

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)

Statement of Actual Services       Request for Predetermination/Preauthorization

EPSDT / Title XIX

2. Predetermination/Preauthorization Number

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code  
 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**UnitedHealthcare Dental**  
**Attn: Claims Unit, PO Box 30567**  
**Salt Lake City, UT 84130-0567**

13. Date of Birth (MM/DD/CCYY)      14. Gender      15. Policyholder/Subscriber ID (SSN or ID#)

M     F

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental?       Medical?       (If both, complete 5-11 for dental only.)

16. Plan/Group Number      17. Employer Name

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)      7. Gender      8. Policyholder/Subscriber ID (SSN or ID#)

M     F

9. Plan/Group Number      10. Patient's Relationship to Person named in #5

Self     Spouse     Dependent     Other

11.

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above

Self     Spouse     Dependent Child     Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)      22. Gender      23. Patient ID/Account # (Assigned by Dentist)

M     F

**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 | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|----|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|--------------------|-----------|-----------------|---------|
| 1  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 2  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 3  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 4  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 5  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 6  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 7  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 8  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 9  |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |
| 10 |                                 |                         |                  |                                  |                   |                    |                    |           |                 |         |

33. Missing Teeth Information (Place an "X" on each missing tooth.)

|    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 |

34. Diagnosis Code List Qualifier  ( ICD-9 = B; ICD-10 = AB )

34a. Diagnosis Code(s)      A \_\_\_\_\_      C \_\_\_\_\_

(Primary diagnosis in "A")      B \_\_\_\_\_      D \_\_\_\_\_

31a. Other Fee(s)

32. Total Fee

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  (e.g. 11=office; 22=O/P Hospital)  
 (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)     Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment      43. Replacement of Prosthesis

No     Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  
 Occupational illness/injury     Auto accident     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

# ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

## 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 #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

## COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

## DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

## PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at [www.cms.gov/PhysicianFeeSched/Downloads/Website\\_POS\\_database.pdf](http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf)

## PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

| Category / Description Code   | Code       |
|---|------------|
| <b>Dentist</b><br>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 |
| <b>General Practice</b>   | 1223G0001X |
| <b>Dental Specialty</b> (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 |

Provider taxonomy codes listed above are a subset of the full code set that is posted at [www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy)