DentaQuest

P.O. Box 9708
Boston, MA 02114-9708

See reverse for instructions

1.	2.	3. Carrier name and address
☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Provider ID #	☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #	

PATIENT COVERAGE INFORMATION

4. Patient name first m.i. last	5. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____	6. Sex m f	7. Patient birthdate MM DD YYYY	8. If full time student school city
9. Employee/subscriber name and mailing address	10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate MM DD YYYY	12. Employer (company) name and address	13. Group number
14. Is patient covered by another dental plan yes no If yes, complete 15-a. Is patient covered by a medical plan? yes no	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employer(s)	
17-a. Employee/subscriber name (if different from patient's)	17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate MM DD YYYY	18. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other _____	

19. I have reviewed the following treatment plan and 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.

> _____ _____
Signed (Patient* - see reverse) Date

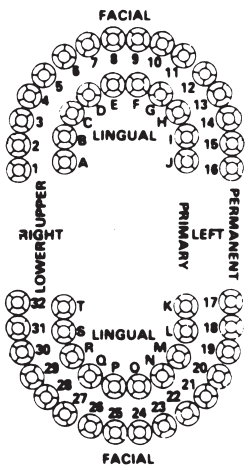
20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

> _____ _____
Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity			30. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates	
22. Address where payment should be remitted			31. Is treatment result of auto accident?				
23. City, State, Zip			32. Other accident?				
24. Dentist Soc. Sec. or T.I.N. (see reverse**)	25. Dentist license no.	26. Dentist phone no.	33. If prosthesis, is this initial placement?			(if no, reason for replacement)	34. Date of prior placement
27. First visit date current series	28. Place of treatment Office Hosp. ECF Other	29. Radiographs or models enclosed? No Yes How many?	35. Is treatment for orthodontics?			If service already commenced enter: Date appliances placed Mos. treatment remaining	

36. Identify missing teeth with "x"



37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

> _____
Signed (Treating Dentist) License Number Date

40. Address where treatment was performed

City State Zip

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

©American Dental Association, 1994
J510 (Same as ADA Dental Claim Form - J504, J511, J512)
DDCF3.1197

FAX REORDERS TO 1-800-299-2212
OR CALL DENTAL FORMS DEPARTMENT
1-800-368-1368 Ext. 270