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

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

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

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

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

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