

Be advised that before a bill can be considered "acceptable" for payment by the Victim Compensation and Government Claims Board, the following sections must be completed correctly or the bill will be returned and payment may be delayed.

Section Number on ADA Dental Claim Form	Information listed below is needed in each section to process your bill.
1	Header Information: Type of Transaction
12	Policyholder/Subscriber Information: Name and Address
15	Policyholder/Subscriber Information: ID (SSN / ID #)
18	Patient Information: Relationship to Policyholder/Subscriber in box 12
20	Patient Information: Patient Name and Address
24	Record of Services Provided: Procedure Date
27	Record of Services Provided: Tooth Number(s) or Letter(s)
29	Record of Services Provided: Procedure Code
30	Record of Services Provided: Description
31	Record of Services Provided: Procedure Code Fee Amount
33	Record of Services Provided: Total Charges/Billed Amount
48	Billing Dentist or Dental Entity: Name and Address
50	Billing Dentist or Dental Entity: License Number
51	Billing Dentist or Dental Entity: Tax ID/SSN/FEIN Number of Payee as Registered with the IRS
52	Billing Dentist or Dental Entity: Phone Number
53	Treating Dentist and Treatment Location Information: Signature and Date
55	Treating Dentist and Treatment Location Information: License Number
56	Treating Dentist and Treatment Location Information: Address where services were rendered if different than box 48
57	Treating Dentist and Treatment Location Information: Phone Number if different than box 52

The CaIVCP Claim Number must be written on the ADA Dental Claim Form.

ATTENTION ALL PROVIDERS ALREADY IN OUR SYSTEM: Number 48 and Number 51 on your bill must match exactly to what is in the system. If YOU/PROVIDER has a new Tax ID please notify the Program immediately.

ADA Dental Claim Form

HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prauthorization <input type="checkbox"/> EPSDT/Title XIX 1											
2. Predetermination/Prauthorization Number											
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION											
3. Company/Plan Name, Address, City, State, Zip Code 12											
13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#) 15											
16. Plan/Group Number 17. Employer Name											
OTHER COVERAGE											
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)											
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)											
6. Date of Birth (MM/DD/CCYY)			7. Gender <input type="checkbox"/> M <input type="checkbox"/> F			8. Policyholder/Subscriber ID (SSN or ID#)					
9. Plan/Group Number			10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code											
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code											
PATIENT INFORMATION											
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse 18 <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other										19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 20											
21. Date of Birth (MM/DD/CCYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> 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
24				27			29	30			31
32. Other Fee(s)											
33. Total Fee 33											
MISSING TEETH INFORMATION											
34. (Place an 'X' on each missing tooth)											
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.											
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.											
ANCILLARY CLAIM/TREATMENT INFORMATION											
38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other										39. Number of Enclosures (00 to 99) <input type="checkbox"/> Radiographs <input type="checkbox"/> Oral Imprints <input type="checkbox"/> Models	
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										41. Date Appliance Placed (MM/DD/CCYY)	
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										44. Date Prior Placement (MM/DD/CCYY)	
43. Replacement of Prosthesis?											
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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 48											
49. NPI 50. License Number 50 51. SSN or TIN 51											
52. Phone Number () 52 - 52A. Additional Provider ID 57. Phone Number () 57 - 58. Additional Provider ID											
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. 53											
54. NPI 55. License Number 55											
56. Address, City, State, Zip Code 56 56A. Provider Specialty Code											