ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Insurance Carrier
900 Cottage Grove Rd
Bloomfield, CT 06002

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 [ ] U

8. Policyholder/Subscriber ID (Assigned by Plan)

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 (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Johnson, Mark L 888
East Harbor Rd
Richmond, VA 23173

13. Date of Birth (MM/DD/CCYY): 07/23/1966

14. Gender [X] M [ ] F [ ] U

15. Policyholder/Subscriber ID (Assigned by Plan): Mark L Johnson/123123123

16. Plan/Group Number: 00654321

17. Employer Name: Richmond Financial

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] 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 [ ] M [ ] F [ ] U

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	6/24/2020	40	JP	30,31	O	D0140	A	01	Limited Oral Evaluation- Problem Focused	$45
2	6/24/2020	40	JP	30,31	O	D9995	A	01	Teledentistry- Synchronous; real-time encounter	$12
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: A B (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A"): A K02.9 B ______ C ______ D ______

31a. Other Fee(s)

32. Total Fee: $57

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 Mark Johnson — 6/24/2020
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 Mark Johnson — 6/24/2020
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: 12 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N): Y

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis [X] 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

Dr. Taylor Smith
222 Fairfield Ln
Richmond, VA 23173

49. NPI: 1212121212

50. License Number: 12345

51. SSN or TIN: 222-22-2222

52. Phone Number: (999) 999 - 9999

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 Dr. Taylor Smith — 6/24/2020
Signed (Treating Dentist) — Date

54. NPI: 1212121212

55. License Number: 12345

56. Address, City, State, Zip Code

222 Fairfield Ln
Richmond, VA 23173

56a. Provider Specialty Code: 122300000X

57. Phone Number: (999) 999 - 9999

58. Additional Provider ID

SAMPLE