

Updating claim and re-validating

1 From claims list; open claim

< Claim List Claim

Search

Search

Claim Status Primary Claim Status Secondary Type of Transaction Claims Created Between From To

Claims

<input type="checkbox"/>	Number	Chart Number	Primary Payer Name	Name	Subscriber Name	Date Created	Claim Status Primary	Claim Status Second	Next Ortho Bill Date	Claim Total	Notes	Months c
<input type="checkbox"/>	> 435	CABMI000	Aetna PPO	Caboose, Michael J	Caboose, Michael J	11/1/25	Attachment Required			\$1,016.00		
<input type="checkbox"/>	> 434	BROJO000	Aetna PPO	Brown, Jon	Brown, Jon	11/1/25	Failed Claim Validation			\$1,111.16		
<input type="checkbox"/>	> 433	ARISU000	Aetna PPO	Arizona, Sunny	Arizona, Sunny	10/24/25	Billed			\$60.00		
<input type="checkbox"/>	> 432	DUCDA000	Aetna PPO	Duck, Daisy	Duck, Daisy	10/24/25	Failed Claim Validation			\$57.00		
<input type="checkbox"/>	> 431	BAGMO000	Aetnamod	Bags, Money	Bags, Money	10/24/25	Billed			\$142.50		
<input type="checkbox"/>	> 430	BAGMO000	Aetnamod	Bags, Money	Bags, Money	10/20/25	Failed Claim Validation			\$519.00		
<input type="checkbox"/>	> 429	CHIBI000	Blue Cross Blue Shield	Chicken, Big	Chicken, Big	10/20/25	Failed Claim Validation			\$21.00		
<input type="checkbox"/>	> 428	VANCA000	Aetnamod	Van Sciver, Camden	Van Sciver, Camden	10/18/25	Failed Claim Validation			\$46.50		
<input type="checkbox"/>	> 427	LANJE000	Aetna PPO	LandShark, Jeff T	LandShark, Jeff T	10/18/25	Billed			\$59.00		
<input type="checkbox"/>	> 426	KRERO000	Denti Cal	Krechmery, Roger	Krechmery, Roger	10/18/25	Ready To Bill			\$87.00		
<input type="checkbox"/>	> 425	DIEAL000	Aetna PPO	Dieu, Alicia	Dieu, Alicia	10/18/25	Failed Claim Validation			\$30.00		
<input type="checkbox"/>	> 424	BROJO000	MetLife Dental	Brown, Jon	Brown, Jon	10/18/25	Failed Claim Validation			\$127.50		
<input type="checkbox"/>	> 423	BURBI000	Aetna PPO	Burner, Billy	Burner, Billy	10/18/25	Failed Claim Validation			\$117.00		
<input type="checkbox"/>	> 422	CHIBI000	MetLife Dental	Chicken, Big	Chicken, Big	10/18/25	Failed Claim Validation			\$127.50		
<input type="checkbox"/>	> 421	10/18/25		

2 Click "Update Claim"

General
Close

Claim Data
Update Claim
Validate Claim
Send E-Claim
Get Claim Status

Attachments
Check Attachment Requirements
Add Attachment

Patient Info
View Patient Info
View Billing Info

Print
Print Claim

ADA Form Billing Claim Information Electronic Attachments

Form
ADA 2024 Claim Form

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) Request for Predetermination/Preauthorization
 Statement of Actual Services EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Aetna PPO
PO Box 14094
Street 2
Lexington, KY 40512

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) mm/dd/yyyy

7. Gender M F U

8. Policyholder/Subscriber ID (Assigned by Plan)

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
Name
Street 1
Street 2
City, State, & Zip

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Brown, Jon
Street

13. Date of Birth (MM/DD/CCYY) 05/01/1998

14. Gender M F U

15. Policyholder/Subscriber ID (Assigned by Plan) 232122

16. Plan/Group Number 11321

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
 Self Spouse Dependent Child Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Brown, Jon
Street

21. Date of Birth (MM/DD/CCYY) 05/01/1998

22. Gender M F U

23. Patient ID/Account # (Assigned by Dentist) BROJ0000

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Area of Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. City	30. Description	31. Fee
11/01/2025			12		D2750			1 crown - porcelain fused to high noble metal	\$1111.16

3 Click "Validate Claim"

General
Close

Claim Data
Update Claim
Validate Claim
Send E-Claim
Get Claim Status

Attachments
Check Attachment Requirements
Add Attachment

Patient Info
View Patient Info
View Billing Info

Print
Print Claim

ADA Form Billing Claim Information Electronic Attachments

Form
ADA 2024 Claim Form

ADA American Dental Association® Dental Claim Form

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