

# ADA American Dental Association® Dental Claim Form

## HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services       Request for Predetermination/Preauthorization

EPSDT / Title XIX

2. Predetermination/Preauthorization Number

Mail Dental Claims to:  
 Anthem Blue Cross  
 P.O. Box 659444  
 San Antonio, TX 78265

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/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

13. Date of Birth (MM/DD/CCYY)      14. Gender      15. Policyholder/Subscriber ID (SSN or ID#)

M     F

16. Plan/Group Number      17. Employer Name

## 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      8. Policyholder/Subscriber ID (SSN or ID#)

M     F

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

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above

Self     Spouse     Dependent Child     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      23. Patient ID/Account # (Assigned by Dentist)

M     F

## 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										
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 \_\_\_\_\_      C \_\_\_\_\_

(Primary diagnosis in "A")      B \_\_\_\_\_      D \_\_\_\_\_

31a. Other Fee(s)

32. Total Fee

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)      39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims")     

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      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

49. NPI      50. License Number      51. SSN or TIN

52. Phone Number ( ) -      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.

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

54. NPI      55. License Number

56. Address, City, State, Zip Code      56a. Provider Specialty Code

57. Phone Number ( ) -      58. Additional Provider ID