ADA Dental Claim Form Sample

Unless the following sections of a dental bill are completed correctly, the bill will be returned and payment may be delayed.

Field	Section	Information Required
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
32	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*

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
Statement of Actual Services 1 Request for Predetermination/Preauthorization
EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)
4. Dental? Medical? (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 12
13. Date of Birth (MM/DD/CCYY) 14. Gender M F 15. Policyholder/Subscriber ID (SSN or ID#) 15
16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION
18. Relationship to Policyholder/Subscriber in #12 Above Self Spouse 18 Dependent Child Other 19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 20
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	29a. Diag Pointer	29b. Qty	30. Description	31. Fee
1	24			27		29			30	31
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A B C D
(Primary diagnosis in "A")
31a. Other Fee(s)
32. Total Fee 32
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 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 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") 39. Enclosures (Y or N)
40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment 43. Replacement of Prosthesis No Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from 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 48
49. NPI 50. License Number 50 51. SSN or TIN 51
52. Phone Number ( ) 52 - 52a. 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
X Signed (Treating Dentist) Date
54. NPI 55. License Number 55
56. Address, City, State, Zip Code 56 56a. Provider Specialty Code
57. Phone Number ( ) 57 - 58. Additional Provider ID

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J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)
To reorder call 800.947.4746 or go online at adacatalog.org

SAMPLE

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

For providers already in CalVCB's system: Number 48 and Number 51 on your bill must match exactly to what is in the system. If you have a new Tax ID, please notify CalVCB immediately.