# ADA Dental Claim Form

**PRIMARY CLAIM No. : 30187 COPY**

## HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [X] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [ ] EPSDT/Title XIX
2. Predetermination/Preauthorization Number

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
   Delta Dental Of California
   P.O Box 997330
   Sacramento, CA 95899-7330

## OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name, (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    Dawirs, Doneen
    1718 E. Commonwealth Avenue #101
    Fullerton, CA 92831
13. Date of Birth (MM/DD/CCYY): 07/27/1958
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#): 558-27-7366
16. Plan/Group Number: 4018-2021
17. Employer Name

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Student Status [ ] FTS [ ] PTS
20. Name, (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender [ ] M [ ] F
23. Patient ID/Account # (Assigned by Dentist): 26101

## RECORD OF SERVICES PROVIDED

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|
| 1 | 09/14/2024 | | JP | | | D1110 | Prophylaxis - Adult | 140.00 |
| 2 | 09/14/2024 | | JP | | | D0120 | Periodic oral evaluation - est. patient | 100.00 |
| 3 | 09/14/2024 | | JP | | | D0230 | Intraoral - Periapical-Each Add'l Rad Img | 15.00 |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

## MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

| 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 |

32. Other Fee(s)
33. Total Fee: 255.00

35. Remarks

## AUTHORIZATIONS

36. 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 prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 09/14/2024
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 09/14/2024
Subscriber signature — Date

## BILLING DENTIST OR DENTAL ENTITY

(Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
    Kevin K Tanaka, DDS
    1111 W Town & Country Rd #22
    Orange, CA 92868
49. NPI: 1588712798
50. License Number: 39096
51. SSN or TIN: TIN:330601169
52. Phone Number: (714)543-2505
52A. Additional Provider ID

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other
39. Number of Enclosures (00 to 99) Radiograph(s): 00 Oral Image(s): Model(s):
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

## TREATMENT DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X — 01/25/2025
Signed (Treating Dentist) Kevin K. Tanaka, D.D.S. — Date

54. NPI: 1588712798
55. License Number: 39096
56. Address, City, State, Zip Code: 1111 W Town & Country Rd #22, Orange, CA 92868
56A. Provider Specialty Code: 122300000X
57. Phone Number: (714)543-2505
58. Additional Provider ID

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J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)