

Blk No.	Block Description
1	Type of Transaction R Check the Request for Predetermination/Preauthorization box if this is a prior authorization or post-operative review request. Check the Statement of Actual Services box if this is a claim for completed services.
2	Predetermination/Preauthorization Number LB Do not complete this block.
3	Name, Address, City, State, Zip Code R Enter the full name and address of the Insurance Company or Dental Benefit Plan. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246).
4	Other Dental or Medical Coverage R If there is other dental/medical coverage, check the appropriate Box and complete items 5–11 below. LB If no other coverage.
5	Name of Policyholder/ Subscriber in #4 Name (Last, First, Middle Initial, Suffix) R If box is checked in Block 4, enter name of policy holder/subscriber of the other insurance indicated in block 4. LB If no information listed on Block 4.
6	Date of Birth (MM/DD/CCYY) R If Block 4 completed, enter the Policyholder/Subscriber's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978). LB If no information listed on Block 4.
7	Gender R If Block 4 completed put an "X" in the appropriate box of the person named in Block 5. Only one box can be selected. LB If no information listed on Block 4.
8	Policyholder/ Subscriber ID # (SSN or ID#) R If Block 4 completed, enter the Social Security Number or Identification Number of the Policyholder/Subscriber. LB If no information listed on Block 4.
9	Plan/Group Number R If Block 4 completed, enter the Plan/Group number if applicable. LB If no information listed on Block 4.
10	Patient's Relationship to Person Named in #5 R If Block 4 completed, enter the Patient's Relationship to person named in Block 5. LB If no information listed on Block 4.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code R If Block 4 completed, enter the full name and address of the Other Insurance or Dental Plan. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246). LB If no information listed on Block 4.
12	Policyholder/ Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code R Enter full name and address of Member. Zip code must be five digits (e.g. 77051) or nine digits (e.g. 770513246).
13	Date of Birth (MM/DD/CCYY) R Enter the date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) of the person named in Block 12.
14	Gender R Enter an "X" in the appropriate box of the named person in Block 12. Only one box can be selected.
15	Policyholder/ Subscriber ID# (SSN or ID#) R Enter the Member's ID, Must 9 Characters.
16	Plan/Group Number LB Do not complete this block.
17	Employer Name R Enter the Employer name of the person named in Block 12.
18	Relationship to Policyholder/ Subscriber in #12 above R Put an "X" in the appropriate box. Only one box can be selected.
19	Reserved for Future Use LB Do not complete this block.
20	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code R Patient Last Name and First name (e.g., Doe, John)
21	Date of Birth (MM/DD/CCYY) R Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
22	Gender R Indicate the patient's gender by placing an X in the appropriate box.
23	Patient ID/Account Number O If entered, must be less than 20 characters
24, (110)	Procedure Date R Enter the procedure date in an eight-digit format (MMDDCCYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 03012007) or in six-digit format (MMDDYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 030107). When box 1, request for predetermination is checked, do not enter procedure date.
25	Area of Oral Cavity A Enter area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'

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26	Tooth System LB Do not complete this block.
27 (1-10)	Tooth Number(s) or Letter(s) R Enter only one tooth number or, letter per claim line. This item must be no longer than 2 characters.
28 (1-10)	Tooth Surface R Values: M—Mesial, D—Distal, O—Occlusal, L—Lingual, F—Facial, B—Buccal, I— Incisal
29 (1-10)	Procedure Code R Enter the code for the procedure performed. The "D" must be entered as the first part of the procedure code.
29a	Diag Pointer R This block may contain up to four digits. If the service was provided for the primary diagnosis (in Block 34a), enter A. If provided for the secondary diagnosis, enter B. If provided for the third diagnosis, enter C, and for the fourth diagnosis, enter D. LB If nothing entered in Box 34a.
29b	Qty R Enter the number of units, services, or items provided. Can enter decimal (e.g., 5.1) but cannot be more than 8 digits.
30	Description R Enter the terminology to describe the service provided.
31 (1-10)	Fee R Enter your usual and customary charge to the general public for the service(s) provided in dollars and cents. Example: \$25.00, \$150.00 If you are billing for multiple units of service, be sure to multiply your usual charge by the number of units billed and enter that amount.
31a	Other Fee(s) O When other applicable dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.
32	Total Fee O Enter total fee. Amount should be the sum of Box 31 (1-10). Amount should be provided in dollars and cents. Example: \$25.00, \$150.00. Multiple page claims are not allowed. If detail requires more than one claim, each claim must be considered a separate claim with its own total charge. \$0 are allowed when box 1, request for predetermination is checked.
33	(Place an 'X' on each missing tooth) LB Do not complete this block.
34	Diagnosis Code List Qualifier (ICD-9=B and ICD-10=AB) R Enter the appropriate code to identify the diagnosis code source. LB If nothing entered in Box 34a.
34a	Diagnosis Code A Only needed when the diagnosis code may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.
35	Remarks O Complete if applicable
36	Patient/Guardian signature and Date O If entered, can enter "Signature on file".
37	Subscriber signature and Date O If entered, can enter "Signature on file".
38	Place of Treatment R Enter the two digit Place of Service Code for Professional claims, a HIPAA standard.
39	Number of Enclosures LB Do not complete this block.
40	Is Treatment for Orthodontics? O Place an "X" in one box only. If No, skip items 41 and 42.
41	Date Appliance Placed (MM/DD/CCYY) O Enter the Date Appliance Placed using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
42	Months of Treatment Remaining A Enter months of orthodontic treatment remaining.
43	Replacement of Prosthesis? R Place an "X" in one box only. If Yes, complete Block 44.
44	Date Prior Placement (MM/DD/CCYY) A Enter the date of prior placement of the prosthesis using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978).
45	Treatment Resulting from A Mark the Occupational Illness/injury if applicable. Mark the Auto accident box to indicate that the treatment is the result of an automobile accident. Mark the Other accident box to indicate that the treatment is the result of non-auto accident. If the treatment is not the result of occupational illness/injury, auto or other type of accident, leave blank.

Blk No.	Block Description
46	Date of Accident (MM/DD/CCYY) A Enter the date of the accident if the treatment is the result of an accident. Enter date in an eight-digit format (MMDDCCYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 03012007) or in six-digit format (MMDDYY). Do not use spaces, slashes, dashes, or hyphens (e.g., 030107).
47	Auto Accident State A Enter two-letter abbreviation for state in which auto accident occurred.
48	Name, Address, City, State, Zip Code R Enter name and address where service was performed. Zip code must be nine digits (e.g. 770513246).
49	NPI Number R Enter the ten-digit NPI number of the billing provider. *NOTE * The treating/servicing NPI number (block 54) is the designated provider to receive payment for the service(s) provided.
50	License Number LB Do not complete this block.
51	SSN or TIN R Enter Provider Tax-ID or SSN# that corresponds to the NPI number entered in block 49.
52	Phone Number R Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code
52A	Additional Provider ID LB Do not complete this block.
53	Signature (Treating Dentist) and Date (MMDDYYYY) R The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. Enter the date using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978)
54	NPI Provider ID R Enter the ten-digit NPI number of the treating/servicing provider.
55	License Number LB Do not complete this block.
56	Address, City, State, Zip Code Provider Specialty Code R Enter the address (Street Address, City, State, and ZIP Code) where the service was performed.
56A	Provider Specialty Code R Enter the code that indicates the type of dental professional who delivered the treatment. (Taxonomy Code)
57	Phone Number O Enter the telephone number of the rendering/treating dentist that provided the service.
58	Additional Provider ID LB Do not complete this block.

LEGEND: **R** – Required **A** – Applicable **O** –
Optional **LB** – Leave Blank