



THE EMPLOYEE BENEFIT SERVICE CENTER

600 D Street, Post Office Box 8130 South Charleston, WV 25303

Telephone: 304.744.7723

Facsimile: 304.744.7759

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/Preauthorization Number

**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  Other

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

**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								
2								
3								
4								
5								
6								
7								
8								
9								
10								

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	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		

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 (Check applicable box)  
 Provider's Office  Hospital  ECF  Other

39. Number of Enclosures (00 to 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  No  Yes (Complete 44)

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. Provider ID      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 procedures.

X \_\_\_\_\_  
 Signed (Treating Dentist)      Date

54. Provider ID      55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) -      58. Treating Provider Specialty