Fact Sheet

U.S. Department of Veterans Affairs
Veterans Health Administration
*Office of Community Care*

# VHA Office of Community Care
## ADA Dental Claim Form Instructions

The following information highlights certain VA specific form completion instructions. Comprehensive ADA Dental Claim Form completion instructions can be found on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

### General Instructions

1. All yellow highlighted fields are required to be completed accurately and fully. Incomplete or erroneous information will result in claim rejection. Yellow highlighted fields include the following sections:
   a. Header Information; fields 1 and 2.
   b. Policy Holders/Subscriber Information; fields 12 through 15.
   c. Patient Information; field 18.
   d. Record of Service Provided; fields 24 through 29, fields 29b through 31, and 32.
   e. Ancillary Claim/Treatment Information; field 38.
   f. Billing Dentist or Dental Entity; fields 48, 49, and 51.
   g. Treating Dentist and Treatment Location Information; fields 53 through 56a.
2. All green highlighted fields may be required or may become required as the result of input on another field. Green highlighted fields include the following sections:
   a. Other Coverage; fields 4, 5, and 8 through 11.
   b. Record of Service Provided; fields 29a, 34 and 34a.
3. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
4. All dates must include the four-digit year.
5. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.
6. GENDER Codes (Required Item 14) must be M = Male or F = Female. Unknown gender is not permissible.

### VA Specific Form Completion Instruction

**Field 1. Type of Transaction**—Must be 'Statement of Actual Services'.

**Field 2. Predetermination/Preauthorization Number**—Must contain the authorization/referral number provided on the required authorization form that is supplied by VA's authorizing department.

- Two formats are acceptable: 'VAXXXXXXXXXX' or 'XXX-XXXXXX-X'.

**Field 14. Gender**—Must be 'Male' or 'Female'.

**Field 15. Policyholder/Subscriber ID (Assigned by Plan)**—Must be Veteran's full 9-digit Social Security Number, no dashes, no spaces.

**Field 18. Relationship to Policyholder/Subscriber in #12 Above**—Must be 'Self'.

### Diagnosis Coding

The form supports reporting up to four diagnosis codes per dental procedure. This information is situationally required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

**Field 29a. Diagnosis Code Pointer** ("A" through "D" as applicable from Item 34a)

**Field 34. Diagnosis Code List Qualifier** (B for ICD-9-CM; AB for ICD-10-CM)

**Field 34a. Diagnosis Codes(s)** / A, B, C, D (up to four, with the primary adjacent to the letter "A")

**Field 56a. Provider Specialty Code:** Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists can be found on the ADA's website. The general code listed as "Dentist" may be used instead of any other dental practitioner codes.

# ADA American Dental Association® Dental Claim Form

* REQUIRED INFORMATION
** POTENTIALLY REQUIRED INFORMATION

## 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 *

## DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

## OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ** ☐ Medical? ** ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 ** (Last, First, Middle Initial, Suffix)

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

7. Gender ☐M ☐F ☐U

8. Policyholder/Subscriber ID**(Assigned by Plan)

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 (Assigned by Plan 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 ☐U

15. Policyholder/Subscriber ID *(Assigned by Plan)

16. Plan/Group Number

17. Employer Name

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above *
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserved For Future Use

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

21. Date of Birth (MM/DD/CCYY)

22. Gender ☐M ☐F ☐U

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* | 29a. Diag. Pointer* | 29b. Qty.* | 30. Description* | 31. Fee* |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier* ☐☐ ( ICD-10 = AB )

34a. Diagnosis Code(s)* (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee*

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* ☐ (e.g. 11=office; 22=O/P Hospital)
(Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

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

42. Months of Treatment

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of 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**

57. Phone Number ( ) -

58. Additional Provider ID