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

INSURANCE COMPANY/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
8. Policyholder/Subscriber ID (SSN or ID#)
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 (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 ☐ M ☐ 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 ☐ 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
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-9 = B; 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

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

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

ORTHODONTIC
Specialists of Florida

INSURANCE INFORMATION ACKNOWLEDGEMENT

1. We have verified your insurance information to the best of our ability. We will complete a claim form and submit it to your insurance company for you.
2. Any overage your insurance company may pay will be credited toward your account or refunded to you once the account is paid in full. The majority of insurance companies pay over the length of treatment. For your benefit, we are billing the insurance company on a fee for service basis which may be different from your payment arrangements.
3. Your payment arrangements apply *regardless of insurance payment schedule and until the account is paid in full.* Some insurance companies do not pay promptly. We are willing to complete and file insurance forms at no additional cost, but we are unable to maintain accounts in arrears.
4. Your account must be paid in full prior to the braces being removed including any outstanding amounts owed/estimated from your insurance company.
5. Insurance policies and payment programs can be confusing, so we require that patients contact their insurance company to confirm that their assumptions regarding coverage for orthodontic treatment are correct. Patients must realize that professional services are rendered to a person, and not the insurance company. Therefore, insurance is not a guarantee of payment and must be the person's responsibility to ensure their insurance company is making payments timely and following up with the office. We cannot render services on the assumption that charges will be paid by an insurance company. However, we will help in any way we can.

Please feel free to ask us any questions which will help clarify these policies for you.

I have read and understand the above policies and acknowledge my responsibilities.

X_____
Signature of Responsible Party (attach copy of Insurance Card)

_____
Responsible Party Printed Name

Date_____

_____
Signature of Consultation Person