Dental Claim Form

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1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services Specialty
2. ☐Medicaid Claim ☐EPSDT Prior Authorization #
3. Carrier Name **Delta Dental of Missouri**
4. Carrier Address P.O. Box 8690 (800) 995-5120
5. City St. Louis 6. MO 7. 63126 (314) 656-3001

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other_____
18. Employer/School Name_____ Address_____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name_____ Address_____
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name_____ Address_____
41.

39. 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 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 under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates_____
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates_____

58. Diagnosis Code Index (optional)
1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent									Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A B C D E		F G H I J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T S R Q P		O N M L K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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J589 (Same as ADA Dental Claim Form) - J588, J590, J591