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

A. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

Gainwell Technologies – RI Medicaid
P.O. Box 2010
Warwick, RI 02887-2010

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)

Jones, Mary R

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
02/02/1976	☐ M ☒ F	ABC123456

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
DEF789123	☐ Self ☐ Spouse ☒ Dependent ☐ Other

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

22T - American Dental

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

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

Smith, Jane L
123 Main Street
Any Town, RI 02000

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
01/01/1999	☐ M ☒ F	123-45-6789

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

Smith, Jane L
123 Main Street
Any Town, RI 02000

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
01/01/1999	☐ M ☒ F	JS1234

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	06/20/2014					D0140		1	Limited Oral Evaluation	100.00
2	06/20/2014					D1110		1	Prophylaxis-Adult	80.00
3	06/20/2014			14	B,O	D2392		1	Resin-based, two surfaces, posterior	150.00
4	06/20/2014			19	L,O	D2393		1	Resin-based, three surfaces, posterior	150.00
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 480.00

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 Signature on file 02/20/2014
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 Signature on file 02/202014
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) 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. 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

Happy Smiles Dental Associates
500 Your Street, Suite 301

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 *John Jones, DDS* 06/20/2014
Signed (Treating Dentist) Date

54. NPI 1234567890

55. License Number DENXXXXX

Providence, RI 02905			56. Address, City, State, Zip Code	56a. Provider Specialty Code 122300000X
49. NPI 1112223334	50. License Number 1223G0001X	51. SSN or TIN 05-5555555	500 Your Street, Suite. 301 Providence, RI 02905	
52. Phone Number (401) 555 - 5555	52a. Additional Provider ID		57. Phone Number (401) 555 - 5555	58. Additional Provider ID

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