

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

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

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

WebMD Payer ID #
72468

13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)

M F

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

16. Plan/Group Number 17. Employer Name

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

6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)

M F

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

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

21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)

M F

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)	33. Total Fee
	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		
																	T	S	R	Q	P	O	N	M	L	K		

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 39. Number of Enclosures (00 to 99)

Provider's Office Hospital ECF Other Radiograph(s) Oral Image(s) Model(s)

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

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



Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section 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 Identifier):** 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 Web Site: www.ada.org/goto/npdi

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

INFORMATIONAL PURPOSES ONLY

Please submit the claim form to:

**ACS Benefit Services, Inc.
P O Box 2000
Winston-Salem, NC 27102-2000**

To submit claims electronically, contact WebMD Transaction Services at (800) 366-5716. Help Desk (800) 845-6592. The payer id is located in the PRIMARY PAYER INFORMATION box on the claim form.