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

MEDICAID or NCHC (enter the plan that the recipient was covered under when the recipient was banded and orthodontic treatment started)

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	8. Policyholder/Subscriber ID (SSN or ID#)
	☐ M ☐ F	

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

Jane Doe

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
01/01/2004	☐ M ☒ F	123456789P

16. Plan/Group Number	17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Student Status
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
	☐ M ☐ F	

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	EXAMPLE #1					D8680	Use for Post Treatment Summary submission	
2								
3								
4	EXAMPLE #2					D8680	Use for Treatment Termination submission	
5								
6								
7	EXAMPLE #3					D8670	Use for Treatment Extension submission	
8								
9								
10								

MISSING TEETH INFORMATION

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

Permanent																Primary										32. Other 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	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

XXXXXXXXX (Billing Provider Taxonomy)

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

North Dental Clinic
PO Box 1234
City, NC 27777-7777

49. NPI	50. License Number	51. SSN or TIN
9999999999		

52. Phone Number	52A. Additional Provider ID
(919) 555 - 5555	

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 *Provider Signature Required Here* 03/13/2018
Signed (Treating Dentist) Date

54. NPI	55. License Number
9999999999	

56. Address, City, State, Zip Code	56A. Provider Specialty Code
North Dental Clinic PO Box 1234, City, NC 27777-7777	

57. Phone Number	58. Additional Provider ID
(919) 555 - 5555	

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