

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

**GENERAL INSTRUCTIONS**

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

**COORDINATION OF BENEFITS (COB)**

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

**DIAGNOSIS CODING**

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

**PLACE OF TREATMENT**

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "[www.cms.gov/PhysicianFeeSched/Downloads/Website\\_POS\\_database.pdf](http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf)"

**PROVIDER SPECIALTY**

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
<b>Dentist</b> A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
<b>General Practice</b>	1223G0001X
<b>Dental Specialty</b> (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "[www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy)"

# ADA American Dental Association® 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/Preauthorization <input type="checkbox"/> EPSDT / Title XIX																								
2. Predetermination/Preauthorization Number					<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b> (For Insurance Company Named in #3)																			
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																								
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>																								
3. Company/Plan Name, Address, City, State, Zip Code																								
13. Date of Birth (MM/DD/CCYY)					14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)																	
<b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)					16. Plan/Group Number		17. Employer Name																	
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <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																								
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other					19. Reserved For Future Use																			
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																								
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																								
1	2	3	4	5	6	7	8	9	10	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					
33. Missing Teeth Information (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier <input type="checkbox"/> <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)					31a. Other Fee(s)									
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16										34a. Diagnosis Code(s) A _____ C _____					32. Total Fee									
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17										(Primary diagnosis in "A") B _____ D _____														
35. Remarks																								
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION														
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 _____										38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")					39. Enclosures (Y or N) <input type="checkbox"/>									
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 _____										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					43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)									
										44. Date of Prior Placement (MM/DD/CCYY)														
										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.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION														
48. Name, Address, City, State, Zip Code										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.  X _____ Signed (Treating Dentist) _____ Date _____														
49. NPI					50. License Number					51. SSN or TIN					54. NPI					55. License Number				
										56. Address, City, State, Zip Code					56a. Provider Specialty Code									
52. Phone Number ( ) -										52a. Additional Provider ID					57. Phone Number ( ) -					58. Additional Provider ID				