| ADA Dental Cla | im | Forr | n | | | | _ | | | | | | |
|--|---------------------|-----------|--------------------------|---------------|------------------------------|--|--|---------------------|----------------------------|-----------------------|-----------|--------------|--|
| HEADER INFORMATION | | | | | | | | | | | | | |
| 1. Type of Transaction (Mark all applicable boxes) | | | | | | | Guardia | an Dental Claims | | | | | |
| Statement of Actual Services Request for Predetermination/Preauthorization | | | | | | GUARDIAN® | PO Box | 2459 | | | | | |
| EPSDT/Title XIX | | | | | | | GUARDIAN | Spokan | ne WA 99210-245 | 9 | | | |
| Predetermination/Preauthorization Number | | | | | | POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) | | | | | | | |
| | | | | | | | 12. Policyholder/Subscriber Name | (Last, First, Mi | iddle Initial, Suffix), Ad | dress, City, State, 2 | Zip Co | ode | |
| INSURANCE COMPANY/D | DENTA | L BEN | EFIT PLAN INFOR | RMATION | | | 1 | | | | | | |
| 3. Company/Plan Name, Addres | ss, City, | State, Z | ip Code | | | | 1 | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | 13. Date of Birth (MM/DD/CCYY) | 14. Gende | er 15. Policyh | nolder/Subscriber IE |) (SSI | N or ID#) | | |
| | | | | | | | Пм | F | | | | | |
| OTHER COVERAGE | | | | | | | 16. Plan/Group Number | 17. Employe | er Name | | | | |
| 4. Other Dental or Medical Cove | erage? | | No (Skip 5-11) | Yes (| Complete 5-11) | | 1 | | | | | | |
| Name of Policyholder/Subscr | riber in : | #4 (Last | First, Middle Initial, S | uffix) | | | PATIENT INFORMATION | | | | | | |
| | | | | | | | 18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status | | | | | | |
| 6. Date of Birth (MM/DD/CCYY) |) | 7. Gend | er 8. Policyh | nolder/Sub | scriber ID (SSN | or ID#) | Self Spouse Dependent Child Other FTS PTS | | | | | | |
| | | MF | | | | | 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | | | | | | |
| 9. Plan/Group Number | | 10. Patie | ent's Relationship to F | Person Nar | ned in #5 | | 1 | | | | | | |
| | | Se | elf Spouse | Depe | endent O | ther | | | | | | | |
| 11. Other Insurance Company/E | Dental E | Benefit P | lan Name, Address, C | ity, State, 2 | Zip Code | | 1 | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | 21. Date of Birth (MM/DD/CCYY) | 22. Gende | er 23. Patient | ID/Account # (Assiç | gned l | by Dentist) | |
| | | | | | | | | М | □F | | | | |
| RECORD OF SERVICES F | PROVI | DED | | | | | • | | • | | | | |
| 24. Procedure Date | 25. Area of Oral | | 27. Tooth Numb | er(s) | 28. Tooth | 29. Proced | ure | 00 December | | | | 04 5 | |
| (MM/DD/CCYY) | | System | or Letter(s) | | Surface | Code | | 30. Descrip | ption | | | 31. Fee | |
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| MISSING TEETH INFORM | ATION | | | | Permanent | | | Primary | у | 32. Other | | | |
| 34. (Place an 'X' on each missin | ng tooth | | 2 3 4 5 | 6 7 | 8 9 10 | | | D E F | | J Fee(s) | | | |
| | | 32 | 31 30 29 28 | 27 26 | 25 24 23 | 22 21 | 20 19 18 17 T S R | Q P C | O N M L I | 33.Total Fee | | - 1 | |
| 35. Remarks | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| AUTHORIZATIONS 26 Library book informed of the treatment plan and appealed from Lagran to be reappropriate for all | | | | | | ANCILLARY CLAIM/TREATMENT INFORMATION 38. Place of Treatment (Check applicable box) 39. Number of Enclosures (00 to 99) | | | | | | | |
| 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 | | | | | | Radiograph(s) Oral Image(s) 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 | | | | | | Provider's Office Hospital ECF Other 40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY) | | | | | | | |
| information to carry out payment activities in connection with this claim. | | | | | | | | | | | | | |
| X | | | | | | 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 Date | | | | | | Remaining | | | e Prior Placement (| WIW/L | DD/CCYY) | | |
| 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named | | | | | No. | Yes (Con | mplete 44) | | | | | | |
| dentist or dental entity. | | | | | 45. Treatment Resulting from | | A | П он | | | | | |
| X | | | | | | | Cocupational illness/injury Auto accident Other accident 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State | | | | | | |
| Subscriber signature Date | | | | | | 46. Date of Accident (MM/DD/CCY | · · | | | nt Sta | ate | | |
| BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber) | | | | | | 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 | | | | | | | |
| <u> </u> | | | | | | | 53. I hereby certify that the procedur visits) or have been completed. | es as indicated | i by date are in progres | s (101 procedures tha | ıı requ | ine multiple | |
| 48. Name, Address, City, State, | ∠ıp Co | ne | | | | | | | | | | | |
| | | | | | X | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | 54. NPI 56. Address, City, State, Zip Code | | 55. License Number | 71 | | | |
| 49. NPI | | Lione - | Number | E1 00M | or TIN | | - Jo. Address, Oily, State, ZIP Code | | Specialty Code | | | | |
| HJ. INFI | 50. | License | Number | 51. SSN | OF THN | | | | | | | | |

57. Phone Number (

52. Phone Number (

58. Additional Provider ID

52A. Additionl Provider ID



American Dental Association www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

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 #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the 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 following instructions that completion is not required.
- D. When a name and address field is required the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's 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).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54. NPI (National Provider Identifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: www.ada.org/goto/npi

ADDITIONAL PROVIDER IDENTIFIER

52A and 58. (Additional Provider Identifier): This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an instrinsic meaning.

PROVIDER SPECIALTY CODES

56A. Provider Specialty Code: Enter the code that indicates the type of dental profissional 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 |
|--|------------|
| 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 |

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at: www.wpc-edi.com/codes/taxonomy