

Dental Claim Form required fields

ADA American Dental Association® Dental Claim Form

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
Referral Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
 VA CCN
 Logistics Health Inc.
 Attn: VA CCN Claims
 328 Front St. S.
 La Crosse, WI 54601

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.)
 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 (Assigned by Plan)

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

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

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
		JP							

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

34. Diagnosis Code List Qualifier (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.
 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.
 Subscriber Signature _____ Date _____

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
 a. Last
 b. Address
 c. City, State, Zip (9 digit)

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number 52a. Additional Provider ID

57. Phone Number 58. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

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

39. Enclosures (Y or N) 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

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.
 Signed (Treating Dentist) _____ Date _____

54. NPI 55. License Number

56. Address, City, State, Zip Code 56a. Provider Specialty Code
 a. Address
 b. City, State, Zip (9 digit)

Referral number is always required. Use VA + 10 digit referral number in this box (e.g. VA0123456789).

Region 1: CCN1
 Region 2: CCN2
 Region 3: CCN3

All medical documentation should be sent directly to the VA via your preferred communication method (e.g. HSRM, secured fax, etc.). For other options, review the dental provider manual on the LHI Provider Portal.

Taxonomy Code Required