

ADA 2006 Completion Guide

ADA 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 2		POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION 3		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
3. Company/Plan Name, Address, City, State, Zip Code			
OTHER COVERAGE 4		13. Date of Birth (MM/DD/CCYY)	
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		14. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) 5		15. Policyholder/Subscriber ID (SSN or ID#)	
6. Date of Birth (MM/DD/CCYY)		16. Plan/Group Number	
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		17. Employer Name	
8. Policyholder/Subscriber ID (SSN or ID#)		PATIENT INFORMATION	
9. Plan/Group Number		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	
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		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		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)	

#	FIELD NAME	FIELD INSTRUCTIONS
2	Predetermination/Preauthorization Number	REQUIRED , if applicable. Enter the assigned seven-digit prior authorization number or "EMERGENCY" for a dental patient between the ages of 19 and 21.
3	Company/Plan Name, Address, City, State, Zip Code	OPTIONAL . Enter Medicaid Claims Receipt, PO Box 2136, Columbia, SC 29202-2136.
4	Other Dental or Medical Coverage	OPTIONAL . Mark "NO" if patient does not have other coverage. Mark "YES" if patient does have other coverage.
5	Name of Policyholder/Subscriber in # 4	OPTIONAL . Enter the name of person who has the other coverage reported here (if patient has other coverage through a spouse, domestic partner, of if a child, through both parents).

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INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION 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#)	
OTHER COVERAGE 4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11) 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		16. Plan/Group Number 17. Employer Name	
6. Date of Birth (MM/DD/CCYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#)		PATIENT INFORMATION 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. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS	
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		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
11. Other Insurance Company/Dental Benefit Plan Name, 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)	

#	FIELD NAME	FIELD INSTRUCTIONS
6	Date of Birth (MM/DD/CCYY)	OPTIONAL. Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.
7	Gender	OPTIONAL. Mark the gender of the person who is listed in #5. Mark "M" for male. Mark "F" for female.
8	Policyholder/Subscriber Identifier (SSN/ID#)	REQUIRED, if applicable. This is a designated private insurance or Medicare field. Enter the private insurance or Medicare policy number if you have billed either one.
9	Plan/Group Number	REQUIRED, if applicable. This is a designated private insurance or Medicare field. Enter three-digit insurance carrier code number. REQUIRED field if reporting a private insurance or Medicare payment.
10	Patient's Relationship To Person in # 5	OPTIONAL. Leave Blank if not reporting a private insurance or Medicare payment or denial.
11	Other Insurance /Benefit Plan Name, Address, City, State, Zip Code	REQUIRED, if applicable. If private insurance company or Medicare denial is listed on the claim with a zero payment, write \$0.00 and put the number "1" in this field. If you have received a payment, put the amount paid to you in this field. Leave this field blank if not reporting private insurance or Medicare information.

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INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION 3. Company/Plan Name, Address, City, State, Zip Code					
OTHER COVERAGE 4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11) 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)			PATIENT INFORMATION 18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other <input type="checkbox"/> FTS <input type="checkbox"/> PTS 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#) <input type="checkbox"/> M <input type="checkbox"/> F	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	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist) <input type="checkbox"/> M <input type="checkbox"/> F		

#	FIELD NAME	FIELD INSTRUCTIONS
12	Name, Address, City, State, Zip Code	REQUIRED , if applicable. This is a designated private insurance or Medicare field. If private insurance company or Medicare denial is listed on the claim with a zero payment, write \$0.00 and the number "1" in this field. If you have received a payment, put the amount paid to you in this field. REQUIRED if reporting a private insurance or Medicare payment denial.
13	Date of Birth (MM/DD/CCYY)	OPTIONAL. Leave Blank if not reporting a private insurance or Medicare payment or denial.
14	Gender	OPTIONAL. Mark the gender of the person who is listed in #5. Mark "M" for male. Mark "F" for female.
15	Policyholder/Subscriber Identifier (SSN/ID#)	REQUIRED , if applicable. This is a designated private insurance or Medicare field. Enter the private insurance or Medicare policy number IF you have billed either one.
16	Plan/Group Number	REQUIRED , if applicable. This is a designated private insurance or Medicare field. Enter three-digit insurance carrier code number. REQUIRED field if reporting a private insurance or Medicare payment.
17	Employer Name	OPTIONAL. Leave Blank if not reporting a private insurance or Medicare payment or denial.

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OTHER COVERAGE		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		
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#) 18
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		
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 <input type="checkbox"/> M <input type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	
PATIENT INFORMATION		
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. Student Status 19 <input type="checkbox"/> FTS <input type="checkbox"/> PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 20		
21. Date of Birth (MM/DD/CCYY) 21	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F 22	23. Patient ID/Account # (Assigned by Dentist) 23

#	FIELD NAME	FIELD INSTRUCTIONS
18	Relationship to Policyholder/Subscriber in #12	OPTIONAL. Mark the relationship of the patient to the person identified in Field #12 who has the primary insurance. If patient is primary, mark "Self" and skip to Field #23.
19	Student Status	OPTIONAL. Mark the appropriate box; "FTS" for full-time or "PTS" for part-time.
20	Name, Address, City, State, Zip Code	OPTIONAL. Enter the patient's name, address, city, state, and zip code.
21	Date of Birth (MM/DD/CCYY)	OPTIONAL. Enter the date of birth of the patient.
22	Gender	OPTIONAL. Mark the appropriate box; "M" for male or "F" for female.
23	Patient ID/Account #	REQUIRED. Enter the beneficiary's ten-digit Medicaid identification number.

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RECORD OF SERVICES PROVIDED																												
24	24. Procedure Date (MM/DD/CCYY)	25	25. Area of Oral Cavity	26	26. Tooth System	27	27. Tooth Number(s) or Letter(s)	28	28. Tooth Surface	29	29. Procedure Code	30. Description		31. Fee														
1																												
2																												
3																												
4																												
5																												
6																												
7																												
8																												
9																												
10																												
MISSING TEETH INFORMATION		Permanent										Primary										32. Other Fee(s)						
34. (Place an 'X' on each missing tooth)		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	33. Total Fee
		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																												

#	FIELD NAME	FIELD INSTRUCTIONS
24	Procedure Date (MM/DD/CCYY)	REQUIRED , if applicable. Enter date of service. All dates must include the four-digit year.
25	Area of Oral Cavity	OPTIONAL . Always report if procedure in #29 requires the identification of a tooth or a range of teeth, if procedure in #29 incorporates a specific area of the oral, or if procedure in #29 does not relate to any portion of the oral cavity. Area of the oral cavity is designated by a two-digit code, selected from the following code list: "00" entire oral cavity, "01" maxillary arch, "02" mandibular, "10" upper right quadrant, "20" upper left quadrant, "30" lower left quadrant, "40" lower right quadrant.
26	Tooth System	OPTIONAL . Enter "JP" when designating teeth using ADA's universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition). Enter "JO" when using the International Standards Organization System.
27	Tooth Number(s) or Letter(s)	REQUIRED , if applicable. Enter valid tooth numbers (1-32 for permanent teeth or letters A-T for primary teeth). Valid quadrant codes (UR, UL, LR, LL) for procedures that may require quadrants can be placed in this column. Do not put a zero in front of a single digit tooth number or your claim will reject.
28	Tooth Surface	REQUIRED , if applicable. Enter tooth surface single letter codes as documented in the patient's medical record. The codes must be used to identify surfaces: B-Buccal & Facial, D- Distal, L-Lingual, M-Mesial, O-Occlusal & Incisal.
29	Procedure Code	REQUIRED . Enter the appropriate CDT procedure Code.

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

#	FIELD NAME	FIELD INSTRUCTIONS
30	Description	OPTIONAL. Enter the description of service rendered.
31	Fee	REQUIRED. Enter your usual and customary fee for the procedure.
32	Other Fee(s)	Leave this field blank.
33	Total Fee	REQUIRED. Enter the amount billed for all line items in Field 31 for each page.
34	Missing Teeth Information	OPTIONAL. Enter the missing teeth.
35	Remarks	REQUIRED, if reporting a private insurance or Medicare field. Enter total amount received from other insurance sources (sum of Fields 11 & 12) if you have filed with a private insurance. Leave this field BLANK if you are billing Medicaid as a primary payer.

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36	38	39
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	ANCILLARY CLAIM/TREATMENT INFORMATION 38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="text"/> <input type="text"/> <input type="text"/>
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) _____
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)	42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)
48. Name, Address, City, State, Zip Code _____ _____ _____	44. Date 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
49. NPI _____	46. Date of Accident (MM/DD/CCYY) _____	47. Auto Accident State _____
50. License Number _____	TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
51. SSN or TIN _____	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	
52. Phone Number () - _____	54. NPI _____	55. License Number _____
52A. Additional Provider ID _____	56. Address, City, State, Zip Code _____ _____	56A. Provider Specialty Code _____
57. Phone Number () - _____	57. Phone Number () - _____	58. Additional Provider ID _____
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#	FIELD NAME	FIELD INSTRUCTIONS
36	Patient Consent Authorization	OPTIONAL. Enter patient's/guardian's signature on file and date.
37	Insured's Signature	OPTIONAL. Enter signature of insured to authorize payment.
38	Place of Treatment	REQUIRED. Provider's Office Field: Place an "X" if treatment occurred in the office, Hospital Field: Place an "X" on the hospital box for treatment that occurs in a hospital. ECF Field: Place an "X" for nursing home, or Other Field: Place an "X" for other places of service (i.e., school).
39	Number of Enclosures (00 to 99)	OPTIONAL. Enter in the amount of enclosures. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and no attachments are missing.
40	Is Treatment for Orthodontics?	OPTIONAL. Enter "Yes" or "No." If no, skip to Field #43.
41	Date Appliance Placed	OPTIONAL. Indicate the date an orthodontic appliance was placed.

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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 42			ANCILLARY CLAIM/TREATMENT INFORMATION 38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) 43 <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <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 46			42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44 44. Date Prior Placement (MM/DD/CCYY) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
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 45. Treatment Resulting from 45 <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 47 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		
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#	FIELD NAME	FIELD INSTRUCTIONS
42	Months of Treatment Remaining	OPTIONAL. Enter the estimated number of months required to complete the orthodontic treatment.
43	Replacement of Prosthesis	OPTIONAL. Mark "No" if the claim does not involve a prosthetic restoration or if the claim is for the initial placement of a crown, or a fixed or removable prosthesis. Mark "Yes" if the patient had previously had these teeth replaced by a crown or if having an existing crown replaced.
44	Date Prior Placement (MM/DD/CCYY)	OPTIONAL. Enter date if answer to field #43 was "yes."
45	Treatment Resulting from	REQUIRED, if applicable. Mark the appropriate box if the dental treatment listed on the claim was provided as a result of an accident or injury.
46	Date of Accident (MM/DD/CCYY)	REQUIRED, if applicable. Enter the date on which the accident noted in field #45 occurred.
47	Auto Accident State	REQUIRED, if applicable. Enter the state in which the auto accident noted in field #45 occurred.

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AUTHORIZATIONS		ANCILLARY CLAIM/TREATMENT INFORMATION	
<p>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.</p> <p>X _____ Patient/Guardian signature Date</p>		<p>38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other</p> <p>39. Number of Enclosures (00 to 99) Radiograph(s) <input type="checkbox"/> Oral Image(s) <input type="checkbox"/> Model(s) <input type="checkbox"/></p>	
<p>37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.</p> <p>X _____ Subscriber signature Date</p>		<p>40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)</p> <p>41. Date Appliance Placed (MM/DD/CCYY)</p>	
<p>BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)</p> <p>48. Name, Address, City, State, Zip Code 48</p>		<p>42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)</p> <p>43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)</p> <p>44. Date Prior Placement (MM/DD/CCYY)</p>	
<p>49. NPI 49</p>		<p>45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident</p>	
<p>50. License Number 50</p>		<p>46. Date of Accident (MM/DD/CCYY)</p>	
<p>51. SSN or TIN 51</p>		<p>47. Auto Accident State</p>	
<p>52. Phone Number () - 52</p>		<p>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</p> <p>53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.</p> <p>X _____ Signed (Treating Dentist) Date</p>	
<p>52A. Additional Provider ID</p>		<p>54. NPI</p>	
<p>57. Phone Number () -</p>		<p>55. License Number</p>	
<p>58. Additional Provider ID</p>		<p>56. Address, City, State, Zip Code</p>	
<p>58A. Provider Specialty Code</p>		<p>57. Phone Number () -</p>	
<p>58. Additional Provider ID</p>		<p>58. Additional Provider ID</p>	

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#	FIELD NAME	FIELD INSTRUCTIONS
48	Name, Address, City, State, Zip Code	REQUIRED. Enter the name and complete address of a dentist or dental entity including the Zip Code + 4. Should the claim need to be returned, this address would be used.
49	NPI	REQUIRED, if applicable. Enter the treating entity's Type 2 – group NPI in this field. This number represents an organization providing dental care services, such as group practices, professional organizations, clinics and hospitals. If you enter a group NPI in this field, then you must enter an individual provider NPI number in Field 54 or your claim will reject.
50	License Number	OPTIONAL. If the billing dentist is an individual, enter the dentist's license number. If a billing entity is submitting the claim, leave blank.
51	SSN or TIN	OPTIONAL. Enter SSN or TIN if the billing dentist is unincorporated; Corporation TIN of the billing dentist or dental entity is a group practice or clinic.
52	Phone Number	OPTIONAL. Enter the business phone number of the billing dentist or dental entity.

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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"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="checkbox"/> <input type="checkbox"/> <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 <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date 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 54			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 53		
49. NPI	50. License Number	51. SSN or TIN	54. NPI 56	55. License Number 55	56A. Provider Specialty Code 56A
52. Phone Number () -		52A. Additional Provider ID	57. Phone Number () -		58. Additional Provider ID
© 2006 American Dental Association J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)			To Reorder call 1-800-947-4746 or go online at www.adacatalog.org		

#	FIELD NAME	FIELD INSTRUCTIONS
53	Certification	OPTIONAL. Enter the signature of the treating or rendering dentist and date the form is signed.
54	NPI	REQUIRED. Enter the treating dentist's Type 1 – individual NPI. This number represents the actual treating dentist who performed the service(s).
55	License Number	OPTIONAL. Enter the license number of the treating dentist. This may vary from the billing dentist.
56	Address, City, State, Zip Code	REQUIRED. Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box. Must include at minimum the Zip code + 4.
56A	Provider Specialty Code	REQUIRED. Enter the taxonomy code that indicates the type of dental professional who delivered the treatment. The taxonomy code reported on the claim must match the taxonomy code registered with SCDHHS.
57	Phone Number	OPTIONAL. Enter the business telephone number of the treating dentist.