

# 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

A. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

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

Hewlett Packard Enterprise – RI Medicaid  
P.O. Box 2010  
Warwick, RI 02887-2010

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

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

Smith, Jane L  
123 Main Street  
Any Town, RI 02000

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

01/01/1999     M  F    100005555

**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

16. Plan/Group Number    17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above    19. Reserved For Future Use

Self     Spouse     Dependent Child     Other

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Smith, Jane L  
123 Main Street  
Any Town, RI 02000

21. Date of Birth (MM/DD/CCYY)    22. Gender    23. Patient ID/Account # (Assigned by Dentist)

01/01/1999     M  F    JS1234

**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
06/20/2014					D0140		1	Limited Oral Evaluation	100.00
06/20/2014					D1110		1	Prophylaxis-Adult	80.00
06/20/2014			14	B,O	D2392		1	Resin-based, two surfaces, posterior	150.00
06/20/2014			19	L,O	D2393		1	Resin-based, three surfaces, posterior	150.00

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

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    480.00

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 Signature on file    000    02/20/2014

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 Signature on file    10000000000    02/20/2014

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")    N

40. Is Treatment for Orthodontics?    41. Date Appliance Placed (MM/DD/CCYY)

No (Skip 41-42)     Yes (Complete 41-42)    \_\_\_\_\_

42. Months of Treatment Remaining    43. Replacement of Prosthesis    44. Date of Prior Placement (MM/DD/CCYY)

\_\_\_\_\_     No     Yes (Complete)    \_\_\_\_\_

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

Happy Smiles Dental Associates  
500 Your Street, Suite 301  
Providence, RI 02905

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

1112223334    1223G0001X    05-5555555

52. Phone Number    52a. Additional Provider ID

(401) 555 - 5555    \_\_\_\_\_

**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 John Jones, DDS    06/20/2014

Signed (Treating Dentist)    Date

54. NPI    55. License Number

1234567890    DENXXXXX

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

500 Your Street, Suite 301    122300000X

Providence, RI 02905

57. Phone Number    58. Additional Provider ID

(401) 555 - 5555    \_\_\_\_\_