16 32 31a. Other Fee(s) 32 70. Heels 32 70. Heels 32. Total Fee 32 70. Heels 32. Total Fee 32 30. Enclosures (Y or N) 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10 | - | | | | | | | | |
| 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 6 7 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 6 7 8 9 10 11 12 13 14 15 16 11 12 13 14 15 15 16 16 16 16 16 11 12 13 16 15 16 16 16 16 16 11 16 16 16 15 16 16 16 16 16 11 16 16 16 15 16 < | | "X" on each missing tooth) | 24 Diagnosia | | | | 31a Other | | |
| 32 31 30 29 28 27 26 25 24 23 22 21 20 19 16 17 (Primary diagnosis in "A") B D D 32. Total Fee 35. Remarks ANTHORIZATIONS 36. Inave 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. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Ancint Law Patient/Guardian Signature 7. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. A patient/Guardian on behalf of the patient or insured/subscriber.) 38. Name, Address, City, State, Zip Code 50. License Number 51. SSN or TIN 52. Phone 52. Phone 52. Phone 53. Cotal Fee 54. Additional 55. License Number 55. State, Zip Code 57. Phone 57. Phone 57. Phone 58. Additional 57. Phone 58. Additional 57. Phone 58. Additional 56. Address, City, State, Zip Code 57. Phone 57. Phone 57. Phone 58. Additional 56. Address, City, State, Zip Code 57. Phone 58. Additional 57. Phone 57. Phone 58. Additional 57. Phone 58. Additional 57. Phone 58. Additional 57. Phone 58. Additional | | | | | | | | | |
| 35. Remarks AUTHORIZATIONS 6. In arge been informed of the treatment plan and associated fees. I agree to be responsible for all of the treatment genetic of dental parcice has a controlutal geneent with my plan prohibited by any of entral geneent with my plan prohibited by any protected health information to carry out payment activities in connection with this claim. 38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N) 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCY) 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCY) 41. Is the extent part of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. 40. Is Treatment for Orthodontics? 41. Date of Prior Placement (MM/DD/CCY) 42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCY) 43. Thereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. 45. Treatment Resulting from 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State TREATING DENTILE ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.) 51. Inereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X 49. NPI 50. License Number 51. SSN or TIN 54. NPI | | | | | R | | 32. Total Fee | | |
| 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 prohibitid by interacting dentist or dental parcetices has a contractual agreement with my plan prohibiting all uses and disclosure of my protected health information to carry out payment activities in connection with this claim. 38. Place of Treatment (e.g. 11=dffice; 22=O/P Hospital) 39. Enclosures (Y or N) V | 35. Remarks | | | · · · | D | | | | |
| 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 prohibitid by interacting dentist or dental parcetices has a contractual agreement with my plan prohibiting all uses and disclosure of my protected health information to carry out payment activities in connection with this claim. 38. Place of Treatment (e.g. 11=dffice; 22=O/P Hospital) 39. Enclosures (Y or N) V | | | | | | | | | |
| charges for dental services and materials not paid by my dental benefit plan, unless prohibiting all inaw, or the treating dentist or dental practical 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. 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCY 42. Months of Treatment of Prosthesis 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCY 42. Months of Treatment of Prosthesis 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCY 44. Date of Prior Placement (MM/DD/CCY 45. Treatment Resulting from Occupational illness/injury Auto 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 52. Phone 52. Phone 52. Additional 57. Phone 57. Phone 58. Additional | AUTHORIZATIONS | | | ANCILLARY C | LAIM/ | TREATMENT INFORMATION | | | |
| Iaw, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting and or a portion of such charges. To the extent permitted by law. consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Image: Consent to the dental permitted by law. consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Image: Consent to the dental permitted by law. consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Image: Consent to the dental permitted by law. consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Image: Consent to the dental permitted by law. consent to your use and disclosure of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Image: Consent to the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Image: Consent to the dental benefits otherwise payable to me, directly to the below named dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.) Image: Consent to the dental benefits otherwise payable to me, directly to the patient or insured/subscriber.) Image: Consent to the dental benefits otherwise payable to me, directly to the patient or insured/subscriber.) Image: Consent to the dental benefits otherwise payable to me, directly to the patient or insured/subscriber.) Image: Consent to the dental benefits otherwise payable to me, directly to the patient or insured/subscriber.) Image: Consent to the dental benefits otherwise payable to the den | | | | | | | | | |
| of my protected health information to carry out payment activities in connection with this claim. 40. Is Treatment for Orthodonics? 41. Date Appliance Placed (MM/DD/CC) Auge and form of my protected health information to carry out payment activities in connection with this claim. 40. Is Treatment for Orthodonics? 44. Date of Prior Placement (MM/DD/CC) Auge and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CC) X X X X X Yes (Complete 41-42) 44. Date of Prior Placement (MM/DD/CC) X X X X X X X Xesting and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. 45. Treatment Resulting from 44. Date of Prior Placement (MM/DD/CC) X X Xestriber Signature Date 46. Date of Accident (MM/DD/CY) 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.) Yes (Complete 41. Yes (Complete | law, or the treating dentist or dental p | practice has a contractual agreement | with my plan prohibiting all | | | | | | |
| A Patient/Guardian Signature Date 42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CC1 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. No Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CC1 X X Subscriber Signature Date 45. Treatment Resulting from Occupational illness/injury Auto accident Other accident BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.) Date 73. 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 50. License Number 51. SSN or TIN 56. Address, City, State, Zip Code 56. Address, City, State, Zip Code 49. NPI 50. License Number 51. SSN or TIN 57. Phone 58. Additional | | | | | | | 41. Date Appliance Placed | I (MM/DD/CCY) | |
| 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Remaining No Yes (Complete 44) 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 51. Ibreby caling claim on behalf of the patient or insured/subscriber.) 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 | Patient/Guardian Signature | Г |)ate | | | | 44 Date of Prior Placemer | | |
| 37.1 Interest automize and direct payment of the dental benefits outerwise payable to me, directly to the below named dentist or dental entity. 45. Treatment Resulting from X Subscriber Signature Date 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 X Signed (Treating Dentist) Date 49. NPI 50. License Number 51. SSN or TIN 57. Phone 57. Phone 58. Additional | • | | | | Remaining | | | | |
| X Subscriber Signature Date 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 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 | | | payable to me, directly | 45. Treatment Res | sulting fr | | | | |
| TREATING 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 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. 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 49. NPI 50. License Number 51. SSN or TIN 52. Phone 52. Additional 57. Phone 58. Additional | x | | | | Occupational illness/injury Auto accident Other accident | | | | |
| submitting claim on behalf of the patient or insured/subscriber.) 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. 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 54. NPI 55. License Number 56. Address, City, State, Zip Code 49. NPI 50. License Number 51. SSN or TIN 52. Phone 52a. Additional 57. Phone 58. Additional | Subscriber Signature Date 2 | | | | 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State | | | | |
| 33. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. 48. Name, Address, City, State, Zip Code 48. Name, Address, City, State, Zip Code 54. NPl 55. License Number 51. SSN or TIN 52. Phone 52. Phone 52. Phone 52. Additional | | | or dental entity is not | TREATING DE | NTIST | AND TREATMENT LOCATIO | ON INFORMATION | | |
| 54. NPl 55. License Number 56. Address, City, State, Zip Code 56a. Provider Specialty Code 57. Phone 57. Phone 52. Phone 58. Additional | | · · · · · · · · · · · · · · · · · · · | | | | | re in progress (for procedur | es that require | |
| 54. NPl 55. License Number 56. Address, City, State, Zip Code 56a. Provider Specialty Code 57. Phone 57. Phone 52. Phone 58. Additional | | | | x | | | | | |
| 49. NPI 50. License Number 51. SSN or TIN 52. Phone 52a. Additional 57. Phone 57. Phone 58. Additional | | | | | | | | | |
| 49. NPI 50. License Number 51. SSN or TIN 52. Phone 52a. Additional 52. Phone 57. Phone 53. Phone 57. Phone 55. SSN or TIN | | | | | | | | | |
| 52. Phone , , 52a. Additional 57. Phone , , 58. Additional | ······ | | | 56. Address, City, | State, Z | ip Code 56a. Pro | y Code | | |
| 52. Phone () 58. Additional | 49. NPI 50. L | License Number 51. SS | in or TIN | | | | | | |
| | 52. Phone (| 52a. Additional | | 57. Phone | |) 58. Addi | tional | | |