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

Insurance Company Name
Address 1
Address 2
City ST ZIP

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

Other Insurance Company Name
Address
City ST ZIP

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Policyholder Name
Address 1
Address 2
City ST ZIP

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

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Student Status
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	☐ FTS ☐ PTS

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

Patient Name
Address 1
Address 2
City ST ZIP

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										32. Other Fee(s)	
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	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

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

Dentist Name
Address 1
Address 2
City ST ZIP

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) –	52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
☐ 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)
	☐ No ☐ Yes (Complete 44)	

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
Address City ST ZIP	

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

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

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