Introduction

The ADA's Council on Dental Benefit Programs has responsibility for electronic and paper dental claim content and completion instructions. Staff from the Center for Dental Benefits, Coding and Quality within the ADA's Practice Institute maintain the paper ADA Dental Claim Form and its completion instructions. According to ADA policy the paper form's data content must be in harmony with the HIPAA standard electronic dental claim transaction.

The ADA Dental Claim Form was last structurally revised in 2012 to incorporate key data content changes that enables diagnosis code reporting that was also incorporated into the now current version of the HIPAA standard (837D v5010) electronic dental claim. This version of the ADA form incorporates editorial changes to further its consistency with the 837D.

Summary of Form Version 2019 Editorial and Completion Instruction Changes

Change Description	Affected Form	
	#	Field Name
Consistent completion instruction captions for these fields.	8 15	Policyholder/Subscriber Identifier
Changed from two check boxes, one for Male (M) and another for Female (F), to three with the third being a box for Unknown (U).	7 14 22	Gender
Addition of NOTE that points to other online guidance on when this information is reported.	25	Area of Oral Cavity
Consistent instructions for reporting procedures involving multiple teeth	27	Tooth Numbers or Letters
Addition of NOTE to clarify that tooth numbers are based on morphology, not anatomic location.	27 33 35	Tooth Numbers or Letters Missing Teeth Remarks
Removal of coding option "B" as it applies to an ICD-10-CM version that is no longer valid for use.	34	Diagnosis Code List Qualifier
Addition of clarifying NOTE that: a) addresses when this information would be reported; and b) refers to other online guidance for completion when this information is reported.	34 34a	Diagnosis Code List Qualifier Diagnosis Code(s)
Additional information concerning completion when teledentistry procedure code is reported.	38 56	Place of Service Code Treatment Location Address

The current version of the paper form (2019 © American Dental Association), front and reverse sides, is illustrated on the next two pages. The illustrations are then followed by comprehensive form completion instructions.

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

DENTAL BENEFIT PLAN INFORMATION

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

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
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐M ☐F ☐U
15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number
17. Employer Name

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 ☐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										
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-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ 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

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment
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

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

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

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The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

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 instructions posted on the ADA's web site (ADA.org).

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.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

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).

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 (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:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/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
Dentist 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
General Practice	1223G0001X
Dental Specialty (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

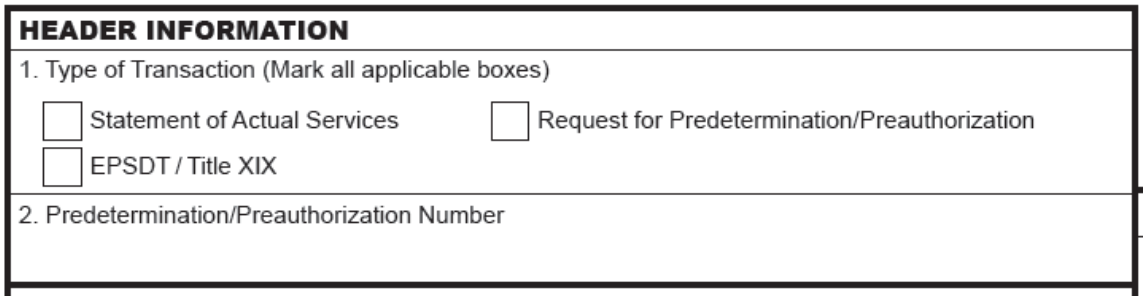
Provider taxonomy codes listed above are a subset of the full code set that is posted at:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

DATA ELEMENT SPECIFIC INSTRUCTIONS

Form completion instructions are provided for each data item, which is indicated by a number. Please note that data items are in groups of related information. These instructions explain the reasons for such groupings, and the relationships (if any) between groups.

Header Information

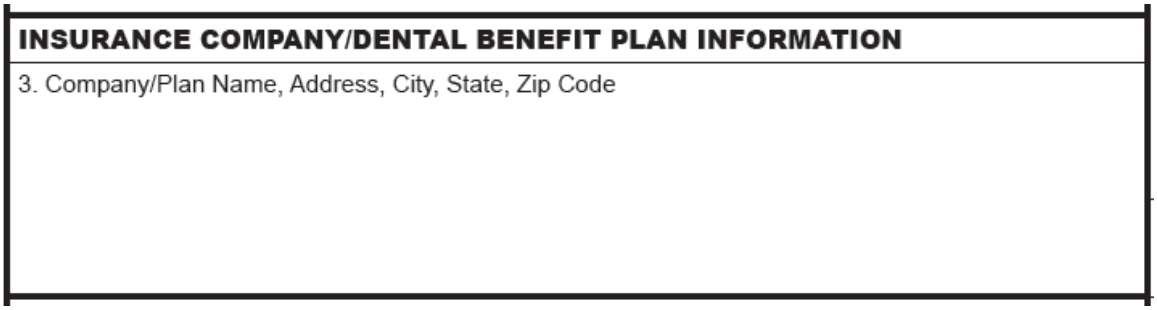
The 'header' provides information about the type of submission being made. This information applies to the entire transaction.



1. Type of Transaction: There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box marked "Request for Predetermination / Preauthorization". If the claim is through the **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment **P**rogram, mark the box marked 'EPSDT/Title XIX'.

2. Predetermination/Preauthorization Number: If you are submitting a claim for a procedure that has been pre-authorized by a third party payer, enter the preauthorization or predetermination number provided by the insurance company.

Insurance Company/Dental Benefit Plan Information



3. Company/Plan Name, Address, City, State, Zip Code: **This Item is always completed**. Enter the information for the insurance company or dental benefit plan that is the third party payer receiving the claim.
    - If the patient is covered by more than one plan, enter the primary insurance company information here for the initial claim submission.
    - When submitting a separate claim to the secondary carrier, place the secondary carrier's company/plan name and address information here.

Other Coverage

This area of the claim form provides information on the existence of additional dental or medical insurance policies. This is necessary to determine if multiple coverages are in effect, and the possibility of coordination of benefits.

- When the claim form is being prepared for submission to the primary carrier the information in "Other Coverage" applies to the secondary carrier.
- When the claim form is being prepared for submission to the secondary carrier the information in "Other Coverage" applies to the primary carrier.

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		

4. Other Dental or Medical Coverage?: Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage.
    - Leave blank when the dentist is not aware of any other coverage(s).
    - When either box is marked, complete Items 5 through 11 in the "Other Coverage" section for the applicable benefit plan.
    - If both Dental and Medical are marked, enter information about the dental benefit plan in Items 5 through 11.

5. Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix): If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.

6. Date of Birth (MM/DD/CCYY): 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: Mark the gender of the person who is listed in Item #5. Mark "M" for Male, "F" for Female, or "U" for Unknown as applicable.

8. Policyholder/Subscriber Identifier (Assigned by Plan): Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in Item #5, which is on their identification card.

9. Plan/Group Number: Enter the group plan or policy number of the person identified in Item #5.

10. Patient's Relationship to Person Named in Item #5: Mark the patient's relationship to the other insured named in Item #5.

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code: Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

Policyholder/Subscriber Information (For Insurance Company Named in Item #3)

This section documents information about the insured person who may or may not be the patient.

- When the claim form is being prepared for submission to the primary carrier the information supplied applies to the person insured by the primary carrier.
- When the claim form is being prepared for submission to the secondary carrier the information entered applies to the person insured by secondary carrier.

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 ☐M ☐F ☐U	15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number	17. Employer Name	

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Enter the complete name, address and zip code of the policyholder/subscriber with coverage from the company/plan named in #3.

13. Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year.

14. Gender: This applies to the primary insured, who may or may not be the patient. Mark "M" for Male, "F" for Female, or "U" for Unknown as applicable.

15. Policyholder/Subscriber Identifier (Assigned by Plan): Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in Item #12, which is on their identification card.

16. Plan/Group Number: Enter the policyholder/subscriber's group plan/policy number.

17. Employer Name: If applicable, enter the name of the policyholder/subscriber's employer.

Patient Information

The information in this section of the claim form pertains to the patient.

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 ☐ M ☐ F ☐ U	23. Patient ID/Account # (Assigned by Dentist)

18. Relationship to Policyholder/Subscriber in #12 Above: Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. **If the patient is also the primary insured, mark the box titled 'Self' and skip to item #23.**

19. Reserved For Future Use: Leave blank and skip to Item #20. (#19 was previously used to report "Student Status.")

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Enter the complete name, address and zip code of the patient.

21. Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.

22. Gender: This applies to the patient. Mark "M" for Male, "F" for Female, or "U" for Unknown as applicable.

23. Patient ID/Account # (Assigned by Dentist): Enter if the dentist's office has assigned a number to identify the patient. This is not required to process claim.

Record Of Services Provided

This section contains information regarding the proposed treatment (predetermination/preauthorization), or treatment performed (actual services).

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.)	34. Diagnosis Code List Qualifier ☐☐ (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 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diagnosis in "A") B _____ D _____	32. Total Fee	
35. Remarks			

NOTE: Items 24 through 31, following, apply to each of the 10 available lines on the claim form for reporting dental procedures provided to the patient. **The remaining Items in this section of the form (33-35) do not repeat**.

24. Procedure Date (MM/DD/CCYY): Enter procedure date for actual services performed or leave blank if the claim is for preauthorization/predetermination. The date, if included, must have two digits for the month, two for the day, and four for the year.

    The presence or absence of a Procedure Date should be consistent with the type of transaction(s) marked in Item #1 (e.g., actual services; predetermination / preauthorization).

25. Area of Oral Cavity: **Use of this field is conditional**. Always report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. For example:

    a. Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as **D4263 bone replacement graft – first site in quadrant**

    b. Do not report the applicable area of the oral cavity when the procedure either: 1) incorporates a specific area of the oral cavity in its nomenclature, such as **D5110 complete denture – maxillary**; or 2) does not relate to any portion of the oral cavity, such as **D9222 deep sedation/general anesthesia – first 15 minutes**.

    NOTE: Detailed guidance on reporting Area of the Oral Cavity, Tooth Numbers and Tooth Surfaces by CDT code is posted on the ADA Dental Claim Form web page –

    ADA Dental Claim Form

Area of the oral cavity is designated by a two-digit code, selected from the following code list:

Code	Area
00	entire oral cavity
01	maxillary arch
02	mandibular arch
10	upper right quadrant
20	upper left quadrant
30	lower left quadrant
40	lower right quadrant

26. Tooth System: Enter "JP" to indicate that teeth are being designated using the ADA's Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition).

27. Tooth Number(s) or Letter(s): **Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank.**

    NOTE: Numbers or letters reported are based on tooth morphology, not anatomic position. This is the traditional and important concept to understand for accurate documentation and reporting. For instance, a tooth may migrate into an edentulous space, but that movement does not change its morphology. Similarly, placement of an implant body need not be in an anatomic tooth position, but the prosthesis placed is the morphological equivalent of a missing tooth or range of teeth.

    If the same procedure is performed on more than a single tooth on the same date of service there are two options for reporting –

    - Report each procedure, the tooth involved, and the fee on separate service lines
    - Report the procedure on a single service line with the teeth involved in #27, the number of times the procedure was delivered in the #29b (Quantity), and the total fee for all in #31 (Fee)

    When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10; 3-5, 22-27).

    Supernumerary teeth in the **permanent** dentition are identified in the ADA's Universal/National Tooth Designation System ("JP") by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32). This enumeration is illustrated in the following chart:

    Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
'Super' #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Arch

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
'Super' #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Supernumerary teeth in the **primary** dentition are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T"). This enumeration is illustrated in the following chart:

Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	A	B	C	D	E	F	G	H	I	J
'Super'#	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Arch

Tooth "#"	T	S	R	Q	P	O	N	M	L	K
Super "#"	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

28. Tooth Surface: This Item is necessary when the procedure performed by tooth involves one or more tooth surfaces. Otherwise leave blank. The following single letter codes are used to identify surfaces:

Surface	Code
Buccal	B
Distal	D
Facial (or labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

Do not leave any spaces between surface designations in multiple surface restorations (e.g., MOD).

29. Procedure Code: Enter the appropriate procedure code found in the version of the *Code on Dental Procedures and Nomenclature* in effect on the "Procedure Date" (Item #24).

NOTE: Additional guidance concerning reporting select CDT codes (e.g., Teledentistry; Sales Tax) are in Coding Education and the ADA Claim Form content linked to the CDT Code Portal web page –

www.ada.org/cdt

29a Diagnosis Code Pointer: Enter the letter(s) from Item 34 that identify the diagnosis code(s)

applicable to the dental procedure. List the primary diagnosis pointer first.

29b Quantity: Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01."

30. Description: Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).

31. Fee: Report the dentist's full fee for the procedure. Resolution 44-2009 Statement on Reporting Fees on Dental Claims adopted by the ADA House of Delegates, as follows, provides guidance on the appropriate entry for this item.

Statement on Reporting Fees on Dental Claims

1) A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist's professional judgment.
2) A contractual relationship does not change the dentist's full fee.
3) It is always appropriate to report the full fee for each service reported to a third-party payer.

(Note: Item 31 above is the last of the repeating 'service line' items.)

31a Other Fee(s): When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.

32. Total Fee: The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a

33. Missing Teeth Information: Mark an "X" on the number of the missing tooth – for identifying missing permanent dentition only. Report missing teeth when pertinent to Periodontal, Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim

NOTE: Numbers marked are based on tooth morphology, not anatomic position.

34. Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source:

AB = ICD-10-CM

34a Diagnosis Code(s): Enter up to four applicable diagnosis codes after each letter (A. – D.). The primary diagnosis code is entered adjacent to the letter "A."

NOTE: #34 and #34a are required when a) the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions; or b) when required by state regulation (e.g., Medicaid) or third-party payer contract provisions.

Detailed guidance on reporting ICD-10-CM diagnosis codes is posted on the ADA Dental Claim Form web page –

ICD Reporting on ADA Dental Claim Form

35. Remarks: This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim (e.g., for a secondary claim, the amount the primary carrier paid).

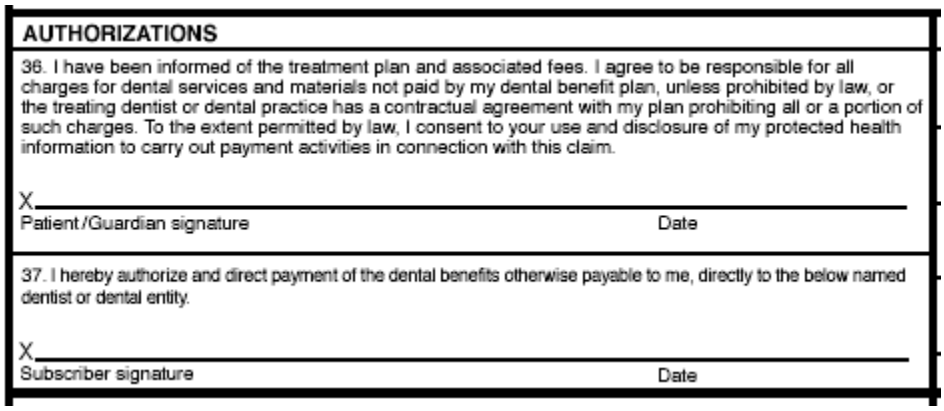
Remarks should be concise and pertinent to the claim submission. Claimants should note that an entry in "Remarks" may prompt review by a person as part of claim adjudication, which may affect

overall time required to process the claim.

NOTE: When the claim is for a multi-unit implant supported prosthesis the supporting implant body locations may not correlate to the anatomic location of a natural tooth. An appropriate notation in "Remarks" may avoid a misunderstanding when the claim is submitted to a third-party payer.

Authorizations

This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.



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

36. Patient Consent: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.

    By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.

    Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.

37. Authorize Direct Payment: The signature and date (or "Signature on File" notice) are required when the Policyholder/Subscriber named in Item #12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company.

    Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.

Ancillary Claim/Treatment Information

This section of the claim form provides additional information to the third party payer regarding the claim.

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment [ ] (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) [ ]
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

38. Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard. Frequently used codes are:

    11 = Office; **12** = Home; **21** = Inpatient Hospital; **22** = Outpatient Hospital; **31** = Skilled Nursing Facility; **32** = Nursing Facility; **02** = Telehealth (aka Teledentistry)

    All current codes are available online from the Centers for Medicare and Medicaid Services in PDF format for download –

    CMS Place of Service Code Set

39. Number of Enclosures (00 to 99): Enter a "**Y**" or "**N**" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).

40. Is Treatment for Orthodontics?: **If no, skip to Item #43**. If yes, answer Items 41 & 42.

41. Date Appliance Placed (MM/DD/CCYY): Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.

42. Months of Treatment: Enter the total number of months required to complete the orthodontic treatment, from the beginning to the end of the treatment plan.

43. Replacement of Prosthesis?: This Item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures).

    Please review the following three situations in order to determine how to complete this Item.

    a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to Item 45.

    b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Item 45.

    c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete section 44.

44. Date of Prior Placement (MM/DD/CCYY): Complete if the answer to Item #43 was "YES."

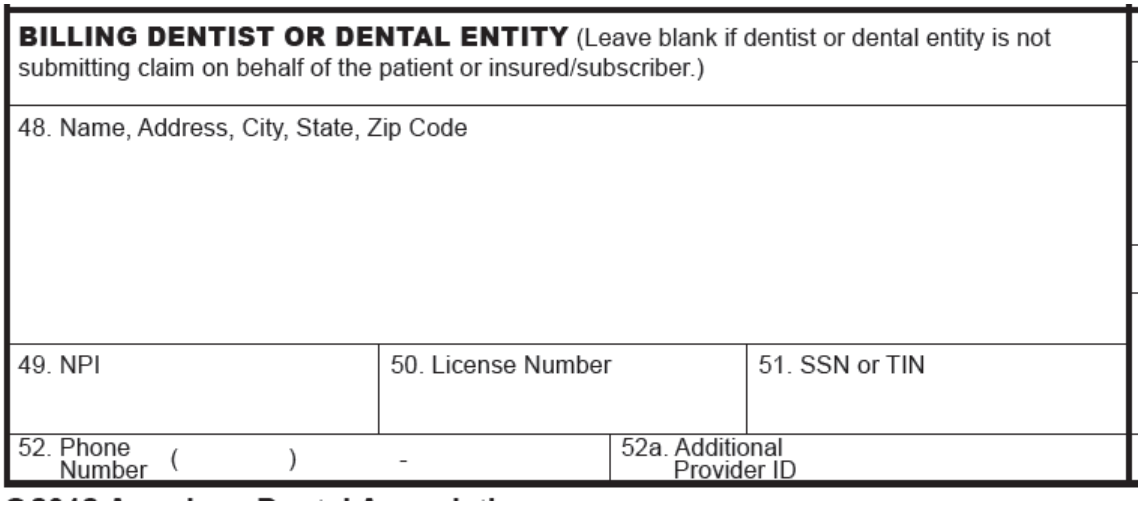
45. Treatment Resulting From: If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to Items #46 and #47. **If the services you are providing are not the result of an accident, this Item does not apply; skip to Item #48**.

46. Date of Accident (MM/DD/CCYY): Enter the date on which the accident noted in Item #45 occurred. Otherwise, leave blank.

47. Auto Accident State: Enter the state in which the auto accident noted in Item #45 occurred. Otherwise, leave blank.

Billing Dentist Or Dental Entity

The 'Billing Dentist' or 'Dental Entity' section provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist. **If the patient is submitting the claim directly, do not complete Items 48-52a**.



48. Name, Address, City, State, Zip Code: Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).

49. NPI (National Provider Identifier): Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.

    NOTE: The NPI is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation.

    An NPI is unique to an individual dentist or dental entity, and has no intrinsic meaning. There are two types of NPI available to dentists and dental practices:

    - Type 1 Individual Provider - All individual dentists are eligible to apply for Type 1

NPIs, regardless of whether they are covered by HIPAA.

- Type 2 Organization Provider - A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.

On paper, there is no way to distinguish a type 1 from a type 2 in the absence of any associated data; they are identical in format. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site –

National Provider Identifier

50. License Number: If the billing dentist is an individual, enter the dentist's license number. If a billing entity (e.g., corporation) is submitting the claim, leave blank.

51. SSN or TIN: Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.

52. Phone Number: Enter the business phone number of the billing dentist or dental entity.

52a. Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; federal government). Some Legacy IDs have an intrinsic meaning.

Treating Dentist And Treatment Location Information

This section must be completed for all claims. Information that is specific to the dentist or practitioner acting within the scope of their state licensure who has provided treatment is entered in this section.

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

53. Certification: Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form.

Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this Item.

54. NPI (National Provider Identifier): Enter the treating dentist's Type 1 – Individual Provider NPI in Item # 54. (See Item #49 for more NPI information.)

55. License Number: Enter the license number of the treating dentist. This may vary from the billing dentist.

56. Address, City, State, Zip Code: Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.

    NOTE: For teledentistry encounters the treatment location is the dentist's practice location, not the patient's location.

56a. Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists follow. The general code listed as "Dentist" may be used instead of any other dental practitioner codes.

Category / Description	Code
Dentist / 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
General Practice / a dentist who provides a variety of dental services to address patient needs.	1223G0001X
Dental Specialty / a practitioner in one of the nine specialty areas recognized by the ADA.	See following list
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

These codes are from the "Dental Service Providers" section of the Healthcare Providers Taxonomy code list, a HIPAA standard, and are a subset of the full list that includes codes for other types of practitioners including dental assistants, dental hygienists, denturists, and dental lab technicians. The current full list is posted online –

Health Care Provider Taxonomy Code Set

57. Phone Number: Enter the business telephone number of the treating dentist.

58. Additional Provider ID: This is an identifier assigned to the treating dentist other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

    The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.