ADA Dental Claim Form

Please send completed claim form to the dental claim address listed on your plan identification card.

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   - ☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number: 0123456789

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code: Bruce Wayne, 1 Arkham St, Gotham, NY, 00001

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☒ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Subscriber Name (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number
10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Bruce Wayne, 1 Arkham St, Gotham, NY, 00001
13. Date of Birth (MM/DD/CCYY): 01/01/1938
14. Gender ☐ M ☐ F
15. Subscriber Identifier (SSN or ID#): 123456789
16. Plan/Group Number: 987654321
17. Employer Name: Wayne Corporation

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Bruce Wayne, 1 Arkham St, Gotham, NY, 00001
21. Date of Birth (MM/DD/CCYY): 01/01/1938
22. Gender ☒ M ☐ F
23. Patient ID/Account # (Assigned by Dentist): 123456789

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	Root Canal	N/A		C5		D0001	Root Canal Performed	1000
2	Descaling	N/A	All	All	All	D0002	Descaling Performed	100
3	Root Canal	N/A		C5		D0001	Root Canal Performed	1000
4	Descaling	N/A	All	All	All	D0002	Descaling Performed	100
5	Root Canal	N/A		C5		D0001	Root Canal Performed	1000
6	Descaling	N/A	All	All	All	D0002	Descaling Performed	100
7	Root Canal	N/A		C5		D0001	Root Canal Performed	1000
8	Descaling	N/A	All	All	All	D0002	Descaling Performed	100
9	Root Canal	N/A		C5		D0001	Root Canal Performed	1000
10	Descaling	N/A	All	All	All	D0002	Descaling Performed	100

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

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
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

32. Other Fee(s)
33. 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 *Bruce Wayne* *10/26/2023*
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 (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from (Check applicable box) ☐ 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: Arkham Dentistry Accounts Payable, 1 Gotham Blvd, Gotham, NY, 00001
49. Provider ID
50. License Number
51. SSN or TIN
52. Phone Number ( ) –

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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X *Harley Quinn* *10/26/2023*
Signed (Treating Dentist) — Date

54. Provider ID
55. License Number
56. Address, City, State, Zip Code: Arkham Dentistry Accounts Payable, 1 Gotham Blvd, Gotham, NY, 00001
57. Phone Number ( ) –
58. Treating Provider Specialty