The Revised ADA Dental Claim Form

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.

This version of the ADA form incorporates editorial changes to further its consistency with the HIPAA standard (837D v5010) electronic dental claim.

Consistent completion instruction captions for these fields — 3, 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).
Changed these fields — 7, 14, 22, Gender

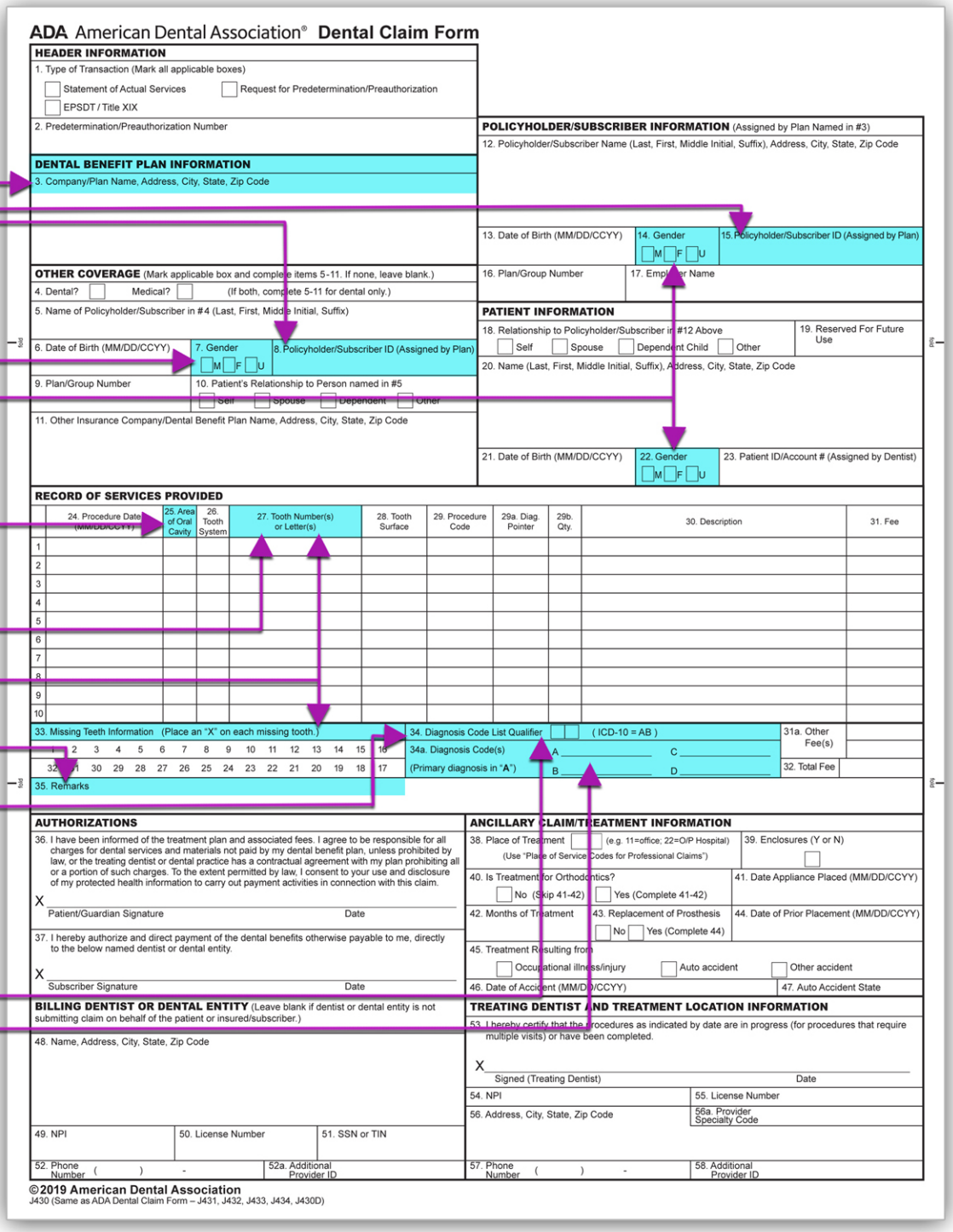
Addition of NOTE that points to other online guidance on when this information is reported.
Change for this field — 25, Area of Oral Cavity

Consistent instructions for reporting procedures involving multiple teeth
Change for this field — 27, Tooth Numbers or Letters

Addition of NOTE to clarify that tooth numbers are based on morphology, not anatomic location.
Change for this field — 27, Tooth Numbers or Letters — 33, Missing Teeth — 35, Remarks

Removal of coding option "B" as it applies to an ICD-10-CM version that is no longer valid for use.
Change for this field — 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.
Change for this field — 34, Diagnosis Code List Qualifier — 34a, Diagnosis Code(s)



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 _____ C _____ B _____ 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

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

W-ADA Change