<b>ADA</b> American Der	าtal <u>As</u>	socia	ation® I	<u>Denta</u>	al Cl <u>aim</u>	ı For	m									
HEADER INFORMATION					Δ DEL	TA F	SENITA	•								
1. Type of Transaction (Mark all applicable boxes)											<b>C</b> DE		JENIM 			
Statement of Actual Services Request for Predetermination/Preauthorization																
EPSDT/Title XIX							L									
2. Predetermination/Preauthoriz	P	OLICYHOLI	DER/SU	UBSCRIBE	R INFORMA	NOITA	(For Insura	ance Company	Named in #3)							
								12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix)								
INSURANCE COMPANY/DEN	NTAL BEN	EFIT PI	LAN INFO	RMATIO	N											
3. Company/Plan Name, Addres																
	13.	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)														
	$\bot$				М	F										
OTHER COVERAGE (Mark ap	16	i. Plan/Group	Numbe	er	17. Employe	r Name										
4. Dental? Medical?	$\perp$															
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)								ATIENT INF						i		
							-				Subscriber in			19. Reserve	ed For Future	
6. Date of Birth (MM/DD/CCYY)	der 	8. Policyholder/Subscriber ID (SSN or ID#					Self Spouse Dependent Child Other  20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
/- N N N N N N N N N N N N N N N N	M 10 Partie	F	1 11 1010 4		named in #5		20	). Name (Las	t, First,	Middle Initi	al, Suffix), Ad	ddress, (	City, State, 2	ip Code		
9. Plan/Group Number																
:: 2:: Carrana (D.	$\dashv$															
11. Other Insurance Company/De	ental Benei	it Plan r	lame, Adar	ess, City,	State, ZIP Cou	le										
	21	Date of Birt	-b (MM/	/DD/CCYY)	22 Gender	. 2	7 Patient ID	/^ccount # (Ass	ianad by Dentist)							
		21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)														
TEST OF SERVICES PRO												<u> </u>				
RECORD OF SERVICES PRO	Area 26.	07			Τ	T., _	•	Ι 5.		1						
24. Procedure Date of O (MM/DD/CCYY)	oral Tooth	27.	Tooth Numb or Letter(s		28. Tooth Surface	29. Proc		29a. Diag. Pointer	29b. Qty.		3	30. Descr	ription		31. Fee	
1	Ly System.					<del>                                     </del>										
2	+				<del> </del>	_										
3	+				+	<del>                                     </del>										
4	1				<del>                                     </del>											
5	+				<del> </del>	_										
6	$\dashv$				<del>                                     </del>	†										
7		†														
8	$\neg$															
9																
10																
33. Missing Teeth Information (	(Place an ")	K" on ea	ch missing	tooth.)	34.	Diagnosi	s Cod	le List Qualifi	er 📗	(ICD	-9 = B; ICD-10	) = AB)		31a. Other		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnosi								s Code(s) A C Fee(s)								
32 31 30 29 28 27 2	26 25 2	24 23	22 21 2	20 19	18 17 (Pr	imary dia	agnosi	gnosis in "A") B D 32. Total Fee								
35. Remarks																
AUTHORIZATIONS							ANC	CILLARY CL	AIM/T	REATMEN	T INFORMA	NOITA				
<ol> <li>I have been informed of the tre charges for dental services and</li> </ol>	38. P	38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)														
law, or the treating dentist or d all or a portion of such charges	<u> </u>	(Use "Place of Service Codes for Professional Claims")														
of my protected health informa	40. Is	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)														
X	No (Skip 41-42) Yes (Complete 41-42)															
Patient/Guardian Signature	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)  No Yes (Complete 44)															
37. I hereby authorize and direct	45.7			No	Yes (Comp	olete 44)										
directly to the below named	45. Treatment Resulting from Occupational illness/injury Auto accident Other accident															
Cubscriber Signature	46.5	46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State														
															dent State	
submitting claim on behalf of the patient or insured/subscriber)											TMENT LO					
48. Name, Address, City, State, 2	Zin Code										een complet		uate are in p	progress (for pr	ocedures that	
40. Name, Address, City, State, 2	,															
								X								
								54. NPI 55. License Numl								
I							<u> </u>	56. Address, City, State, Zip Code 56a. Provider								
49. NPI 50. License Number 51. SSN or TIN								Specialty Code								
3.1111	Jo. Licerisc	rambe		01. 0011	51 1111											
2. Phone			52a. Additio				57. Phone 58. Additional									
Number			Provid	ler ID		l	N	Number Provider ID								