

Dental Claim Form

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1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Specialty (see backside)	3. Carrier Name
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT	Prior Authorization #	4. Carrier Address
		5. City
		6. State
		7. Zip

PATIENT	8. Patient Name (Last, First, Middle)				9. Address				10. City		11. State	
	12. Date of Birth (MM/DD/YYYY)		13. Patient ID#		14. Sex <input type="checkbox"/> M <input type="checkbox"/> F		15. Phone Number ()			16. Zip Code		
	17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						18. Employer/School Name _____ Address _____					

SUBSCRIBER/EMPLOYEE	19. Subs./Emp. ID#/SSN#		20. Employer Name		21. Group #		OTHER POLICIES	31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical		32. Policy #			
	22. Subscriber/Employee Name (Last, First, Middle)							33. Other Subscriber's Name		34. Date of Birth (MM/DD/YYYY)		35. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
	23. Address				24. Phone Number ()			36. Plan/Program Name		37. Employer/School Name _____ Address _____			
	25. City		26. State		27. Zip Code			38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student		39. 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 plan, unless the treating dentist or dental practice has a contractual agreement with y plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.		40. Employer/School Name _____ Address _____	
	28. Date of Birth (MM/DD/YYYY)		29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		30. Sex <input type="checkbox"/> M <input type="checkbox"/> F			41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.		X _____ Signed (Employee/subscriber)		Date (MM/DD/YYYY)	
								42. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.		X _____ Signed (Employee/subscriber)		Date (MM/DD/YYYY)	

BILLING DENTIST	42. Name of Billing Dentist or Dental Entity				43. Phone Number ()		44. Provider ID #		45. Dentist Soc. Sec. Or T.I.N.	
	46. Address				47. Dentist License #		48. First visit date of current series:		49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other	
	50. City		51. State		52. Zip Code		53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____	
	55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement: _____ Date of prior replacement: _____						56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief Description and dates _____		57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____	
							58. Diagnosis Code Index (optional)		1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	
							59. Examination and treatment plans - List teeth in order			

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Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin Use Only	

60. Identify all missing teeth with "X"												Total Fee														
Permanent						Primary																				
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	Payment by other plan
32	31	30	29	28	27	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable	
61. Remarks for unusual services														Deductible		Carrier %		Carrier pays		Patient pays						

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures						63. Address where treatment was performed					
X _____ Signed (Treating Dentists)						64. City					
License # _____						65. State					
Date (MM/DD/YYYY) _____						66. Zip Code					