ADA Dental Claim Form

	IEADER INFORMATION . Type of Transaction (Mark a		able box	es)									<i>></i>	- J			
Statement of Actual Services Request for Predetermination/Preauthorization									SECURECARE DENTAL								
EPSDT/Title XIX								THE COURSE WE SEE THE SECOND S									
2. Predetermination/Preauthorization Number									POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
١.,	VICURANCE COMPANY	DENT	I DEN	eer o	LANINEO	28447101		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
	NSURANCE COMPANY/ Company/Plan Name, Addre					TWATIO	V	· · · · · · · · · · · · · · · · · · ·									
	SecureCa																
					uite 12	1											
777 E Missouri Ave, Suite 121 Phoenix AZ 85014								13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscrib				der/Subscriber I	er ID (SSN or ID#)				
L											M	F					
OTHER COVERAGE									16. Plan/Group Nui	mber .	17. Employer	Name					
4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)									DESIGNATION OF THE PROPERTY OF								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)									PATIENT INFORMATION 18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status								
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)								18. Helationship to Policyholder/Subscriber in #12 Above 19. Student Status Self Spouse Dependent Child Other FTS PTS									
M F						20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code											
9.	. Plan/Group Number		10. Patie	ent's Re	lationship to	Person Na	med in #5		, , , , , ,	,	•		•				
L			s	elf	Spouse	Dep	endent O	ther									
11	1. Other Insurance Company/	Dental E	Benefit P	lan Nam	e, Address, C	City, State,	Zip Code										
											T						
	·								21. Date of Birth (M	M/DD/CCYY)	22. Gender		23. Patient ID/	Account # (Assi	gned by	Dentist)	
_		DD014		***************************************							М	F_				***************************************	
n	ECORD OF SERVICES	25. Area	,		Ta sale bloom	/ . \	00 Table	00 0							ī	·	
	24. Procedure Date (MM/DD/CCYY)	of Oral Cavity	Tooth	. 27	. Tooth Numb or Letter(s		28. Tooth Surface	29. Procedu Code	ire		30. Descrip	tion			3.	. Fee	
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10																!	
-	I IISSING TEETH INFORM	IATION	1	L			Permanent	Accessors and a second			Primary			32. Other			
Г			1	2 3	3 4 5	6 7	8 9 10	11 12	13 14 15 16	A B C I	D E F	G	H I J	Fee(s)			
34	4. (Place an 'X' on each missi	ng tooth	32	31 3	0 29 28	27 26	25 24 23	22 21 :	20 19 18 17	TSRO	Q P O	N I	VI L K	33.Total Fee		i	
35	5. Remarks																
Α	UTHORIZATIONS								ANCILLARY CL	AIM/TREATME	NT INFOR	MATIO	У .				
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							38. Place of Treatment 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)							99) Model(s)			
							Provider's Office Hospital ECF Other										
	formation to carry out payme								40. Is Treatment for				41. Date A	ppliance Placed	(MM/Di	D/CCYY)	
X								No (Skip 41-42) Yes (Complete 41-42) 42. Months of Treatment 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)									
Patient/Guardian signature Date									42. Months of Treatment Handle 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY) No Yes (Complete 44)								
	7. I hereby authorize and direct pentist or dental entity.	payment (of the der	ntal benefi	ts otherwise p	ayable to m	e, directly to the be	low named	45. Treatment Resu		res (Com	hiera 44)					
									Occupational illness/injury Auto accident Other accide						nt		
X.	ubscriber signature	Da	ite		46. Date of Acciden	<u>-</u>				47. Auto Accide							
В	ILLING DENTIST OR DE	NTAL	ENTIT	Y (Leave	a blank if den	list or den	tal entity is not su	bmitting	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
cl:	aim on behalf of the patient o		-	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 FA NEL FE License Number								
								54. NPI 55. License Number 56. Address, City, State, Zip Code 56A. Provider Specialty Code									
49	9. NPI	50.	License	Number		51. SSN	l or TIN		oo. nauress, Oily, S	лань, др 000е		Special	ty Code				
5	2. Phone	_			52A Adabii	nna!			57 Phone			58 A44	itional				
1	Number ()	_			52A. Additi Provid	ler ID			57. Phone Number () –		58. Add Prov	vider ID				