ADA Dental Claim Form

HUMANA
Specialty Benefits
P.O. Box 14283
Lexington, KY
40512-4283

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services **– OR –** ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. 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. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) | Oral Image(s) | Model(s)

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)

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

45. Treatment Resulting from (Check applicable box) ☐ 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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

General Instructions:

The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the left and right margins. The upper-right blank space is provided for insertion of the third-party payer's claim or control number.

a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow.
b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20 and 48).
c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53.
d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the third-party payer.

Data Element Specific Instructions

1. **EPSDT / Title XIX** -- Mark box if patient is covered by state Medicaid's **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment program for persons under age 21.
2. Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
4-11. Leave blank if no other coverage.
8. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
15. The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
16. Subscriber's or employer group's Plan or Policy Number. May also be known as the Certificate Number. [Not the subscriber's identification number.]
19-23. Complete only if the patient is **not** the Primary Subscriber. (i.e., "Self" not checked in Item 18)
19. Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
23. Enter if dentist's office assigns a unique number to identify the patient that is **not** the same as the Subscriber Identifier number assigned by the payer (e.g., Chart #).
25. Designate tooth number or letter when procedure code directly involves a tooth. Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.
26. Enter applicable ANSI ASC X12 code list qualifier: Use "**JP**" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "**JO**" when using the ANSI/ADA/ISO Specification No. 3950.
27. Designate tooth number when procedure code reported directly involves a tooth. If a range of teeth is being reported use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.
28. Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: **B** = Buccal; **D** = Distal; **F** = Facial; **L** = Lingual; **M** = Mesial; and **O** = Occlusal.
29. Use appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.
31. Dentist's full fee for the dental procedure reported.
32. Used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
33. Total of all fees listed on the claim form.
34. Report missing teeth on each claim submission.
35. Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
36. Patient Signature: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
37. Subscriber Signature: Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
38. ECF is the acronym for **E**xtended **C**are **F**acility (e.g., nursing home).
48-52. Leave blank if dentist or dental entity is **not** submitting claim on behalf of the patient or insured/subscriber.
48. The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
49. Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim
50. Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating dentist's signature block.
52. The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or dental entity be supplied **only** if the provider accepts payment directly from the third-party payer.
When the payment is being accepted directly report the: 1) SSN if the billing dentist in unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
53. The treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
56. Full address, including city, state and zip code, where treatment performed by treating (rendering) dentist.
58. Enter the code that indicates the type of dental professional rendering the service from the 'Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list. The current list is posted at: http://www.wpc-edi.com/codes/codes.asp. The available taxonomy codes, as of the first printing of this claim form, follow printed in **boldface**.

122300000X 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.

Many dentists are general practitioners who handle a wide variety of dental needs.

1223G0001X General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

1223D0001X Dental Public Health
1223E0200X Endodontics
1223P0106X Oral & Maxillofacial Pathology
1223D0008X Oral and Maxillofacial Radiology
1223S0112X Oral & Maxillofacial Surgery
1223X0400X Orthodontics
1223P0221X Pediatric Dentistry (Pedodontics)
1223P0300X Periodontics
1223P0700X Prosthodontics