Please fill out this form for insurance billing. It will help speed up the filing process. If your insurance does not have a unique ID#, we will need to have your Social Security #. All insurance companies, except for Metlife and Delta Dental issue you an ID card. Please bring that card along so we may make a copy for our files.

DENTAL INSURANCE INFORMATION

Patient Name_____ **Date**_____

1. **First & Last** name of **card holder**_____
2. **SS #** of card holder or **ID#** _____
3. **Date** of **Birth** of **card holder**_____
4. **Group #** and **Employer Name**_____
5. Address to send insurance claim to:_____

_____

If you have a **secondary** insurance, please provide the same information.

1. **First** & Last name of card holder_____
2. **SS #** of card holder or **ID#**_____
3. **Date** of **Birth** of **card holder**_____
4. **Group #** and **Employer Name**_____
5. Address to send insurance claim to:_____

_____

While we will make every effort to find out what your insurance benefits are, this is not a guarantee of payment from them. Ultimately payment is your responsibility.

ADA Dental Claim Form

HEADER INFORMATION

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

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

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 Child ☐ Other
11. Other Carrier Name, Address, City, State, Zip Code

(CARDHOLDER)

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) / /
14. Gender ☐ M ☐ F
15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number
17. Employer Name

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
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	/ /							0.00
2	/ /							0.00
3	/ /							0.00
4	/ /							0.00
5	/ /							0.00
6	/ /							0.00
7	/ /							0.00
8	/ /							0.00
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	125.00

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 _____
Parent/Guardian Signature Date

37. I hereby autohrize 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) [X] Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00-99) 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
49. NPI
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 procedure

X _____
Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code 1223X0400X
57. Phone Number
58. Additional Provider ID