ADA American Dental Association® Dental Claim Form

R Required - claim block must be completed
A Applicable - claim block must be completed, if applicable
O Optional - claim block is optional
LB Leave Blank - claim block should be left blank

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) R
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number LB

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ R LB (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) R LB

6. Date of Birth (MM/DD/CCYY) R LB

7. Gender R LB ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#) R LB

9. Plan/Group Number R LB

10. Patient's Relationship to Person named in #5 R LB ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code R LB

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code R

13. Date of Birth (MM/DD/CCYY) R

14. Gender R ☐ M ☐ F

15. Policyholder/Subscriber ID (SSN or ID#) R

16. Plan/Group Number LB

17. Employer Name R

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above R ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserved For Future Use LB

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code R

21. Date of Birth (MM/DD/CCYY) R

22. Gender R ☐ M ☐ F

23. Patient ID/Account # (Assigned by Dentist) O

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	R	A	LB	R	R	R	R LB	R	R	R
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.) LB
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 R LB (ICD-9 = B; ICD-10 = AB)

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

31a. Other Fee(s) O

32. Total Fee O

35. Remarks O

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. O

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. O

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 R

49. NPI R

50. License Number LB

51. SSN or TIN R

52. Phone Number (R) -

52a. Additional Provider ID LB

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) R (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) LB ☐

40. Is Treatment for Orthodontics? O ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY) O

42. Months of Treatment A

43. Replacement of Prosthesis R ☐ No ☐ Yes (Complete 44)

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

45. Treatment Resulting from A ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) A

47. Auto Accident State A

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. R

X _____
Signed (Treating Dentist) Date

54. NPI R

55. License Number LB

56. Address, City, State, Zip Code R

56a. Provider Specialty Code R

57. Phone Number ( ) O -

58. Additional Provider ID LB

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

To reorder call 800.947.4746
or go online at adacatalog.org

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

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 CDT manual's instructions.

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.

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). There are additional detailed completion instructions in the CDT manual.

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 (B for ICD-9-CM; 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 "www.cms.gov/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 "www.wpc-edi.com/codes/taxonomy"

Blk No.	Block Description
1	**Type of Transaction** R Check the Request for Predetermination/Preauthorization box if this is a prior authorization or post-operative review request. Check the Statement of Actual Services box if this is a claim for completed services.
2	**Predetermination/Preauthorization Number** LB Do not complete this block.
3	**Name, Address, City, State, Zip Code** R Enter the full name and address of the Insurance Company or Dental Benefit Plan. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246).
4	**Other Dental or Medical Coverage** R If there is other dental/medical coverage, check the appropriate Box and complete items 5–11 below. LB If no other coverage.
5	**Name of Policyholder/ Subscriber in #4 Name (Last, First, Middle Initial, Suffix)** R If box is checked in Block 4, enter name of policy holder/subscriber of the other insurance indicated in block 4. LB If no information listed on Block 4.
6	**Date of Birth (MM/DD/CCYY)** R If Block 4 completed, enter the Policyholder/Subscriber's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978). LB If no information listed on Block 4.
7	**Gender** R If Block 4 completed put an "X" in the appropriate box of the person named in Block 5. Only one box can be selected. LB If no information listed on Block 4.
8	**Policyholder/ Subscriber ID # (SSN or ID#)** R If Block 4 completed, enter the Social Security Number or Identification Number of the Policyholder/Subscriber. LB If no information listed on Block 4.
9	**Plan/Group Number** R If Block 4 completed, enter the Plan/Group number if applicable. LB If no information listed on Block 4.
10	**Patient's Relationship to Person Named in #5** R If Block 4 completed, enter the Patient's Relationship to person named in Block 5. LB If no information listed on Block 4.
11	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code** R If Block 4 completed, enter the full name and address of the Other Insurance or Dental Plan. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246). LB If no information listed on Block 4.
12	**Policyholder/ Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code** R Enter full name and address of Member. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246).
13	**Date of Birth (MM/DD/CCYY)** R Enter the date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) of the person named in Block 12.
14	**Gender** R Enter an "X" in the appropriate box of the named person in Block 12. Only one box can be selected.
15	**Policyholder/ Subscriber ID# (SSN or ID#)** R Enter the Member's ID, Must 9 Characters.
16	**Plan/Group Number** LB Do not complete this block.
17	**Employer Name** R Enter the Employer name of the person named in Block 12.
18	**Relationship to Policyholder/ Subscriber in #12 above** R Put an "X" in the appropriate box. Only one box can be selected.
19	**Reserved for Future Use** LB Do not complete this block.
20	**Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code** R Patient Last Name and First name (e.g., Doe, John)
21	**Date of Birth (MM/DD/CCYY)** R Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
22	**Gender** R Indicate the patient's gender by placing an X in the appropriate box.
23	**Patient ID/Account Number** O If entered, must be less than 20 characters
24, (110)	**Procedure Date** R Enter the procedure date in an eight-digit format (MMDDCCYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 03012007) or in six-digit format (MMDDYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 030107). When box 1, request for predetermination is checked, do not enter procedure date.
25	**Area of Oral Cavity** A Enter area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'

Blk No.	Block Description
26	**Tooth System** LB Do not complete this block.
27 (1-10)	**Tooth Number(s) or Letter(s)** R Enter only one tooth number or, letter per claim line. This item must be no longer than 2 characters.
28 (1-10)	**Tooth Surface** R Values: M—Mesial, D—Distal, O—Occlusal, L—Lingual, F—Facial, B—Buccal, I— Incisal
29 (1-10)	**Procedure Code** R Enter the code for the procedure performed. The "D" must be entered as the first part of the procedure code.
29a	**Diag Pointer** R This block may contain up to four digits. If the service was provided for the primary diagnosis (in Block 34a), enter A. If provided for the secondary diagnosis, enter B. If provided for the third diagnosis, enter C, and for the fourth diagnosis, enter D. LB If nothing entered in Box 34a.
29b	**Qty** R Enter the number of units, services, or items provided. Can enter decimal (e.g., 5.1) but cannot be more than 8 digits.
30	**Description** R Enter the terminology to describe the service provided.
31 (1-10)	**Fee** R Enter your usual and customary charge to the general public for the service(s) provided in dollars and cents. Example: $25.00, $150.00 If you are billing for multiple units of service, be sure to multiply your usual charge by the number of units billed and enter that amount.
31a	**Other Fee(s)** O When other applicable 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** O Enter total fee. Amount should be the sum of Box 31 (1-10). Amount should be provided in dollars and cents. Example: $25.00, $150.00. Multiple page claims are not allowed. If detail requires more than one claim, each claim must be considered a separate claim with its own total charge. $0 are allowed when box 1, request for predetermination is checked.
33	**(Place an 'X' on each missing tooth)** LB Do not complete this block.
34	**Diagnosis Code List Qualifier (ICD-9=B and ICD-10=AB)** R Enter the appropriate code to identify the diagnosis code source. LB If nothing entered in Box 34a.
34a	**Diagnosis Code** A Only needed when the diagnosis code 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.
35	**Remarks** O Complete if applicable
36	**Patient/Guardian signature and Date** O If entered, can enter "Signature on file".
37	**Subscriber signature and Date** O If entered, can enter "Signature on file".
38	**Place of Treatment** R Enter the two digit Place of Service Code for Professional claims, a HIPAA standard.
39	**Number of Enclosures** LB Do not complete this block.
40	**Is Treatment for Orthodontics?** O Place an "X" in one box only. If No, skip items 41 and 42.
41	**Date Appliance Placed (MM/DD/CCYY)** O Enter the Date Appliance Placed using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
42	**Months of Treatment Remaining A Enter months of orthodontic treatment remaining.**
43	**Replacement of Prosthesis?** R Place an "X" in one box only. If Yes, complete Block 44.
44	**Date Prior Placement (MM/DD/CCYY)** A Enter the date of prior placement of the prosthesis using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
45	**Treatment Resulting from** A Mark the Occupational Illness/injury if applicable. Mark the Auto accident box to indicate that the treatment is the result of an automobile accident. Mark the Other accident box to indicate that the treatment is the result of non-auto accident. If the treatment is not the result of occupational illness/injury, auto or other type of accident, leave blank.

Blk No.	Block Description
46	**Date of Accident (MM/DD/CCYY)** **A** Enter the date of the accident if the treatment is the result of an accident. Enter date in an eight-digit format (MMDDCCYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 03012007) or in six-digit format (MMDDYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 030107).
47	**Auto Accident State** **A** Enter two-letter abbreviation for state in which auto accident occurred.
48	**Name, Address, City, State, Zip Code** **R** Enter name and address where service was performed. Zip code must be nine digits (e.g. 770513246).
49	**NPI Number** **R** Enter the ten-digit NPI number of the billing provider. *NOTE * The treating/servicing NPI number (block 54) is the designated provider to receive payment for the service(s) provided.
50	**License Number** **LB** Do not complete this block.
51	**SSN or TIN** **R** Enter Provider Tax-ID or SSN# that corresponds to the NPI number entered in block 49.
52	**Phone Number** **R** Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code
52A	**Additional Provider ID** **LB** Do not complete this block.
53	**Signature (Treating Dentist) and Date (MMDDYYYY)** **R** The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. Enter the date using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978)
54	**NPI Provider ID** **R** Enter the ten-digit NPI number of the treating/servicing provider.
55	**License Number** **LB** Do not complete this block.
56	**Address, City, State, Zip Code Provider Specialty Code** **R** Enter the address (Street Address, City, State, and ZIP Code) where the service was performed.
56A	**Provider Specialty Code** **R** Enter the code that indicates the type of dental professional who delivered the treatment. (Taxonomy Code)
57	**Phone Number** **O** Enter the telephone number of the rendering/treating dentist that provided the service.
58	**Additional Provider ID** **LB** Do not complete this block.

LEGEND: R – Required A – Applicable O – Optional LB – Leave Blank