TELEDENTISTRY.COM
Your Dentist, Anytime Anywhere®

# Instructions for Filling out the ADA Claim Form

**HEADER INFORMATION (questions #1 and #2)**

1. Type of Transaction: **DO NOT FILL IN THIS QUESTION.** This question has been pre populated by Teledentistry.com

2. Predetermination/Preauthorization Number: **DO NOT FILL IN THIS QUESTION**. This question has been pre-populated by Teledentistry.com

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION (question #3) •**

**Question #3 MUST BE COMPLETED**

3. Company/Plan Name, Address, City, State, Zip Code: ***Please Fill-In this information*** •
   Enter the information for the insurance company or dental benefit plan that is the third party payer receiving the claim.
   • If you are covered by more than one plan, enter the primary insurance company information here for the initial claim submission.
   • When submitting a separate claim to the secondary carrier, place the secondary carrier's company/plan name and address information here.

**OTHER COVERAGE (questions #4, 5, 6, 7, 8, 9, 10, and 11)**

• When the claim form is being prepared for submission to the primary carrier the information in "Other Coverage" applies to the secondary carrier.
• When the claim form is being prepared for submission to the secondary carrier the information in "Other Coverage" applies to the primary carrier.

4. Other Dental or Medical Coverage? : **DO NOT FILL IN THIS QUESTION**. This question has been pre-populated by Teledentistry.com

• **Questions #5, 6, 7, 8, 9, 10, and 11 MUST BE COMPLETED**

5. Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix): ***Please Fill-In this information***
    - If you have other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.

6. Date of Birth (MM/DD/YYYY): ***Please Fill-In this information***
    - Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.

7. Gender: ***Please Fill-In this information***
    - Mark the gender of the person who is listed in Item #5. Mark “M” for Male, “F” for Female, or “U” for Unknown as applicable.

8. Policyholder/Subscriber Identifier (Assigned by Plan): ***Please Fill-In this information***
    - Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in Item #5, which is on their identification card.

9. Plan/Group Number: ***Please Fill-In this information***
    - Enter the group plan or policy number of the person identified in Item #5

10. Patient’s Relationship to Person Named in Item #5: ***Please Fill-In this information*** • Mark the patient’s relationship to the other insured named in Item #5.

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code: ***Please Fill-In this information***
    - Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

**POLICY HOLDER/SUBSCRIBER INFORMATION (*For Insurance Company Named in Item #3*)** • This section documents information about the insured person who may or may not be the patient.
- When the claim form is being prepared for submission to the primary carrier the information supplied applies to the person insured by the primary carrier.
- When the claim form is being prepared for submission to the secondary carrier the information entered applies to the person insured by secondary carrier.

- **Questions #12, 13, 14, 15, 16, and 17 MUST BE COMPLETED**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: ***Please Fill-In this information***
    - Enter the complete name, address and zip code of the policyholder/subscriber with coverage from the company/plan named in #3.

13. Date of Birth (MM/DD/CCYY): ***Please Fill-In this information***
    - A total of eight digits are required in this field;
    - Two for the month, two for the day of the month, and four for the year.

14. Gender: ***Please Fill-In this information***
    - This applies to the primary insured, who may or may not be the patient.
    - Mark “M” for Male, “F” for Female, or “U” for Unknown as applicable.

15. Policyholder/Subscriber Identifier (Assigned by Plan): ***Please Fill-In this information*** • Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in Item #12, which is on their identification card.

16. Plan/Group Number: ***Please Fill-In this information***
    - Enter the policyholder/subscriber’s group plan/policy number.

17. Employer Name: ***Please Fill-In this information***
    - If applicable, enter the name of the policyholder/subscriber’s employer.

**PATIENT INFORMATION (Questions #18, 19, 20, 21, 22, and 23)**

- The information in this section of the claim form ***pertains to the patient***.

- **Question #18 MUST BE COMPLETED**
- **Question #19 should NOT be filled in**
- **Question #23 should *NOT* be filled in**

18. Relationship to Policyholder/Subscriber in #12 Above:
    - Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage.
    - ***If the patient is also the primary insured, mark the box titled ‘Self” and skip to #36***

19. Reserved For Future Use: **DO NOT FILL IN THIS SECTION.**

**IF the patient is NOT the primary insured:**

- **Questions #20, 21, and 22 MUST BE COMPLETED**
- **Section #23 should *NOT* be filled in**

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: ***Please Fill-In this information if the patient is NOT the primary insured***
    - Enter the complete name, address and zip code of the patient.

21. Date of Birth (MM/DD/CCYY): ***Please Fill-In this information if the patient is NOT the primary insured***
    - A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.

22. Gender: ***Please Fill-In this information if the patient is NOT the primary insured*** • This applies to the patient. Mark “M” for Male, “F” for Female, or “U” for Unknown as applicable.

23. Patient ID/Account # (Assigned by Dentist) **DO NOT FILL IN THIS SECTION**

**RECORD OF SERVICES PROVIDED (Questions #24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, and 35)** • **DO NOT FILL IN ANY OF THIS SECTION**. This section has been pre-populated by Teledentistry.com

**AUTHORIZATIONS (Questions #36 and #37)**

• This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity. • **Section #36 MUST BE COMPLETED**

36. Patient Consent: ***Please Fill-In this information***

- The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care.
- For matters relating to communication of information and consent, the term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.

37. Authorize Direct Payment: **DO NOT FILL IN THIS SECTION**

**ANCILLARY CLAIM/TREATMENT INFORMATION (Questions #38, 39, 40, 41, 42, 43, 44, 45, 46, 47)**

• **DO NOT FILL IN ANY OF THIS SECTION**. This section has been pre-populated by Teledentistry.com

**BILLING DENTIST OR DENTAL ENTITY (Questions #48, 49, 50, 51, 52, 52a)** • **DO NOT FILL IN ANY OF THIS SECTION**. This section has been pre-populated by Teledentistry.com

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION (Questions #53, 54, 55, 56, 56a, 57, 58)**

- This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient.
- **Question #53 and #55 MUST BE COMPLETED (Teledenistry.com will provide you with this information)**
- **Questions #54, 56, 56a, 57, and 58 SHOULD *NOT* BE COMPLETED**

53. Certification: ***Please Fill-In this information***

- Teledentistry.com will provide you with the name and correct spelling of the dentist who performed your examination

• Please PRINT the name of your Teledentistry.com dentist on the signature line • Please fill in the date of your Teledentistry.com examination

54. NPI (National Provider Identifier): **DO NOT FILL IN ANY OF THIS SECTION**. This section has been pre-populated by Teledentistry.com

55. License Number: ***Please Fill-In this information***. This section has been pre-populated by Teledentistry.com

- Teledentistry.com will provide you with the license number of the dentist who performed your examination.

56. Address, City, State, Zip Code: **DO NOT FILL IN ANY OF THIS SECTION**. This section has been pre-populated by Teledentistry.com

56a. Provider Specialty Code: **DO NOT FILL IN ANY OF THIS SECTION**. This section has been pre-populated by Teledentistry.com

57. Phone Number: **DO NOT FILL IN ANY OF THIS SECTION**. This section has been pre populated by Teledentistry.com

58. Additional Provider ID: **DO NOT FILL IN ANY OF THIS SECTION**. This section has been ***purposely left blank*** by Teledentistry.com

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Questions? Email: support@teledentistry.com