ADA Dental Claim Form HEADER INFORMATION 1. Type of Transaction (Mark all applicable boxes) Request for Predetermination/Preauthorization Statement of Actual Services TEPSDT/Tille XIX 2. Predetermination/Preauthorization Number POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION Company/Plan Name, Address, City, State, Zip Code 13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#) ∏м ∏ғ OTHER COVERAGE 16. Plan/Group Number 17. Employer Name 4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11) PATIENT INFORMATION 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) 18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status FTS 6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#) Self Spouse Dependent Child Other Пм Пр 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 10. Patlent's Relationship to Person Named in #5 9. Plan/Group Number Self Spouse Dependent Other 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zlp Code 21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist) __ м ___ F RECORD OF SERVICES PROVIDED 26. Tooth 24. Procedure Date 27. Tooth Number(s) or Letter(s) 28. Tooth 29. Procedure 30. Description 31. Fee (MM/DD/CCYY) Surface Code MISSING TEETH INFORMATION Primary Fee(s) 8 9 10 11 12 13 14 15 16 Ε 2 5 Α В D F G 34. (Place an 'X' on each missing tooth) 32 26 25 24 23 22 21 20 19 18 17 Т S R Q Р 33. Total Fee 31 30 29 28 .27 0 Ν 35. Remarks ANCILLARY CLAIM/TREATMENT INFORMATION **AUTHORIZATIONS** 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Mod 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 38. Place of Treatment So. There been informed or the idealinest part and associated reset: agree to be responsible to an of an other 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. Provider's Office Hospital ECF Other 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY) No (Skip 41-42) Yes (Complete 41-42) 42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY) Patlent/Guardian signature No Yes (Complete 44) 37. I hereby 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 Occupational illness/injury Auto accident Other accident Subscriber signature 46. Date of Accident (MM/DD/CCYY) TREATING DENTIST AND TREATMENT LOCATION INFORMATION BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not 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 Signed (Treating Dentist) Date 55. License Number 56. Address, City, State, Zip Code 56A. Provider Specially Code 49. NPI 51, SSN or TIN 50 License Number

57. Phone Number (58. Additional Provider ID

52A. Additlonal Provider ID



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 <u>Provider Specialty Code</u>: 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