## 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:

Billing	Information
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Total Charges:

## **Insurance Information**

Insurance Name:

Group Number:

Policyholder:

## Supporting Documentation

Submission:

Outcome