ADA Dental Cla	aim	Forr	n																					
HEADER INFORMATION																								
1. Type of Transaction (Check	all applic	cable bo	xes)																					
Statement of Actual Serv	vices		Reque	st for F	Predete	rminatior	n/Prea	uthorization	on															
EPSDT/Title XIX																								
2. Predetermination/Preauthorization Number							Р	PRIMARY INSURED INFORMATION																
							11	12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																
PRIMARY PAYER INFORMATION							_																	
3. Name, Address, City, State, Zip Code																								
										-		<i>(</i> 1.1.	4/00/00/04	<u>. T.</u>	11.0-			145	0			ON -		
										18	B. Date of Birth	(IVII)	W/DD/CCYY)	14. Ge ا ا	_	F	15	o. Subs	scriber	Identifier (S	SIN OI	r ID#)	
OTHER COVERAGE										- 1	6. Plan/Group N	Mun	nhor	17	Emple							—		
Other Dental or Medical Cov	/erage?		No (Skip	5-11)		Yes (Comp	lete 5-11)		╡	o. i iaii/Group i	vuii	ilbei	''	LIIIpii	Oyoi i	varrio							
										-	ATIENT INEC)RI	MATION											
5. Other Insured's Name (Last, First, Middle Initial, Suffix)							PATIENT INFORMATION 18. Relationship to Primary Insured (Check applicable box) 19. Student Status																	
6. Date of Birth (MM/DD/CCYY	<i>'</i>)	7. Gend	er	8. 5	Subscrib	ber Identi	fier (S	SN or ID#)	\dashv	Self	_	Spouse		epend			\prod	Othe	er	П			PTS
,	´	М	ΠF				,			2	D. Name (Last, I	Firs	st, Middle Ini					, Sta	te, Zip	Code				
9. Plan/Group Number		10. Patie	ent' s Rela	ationsh	ip to Ot	ther Insur	red (Cl	neck appli	cable box	()														
		Se	əlf	Spou	ıse	Depe	endent	: 🔲 c	ther															
11. Other Carrier Name, Addres	ss, City,	State, Z	ip Code																					
										2	1. Date of Birth	(MI	M/DD/CCYY	′) 2	2. Ger	nder_	_	23.	Patier	nt ID/A	Account # (A	.ssigne	ed by	Dentist)
																М	F							
RECORD OF SERVICES																								
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral	Tooth					3. Tooth surface	29. Procedui Code					3	0. Des	scription	on						31	. Fee	
<u> </u>	Cavity	System	-				-	ullace	- 00	ue												+		
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MISSING TEETH INFORM	IATION						Perma	anent			'				Prir	mary					32. Other			i
34. (Place an 'X' on each missi	na tooth	, 1	2 3	4	5	6 7	8	9 10	11 1	2 13	14 15 16	3	А В	C D	Е	F	G	Н	I	J	Fee(s			-
04. (Flace all X off each fillissi	ing tootin	32	31 30	29	28	27 26	25	24 23	22 2	1 20	19 18 17	7	T S	R Q	Р	0	N	М	L	K	33.Total Fe	e.		i
35. Remarks																								
AUTHORIZATIONS										_	NCILLARY C	_				_	/IATI	ON	1					
36. I have been informed of the charges for dental services and	d materia	als not p	aid by my	/ dental	I benefi	it plan, ur	nless p	rohibited I	by law, or		8. Place of Trea		`—		_	´ _	_		39		per of Enclo			Model(s)
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 correct out to provide the consent of the properties to correct out to the properties t				ı H																				
information to carry out payment activities in connection with this claim.					4	40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)																		
XPatient/Guardian signature Date					-	No (Skip 41-42) Yes (Complete 41-42) 42. Months of Treatment 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)																		
Patient/Guardian signature						Da	te			4	Remaining	eau		· —	Yes (0				44. D	ale FII	IOI FIACEITIE	TIL (IVII	VI/UU/	CCTT)
 I hereby authorize and direct p dentist or dental entity. 	ayment o	of the der	ıtal benefits	s otherv	vise pay	able to me	e, direc	tly to the be	elow name		5. Treatment Re	١١٥٥						4)						
defined of defined entity.										- []			al illness/inji		Г	_	^) ito acc	ciden	ıt	Г	Other acc	ident		
XSubscriber signature						Da	te			- 4	6. Date of Accid							0.00		一	47. Auto Ac		State	
BILLING DENTIST OR DE	ΝΤΔΙ	FNTIT	V (Leave	hlank	if dentis			ty is not s	ıhmitting	_	REATING DE				TMEN	NT L	OCA.	TION	I INF					
claim on behalf of the patient o				DIATIK	ii deniii	st or derit	ai eiili	ty is not si	Julillillilli	5	3. I hereby certify	y th	at the proce	dures as	indica	ted by	/ date	are ir	n progr	ress (fo	or procedure:	that r	equire	multiple
48. Name, Address, City, State	, Zip Co	de									isits) or have been ollect for those p			nd that th	e fees	subm	itted a	are th	e actua	al fees	I have chare	ed and	d inter	nd to
										- I.	,													
						s	XSigned (Treating Dentist) Date																	
										5	4. Provider ID						55. Li	icens	e Num	nber				
										5	6. Address, City	y, S	state, Zip Co	de										
49. Provider ID	50.	License	Number		T	51. SSN	or TIN	1		1														
										\perp														
52. Phone Number ()										5	7. Phone Numb	er (()				58	. Trea	ating F	Provide	er			

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 6 of the ADA Publication titled CDT-2005. Key extracts from that section of CDT-2005 follow:

GENERAL INSTRUCTIONS

- A. The form is designed so that the Primary Payer's (primary insurance company) name and address (Item 3) are visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- B. \square n the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the \square assignment of a claim or control number.
- C. □All Items in the form must be completed unless it is noted on the form or in the comprehensive instructions that completion is not required. □
- D. DWhen a name and address field is required the full name of an individual or a business, address and zip code must be entered.
- E. □All dates must include the four-digit year.
- F. \square If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be \square listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to a secondary payer, complete the form in its entirety and attach the primary payers Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

ITEMS OF NOTE

- 39. □ Number of Enclosures (00 to 99): This item is completed whether or not radiographs, oral images, or study models are submitted □ with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore no □ possible attachments are missing.
 - When supplementary material is sent with the claim, the number of each type is entered in the appropriate box, using two digits. If less than 10, use 0 in the first position. 'Oral Images' include digital radiographic images and photographs and are reported by the \Box number of images.
 - 43. Replacement of Prosthesis?: This Item applies to Crowns and all Fixed or Removable Prostheses (e.g. bridges and dentures). Please review the following three situations in order to determine how to complete this Item.
 - a) If the claim does not involve a prosthetic restoration check "NO" and proceed to Item 45.
 - b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, check "NO" and proceed to Item 45.
 - c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, check the "YES" field and complete section 44.
 - 53. Certification: Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in □ the process of performing, procedures indicated by date for the patient. If the claim form is being used to obtain a pre-estimate or □ pre-authorization, it is not necessary for the dentist to sign the form. Dentists should be aware that they have an ethical and legal □ obligation to refund fees for services that are paid in advance but are not completed.

PROVIDER TAXONOMY CODES

58. <u>□reating Provider Specialty</u>: Enter the code that indicates the type of dental professional who delivered the treatment.

□ Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
	Couc
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 / Many dentists are general practitioners who handle a wide variety of dental needs.	1223G0001X
Dental Specialty /	Various
Other dentists practice in one of the nine specialty areas recognized by the American Dental Association.	(see following list)
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

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:

http://www.wpc-edi.com/codes/codes.asp



Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

The authorization shall remain in effect for the term of your coverage. You or your designated representative is entitled to receive a copy of this claim form.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each such violation.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

CIGNA Dental refers to CIGNA Dental Health, Inc., and its operating subsidiaries as well as its affiliated companies Connecticut General Life Insurance Company and CIGNA HealthCare of Connecticut, Inc.