ADA American Deni	tal Asso	ociation Dent	ai Ciaim	For	m										
HEADER INFORMATION 1. Type of Transaction (Mark all applicable boyes)					4										
1. Type of Transaction (Mark all applicable boxes)															
Statement of Actual Services		Request for Predetermination	n/Preauthorizatio	n											
EPSDT / Title XIX															
2. Predetermination/Preauthorization Number					_	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)									
					12	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION					_										
3. Company/Plan Name, Address, City, State, Zip Code															
										,					
						13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)									
									M L	F					
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)						6. Plan/Group	Numbe	r	17. Employer I	Name					
4. Dental? Medical? (If both, complete 5-11 for dental only.)					<u> </u>										
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)						PATIENT INFORMATION									
						18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Future									
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)						Self Spouse Dependent Child Other									
	M	1 F			20). Name (Last	, First, N	/liddle Initial	, Suffix), Addre	ess, City, S	tate, Zip Cod	le			
9. Plan/Group Number	10. Patient	t's Relationship to Person na	med in #5												
	Self	Spouse Depe	ndent Othe	er											
11. Other Insurance Company/Denta	l Benefit Pla	an Name, Address, City, State	e, Zip Code		7										
					21	1. Date of Birt	h (MM/D	DD/CCYY)	22. Gender	23.	. Patient ID/A	ccount # (Assi	igned by Dentist)		
									М	F					
RECORD OF SERVICES PRO	VIDED														
24 Procedure Date 25. Are	a 26.	27. Tooth Number(s)	28. Tooth	29. Proc	edure	29a. Diag.	29b.								
(MM/DD/CCYY) of Ora		or Letter(s)	Surface	Cod		Pointer	Qty.		3	Description	on		31. Fee		
1															
2															
3															
4	+ +														
5															
6	+ +														
7	+ +														
8	+ +														
9	+ +														
10	+ +														
1.0	on "V" on or	ash missing tooth \	104 5		0-4-	List Ovelifies		(100.0	= B; ICD-10 = A	.D.)	12	1a. Other			
33. Missing Teeth Information (Place						List Qualifier	Щ.	(ICD-9 =		(В)	³	Fee(s)			
						00 T-1-15									
	25 24	23 22 21 20 19 18	8 17 (PIIII	ary diag	nosis i	III A)	В		D			2. 10tai i ee			
35. Remarks															
ALITHODIZATIONS					ANIC	CILL ABV C			NT INFORM	AATION					
AUTHORIZATIONS 36. I have been informed of the treatment	nont plan and	ad associated foos. Lagron to b	ho roeponeiblo for	r all	_	Place of Treatr			1=office; 22=O/F		30 Enclos	ures (Y or N)			
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									Professional Clai		39. LIICIOS				
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.					40. Is Treatment for Orthodontics?						41. Date Appliance Placed (MM/DD/CCYY)				
					No (Skip 41-42) Yes (Complete 41-42)						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
					42 N							14. Date of Prior Placement (MM/DD/CCYY)			
						Remaining						noi Piacemen	it (MIM/DD/CC11)		
					45. Treatment Resulting from										
					45. Treatment Resulting from Occupational illness/injury Auto accident Other accident										
X Date															
					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.)					_	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.										
48. Name, Address, City, State, Zip Code					"			50mp							
						X									
						Signed (Treating Dentist) Date									
						54. NPI 55. License Number									
		r			56. A	ddress, City,	State, Z	ip Code		56a. Prov Specialty	Code				
49. NPI 50	. License Nu	umber 51. SSN	or TIN												
F2 Phone		EQu Addition -			E7 P	Phone				EO V '1-1:0.	ional				
52. Phone Number () -		52a. Additional Provider ID			57. P	Phone Number () -		58. Additi	onai der ID				

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

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 #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. 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.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is 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:

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

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a - Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

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		

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"