ADA Claim Form for Healthcare Professionals

Patient Information
Name:
Date of Birth:
Address:
Insurance:

Provider Details
Healthcare Provider:
NPI Number:
TIN:

Service Details
Date of Service:
Description of Service:
CPT Code:
ICD-10 Code:
Total Session Duration:

Authorization and Signature
Patient Signature:
Date:

Billing Information
Total Charges:

Insurance Information
Insurance Name:
Group Number:
Policyholder:

Supporting Documentation

Submission:

Outcome