A\D)A Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Check all applicable boxes}

☐ Statement of Aclual Services - OR - ☐ Request for Predelermination/

P r eaulhoriza1ion 0 F.PSDT / Tille XIX

2 Prede1ermina1ion/Preau1horizat1on Number

PRIMARY PAYER INFORMATION

Name. Address, City, State, and Zip

PRIMARY SUBSCRIBER INFORMATION

Name Address, City, State, and Zip Code

13. Date of Birth:

14. Gender ☐ Male ☐ Female

15. Subscriber Idenlifier (SSN or ID#) 1

16. Plan/Group Number

17. Employer Name

OTHER COVERAGE

4 Other Denial or Medical Coverage? ☐ No (Skip 5·11) ☐ Yes (Complete 5·11)

5. Subscriber Name (Lasl. Firsl. Middle Initial. Sullix)

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

7. Gender OM OF

8. Subscriber Idenlilier (SSN or ID#) I

9. Plan/Group Number

10. Relationship to Primary Subscriber (Check applicable box)

☐ Self ☐ Spouse ☐ Dependent ☐ Other

PATIENT INFORMATION

Relalionship to Primary Subscriber (Check applicable box)

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

19. STUDENT sTATUS

☐ FULL TIME ☐ PART TIME

Name Address, City, State, and Zip Code

21. Dale of Birlh (MM/DD/CCYY)

22. Gender ☐ Male ☐ Female

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/YY)	25. Area of Oral Cavity		27. Toolh Number(s) Le[ter(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 1001h)

Pe,manenl																Primary										32. 01he r Fee(s)	
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	2s	24	23	22	21	20	19	18	17	T	s	A	a	p	Jo		N M	L	K	33. Total Fee\	

35. Remarks

AUTHORIZATIONS

36. 1 have been inlormed of lhe 1realmenl plan and associaled lees. I agree 10 be responsible for all charges for denlal services and malerials not paid denlal benelil plan, aw, or lhe 1rea1ing dentislor denial praclice has a con1rac my enl will my plun less po rlion

Patient or Guardian Dale

I hereby authoriz and c1recl paym[nl of the deolal benelils olh[rwise payable lo me, d1recdy 10 lhe below named 3i11Sl or dental enlily

Subscriber Signature Dale

BILLING DENTIST OR DENTAL ENTITY (Leave blank ii den1is1 or denial enli1y is no! submilling claim on behalf ol lhe pa11en1 or insured/subscriber)

48. Name. Address. Cily, Slate. Zip Code

119. Provider ID

50. License Number 1

5t. SSN orTIN

52. Phone Number ( )

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatmenl (Check applicable box)

☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiographs Oral Images

40. Is Treatment for 0rthodonlics?

☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

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

42. Monlhs ofTrealmenl

43. Aeplacemenl of Prosthesis?

44. Dale Prior Placemen!

45. Treatment Resulting from (Check applicable box)

46. Date of Accidenl (MM/DD/YY)

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Signed (Treating Dentist) Dale

54. Provider ID

55. License Number

56. Address. Cily, S1a1e, Zip Code

57. Phone Number ( )

56. Treal!n ff, rovider Spec1a