ADA American Dent	tal Ass	ociation®	Dent	al Clain	n For	m							
HEADER INFORMATION									λ	DELTA	DENT	A *	
Type of Transaction (Mark all appli	icable boxes	5)									NERU	^ \	
Statement of Actual Services		Request for Pred	eterminatio	n/Preauthoriza	ation								
EPSDT / Title XIX													
2. Predetermination/Preauthorization	Number											ned by Plan Named i	
DENTAL BENEFIT PLAN INF	OPMATIC	N				- '-	z. Folicyfloide	1/300501	ibei Name (Last, First, Mild	ule Illiliai, Sullix	t), Address, City, Sta	te, zip Code
Company/Plan Name, Address, Ci						\dashv							
	,,,												
						13	3. Date of Birt	h (MM/D	D/CCYY)	14. Gender	15 Policy	holder/Subscriber ID (Assigned by Plan)
						- []		(]υ		,g.,,,
OTHER COVERAGE (Mark appli	icable box a	nd complete items	5-11. If n	one, leave blar	nk.)	16	6. Plan/Group	Number	r '	17. Employer N	ame		
4. Dental? Medical?	(If	ooth, complete 5-	11 for denta	al only.)									
5. Name of Policyholder/Subscriber i	in #4 (Last,	irst, Middle Initia	, Suffix)			P	ATIENT IN	FORM/	ATION				
						18	8. Relationshi	p to Poli	cyholder/Sul	bscriber in #12	Above	19. Reserve	ed For Future
6. Date of Birth (MM/DD/CCYY)	7. Gender	_	nolder/Subs	scriber ID (Assig	gned by Pla	`⊢	Self		ouse	Dependent Ch	other s, City, State, Z		
Plan/Group Number		's Relationship to	Person na	med in #5		- 20	J. Name (Lasi	., riist, iv	muule IIIIIai,	Sullix), Addres	ss, Oily, State, Z	ip code	
	Self	Spouse			Other								
11. Other Insurance Company/Denta	l Benefit Pla	n Name, Address	, City, Stat	e, Zip Code									
						21	1. Date of Birt	h (MM/D	D/CCYY)	22. Gender	23. Patier	nt ID/Account # (Assi	gned by Dentist)
										M F]u		
RECORD OF SERVICES PROV	VIDED												
24. Procedure Date of Ora		27. Tooth Numb		28. Tooth	29. Prod		29a. Diag.	29b.		30.	. Description		31. Fee
(MM/DD/CCYY) Cavity		or Letter(s		Surface	Cod	de	Pointer	Qty.					
2													
3	+ +				+								
4													
5	+ +												
6													
7	+ +												
8	+ +												
9													
10	+ +												
33. Missing Teeth Information (Place	an "X" on e	ach missing tooth)	34	. Diagnosis	Code	List Qualifier		(ICD-10 :	= AB)		31a. Other	
1 2 3 4 5 6 7		10 11 12			a. Diagnos			A	(C		Fee(s)	
32 31 30 29 28 27 26	25 24	23 22 21 2	0 19 1	8 17 (P	rimary diag	gnosis	in " A ")	В		D		32. Total Fee	
35. Remarks										<u> </u>			
AUTHORIZATIONS						ANG	CILL ABV C	L A IM/7	DE ATME	NT INFORM	ATION		
36. I have been informed of the treatn	nent plan an	d associated fees.	I agree to	be responsible	for all	-	Place of Treatr			l=office; 22=O/P		Enclosures (Y or N)	
charges for dental services and m	naterials not	paid by my dental	benefit pla	n, unless prohil	bited by	00.1				rofessional Claim			
or a portion of such charges. To the	ne extent per	mitted by law, I co	nsent to yo	our use and dis	closure	40. Is	s Treatment fo	or Orthod	dontics?		41. Da	ate Appliance Placed	(MM/DD/CCYY)
X	r to carry ou	payment activitie	s iii coiiilec	CHOIT WILLT LITTS C	iaiiii.		No (Sk	ip 41-42) Yes	(Complete 41-4	12)		
Patient/Guardian Signature			Dat	e		42. N	Months of Trea	atment	43. Repla	cement of Pros	thesis 44. Da	ate of Prior Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct pay to the below named dentist or de	ment of the	dental benefits ot	nerwise pa	yable to me, d	irectly	45 T	reatment Res	ulting fr	No No	Yes (Comple	ete 44)		
to and bottom married definition of de-	oridiy.					J +J. 1		-	ness/injury	Auto	o accident	Other accider	nt
Subscriber Signature			Dat	e		46 F	Date of Accide					47. Auto Accide	
				-	FREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the pati												ogress (for procedure	es that require
48. Name, Address, City, State, Zip C	Code					n	nultiple visits)	or have	been compl	eted.			·
						X							
						Signed (Treating Dentist) Date							
						54. N					55. License Nun	mber	
						56. A	Address, City,	State, Zi	ip Code		56a. Provider Specialty Code		
49. NPI 50	. License Ni	ımber	51. SSN	or TIN									
52. Phone Number				57. F	57. Phone 58. Additional Provider ID								
		, 110010									ovider 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 posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

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 instructions posted on the ADA's web site (ADA.org).
- 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.
- F. GENDER Codes (Items 7, 14 and 22) M = Male; F = Female; U = Unknown

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).

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 (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:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/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: http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/