

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services Request for Predetermination/Preaduthorization
 EPSDT / Title XIX

2. Predetermination/Preaduthorization 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 8. Policyholder/Subscriber ID (Assigned by Plan)
 M F U9. 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 15. Policyholder/Subscriber ID (Assigned by Plan)
 M F U

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

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 1734. Diagnosis Code List Qualifier (ICD-10 = AB)

31a. Other Fee(s)

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

32. Total Fee

35. Remarks

AUTORIZATIONS

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

Exhibit No. 2

Date 2-8-23
Bill No. SB 238

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")

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

44. Date of Prior Placement (MM/DD/CCYY)

 No Yes (Complete 44)

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