# 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

Anthem
PO Box 659444
San Antonio, TX 78265

## 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 |
|---|---|
| | KLDTA |

## 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 0

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 |
|---|---|
| Address<br>City ST ZIP | |

| 57. Phone Number ( ) – | 58. Additional Provider ID |
|---|---|
| | |

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Comprehensive completion instructions for the ADA Dental Claim Form are found in the current version of the CDT manual published by the ADA. Five relevant extracts from that manual 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**