

ADA Dental Claim Form

Newman Company
 925 Hempstead Tpke. Ste.340 (516-488-1100)
 Franklin Square, NY 11010

HEADER INFORMATION		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX		
2. Predetermination/Preauthorization Number		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		
3. Company/Plan Name, Address, City, State, Zip Code NCCFT		
OTHER COVERAGE		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender <input type="checkbox"/> M <input type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number D106	17. Employer Name	
PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> 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	Permanent																Primary										32. Other Fee(s)
34. (Place an 'X' on each missing tooth)	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	33.Total Fee
	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	
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

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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		
49. NPI	50. License Number	51. SSN or TIN
52. Phone Number () -	52A. Additional Provider ID	

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 _____ Signed (Treating Dentist)	_____ Date
54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code
57. Phone Number () -	58. Additional Provider ID