

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 #		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/Employer Name (Last, First, Middle)									33. Other Subscriber's Name							
	23. Address				24. Phone Number ()				34. Date of Birth (MM/DD/YYYY) / /			35. Sex <input type="checkbox"/> M <input type="checkbox"/> F					
	25. City			26. State		27. Zip Code			37. Employer/School Name _____ Address _____			38. Plan/Program Name					
	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			38. Subscriber/Employer 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 benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim. X Signed (Patient/Guardian) _____ Date (MM/DD/YYYY) _____						40. Employer/School Name _____ Address _____						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) _____				

BILLING DENTIST	42. Name of Billing Dentist or Dental Entity			43. Phone Number ()			44. Provider ID #			45. Dentist Soc. Sec. or I.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 _____ if no, reason for replacement: _____ initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of prior placement: _____						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																										
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					Payment by other plan																	
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	Deductible
61. Remarks for unusual services						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. X Signed (Treating Dentist) _____ License # _____ Date (MM/DD/YYYY) _____			63. Address where treatment was performed		
64. City		65. State		66. Zip Code	

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