ADA Dental Claim Form STANDARD 2007

ATTENDING DENTIST'S STATEMENT

Mail this form to: HumanaDental Claims Office
PO Box 14611
1-800-233-4013 Lexington, KY 40512-4611

Header information

1. Type of transaction (mark all applicable boxes)
   - ❑ Statement of actual services
   - ❑ EPSDT/Title XIX
   - ❑ Request for predetermination / preauthorization
2. Predetermination/preauthorization number

Insurance company / dental benefit plan information

3. Company/plan name, address, city, state, ZIP code

Other coverage

4. Other dental or medical coverage? ❑ No (Skip 5-11) ❑ Yes (Complete 5-11)
5. Name of policyholder/subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of birth (MM/DD/YYYY)
7. Gender ❑ M ❑ F
8. Policyholder Subscriber ID #
9. Plan/group number
10. Patient's Relationship to Person Named in #5 ❑ Self ❑ Spouse ❑ Dependent/Other
11. Other insurance company/plan name, address, city, state, ZIP code

Policyholder / subscriber information

12. Subscriber name, address, city, state, ZIP code
13. Date of birth (MM/DD/YYYY)
14. Gender ❑ M ❑ F
15. Policyholder ID#
16. Plan/group number
17. Employer name

Patient information

18. Relationship to policyholder above ❑ Self ❑ Spouse ❑ Dependent/Other
19. Student Status ❑ FTS ❑ PTS
20. Patient name, address, city, state, ZIP code
21. Date of birth (MM/DD/YYYY)
22. Gender ❑ M ❑ F
23. Patient ID #/Acct #

Record of services provided

	24. Procedure date (MM/DD/YYYY)	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								

Missing teeth information

34. Place an 'X' on each missing tooth

Permanent																Primary										32. Other Fee(s)	
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	33. Total Fee	

35. Remarks

Authorizations

36. Patient signature Date

X

37. Subscriber signature authorize payment Date

X

Billing dentist or dental entity

48. Name, address, city, state, ZIP code
49. NPI
50. License #
51. SSN or TIN
52. Phone number
52A. Additional provider ID #

Ancillary claim/treatment information

38. Place of treatment: ❑ Clinic ❑ Hospital
39. Number of enclosures: ❑ X-Rays ❑ Models
40. Is treatment for Orthodontics? ❑ No ❑ Yes
41. Date appliance placed
42. Months of treatment remaining
43. Replacement of prosthesis? ❑ No ❑ Yes
44. Date Prior Placement (MM/DD/YYYY)
45. Treatment Resulting from: ❑ Occupational Illness ❑ Auto ❑ Other Injury
46. Date of Accident
47. Auto Accident State

Treating dentist and treatment location

53. I hereby certify that the procedures as indicated by (print name):

X

54. NPI
55. Address, city, state

Please note: Pretreatment Review is not a guarantee of benefits payable.

This estimate advises you in advance of the amount of insurance benefits payable if the described procedures are performed during a period of the patient's eligibility.