

Survey of Charges—Pediatric

This survey represents the most frequently billed procedure codes.

DIAGNOSTIC

CLINIC ORAL EVALUATIONS

D0120 \$ _____ Periodic oral evaluation
D0140 \$ _____ Limited oral evaluation
D0150 \$ _____ Comprehensive oral evaluation

RADIOGRAPHS

D0210 \$ _____ Intraoral-complete series
D0220 \$ _____ Intraoral-periapical first film
D0230 \$ _____ Intraoral-periapical each additional film
D0240 \$ _____ Intraoral-occlusal film
D0270 \$ _____ Bitewing-single film
D0272 \$ _____ Bitewings-two films
D0274 \$ _____ Bitewings-four films
D0330 \$ _____ Panoramic film

Additional codes

_____ \$ _____
_____ \$ _____
_____ \$ _____

PREVENTIVE

DENTAL PROPHYLAXIS

D1110 \$ _____ Prophylaxis-adult
D1120 \$ _____ Prophylaxis-child

FLUORIDE TREATMENT

D1203 \$ _____ Topical application of fluoride (prophylaxis not included)-child
D1204 \$ _____ Topical application of fluoride (prophylaxis not included)-adult

OTHER PREVENTIVE SERVICE

D1351 \$ _____ Sealant-per tooth

Additional codes

_____ \$ _____
_____ \$ _____
_____ \$ _____

SPACE MANAGEMENT THERAPY

D1510 \$ _____ Space maintainer-fixed-unilateral
D1515 \$ _____ Space maintainer-fixed-bilateral
D1520 \$ _____ Space maintainer-removable-unilateral
D1525 \$ _____ Space maintainer-removable-bilateral
D1550 \$ _____ Recementation of space maintainer

Additional codes

_____ \$ _____
_____ \$ _____
_____ \$ _____

RESTORATIVE

AMALGAMS

D2140 \$ _____ Amalgam-one surface, permanent
D2150 \$ _____ Amalgam-two surfaces, permanent
D2160 \$ _____ Amalgam-three surfaces, permanent
D2161 \$ _____ Amalgam-four or more surfaces, permanent

COMPOSITE RESIN RESTORATIONS

D2330 \$ _____ Resin-based composite-one surface, anterior
D2331 \$ _____ Resin-based composite-two surfaces, anterior
D2332 \$ _____ Resin-based composite-three surfaces, anterior
D2335 \$ _____ Resin-based composite-four or more surfaces or involving incisal angle (anterior)
D2391 \$ _____ Resin-based composite-one surface, posterior
D2392 \$ _____ Resin-based composite-two surfaces, posterior
D2393 \$ _____ Resin-based composite-three surfaces, posterior
D2394 \$ _____ Resin-based composite-four or more surfaces, anterior

Additional codes

_____ \$ _____
_____ \$ _____
_____ \$ _____

CROWNS

SINGLE RESTORATION ONLY

D2710 \$ _____ Crown-resin (laboratory)

D2930 \$ _____ Prefabricated stainless steel crown-
primary tooth
 D2931 \$ _____ Prefabricated stainless steel crown-
permanent tooth
 D2933 \$ _____ Prefabricated stainless steel crown with
resin window
 D2940 \$ _____ Sedative filling
 D2950 \$ _____ Core buildup, including any pins
 D2951 \$ _____ Pin retention-per tooth, in addition to
restoration
 D2952 \$ _____ Cast post and core in addition to crown

Additional codes

_____ \$ _____
 _____ \$ _____
 _____ \$ _____

ENDODONTICS

PULP CAPPING

D3110 \$ _____ Pulp cap-direct (excluding final restoration)

PULPOTOMY

D3220 \$ _____ Therapeutic pulpotomy (excluding final
restoration)-removal of pulp coronal to
the dentinocemental junction and appli-
cation of medicament
 D3221 \$ _____ Gross pulpal debridement, primary and
permanent teeth

Additional codes

_____ \$ _____
 _____ \$ _____
 _____ \$ _____

ORAL SURGERY

*EXTRACTIONS (INCLUDES LOCAL ANESTHESIA,
SUTURING, IF NEEDED, AND ROUTINE POSTOPERA-
TIVE CARE)*

D7111 \$ _____ Coronal remnants-deciduous tooth
 D7140 \$ _____ Extraction, erupted tooth or exposed root
(elevation and/or forceps removal)

Additional codes

_____ \$ _____
 _____ \$ _____
 _____ \$ _____

ADJUNCTIVE GENERAL SERVICES

D9110 \$ _____ Palliative (emergency) treatment of den-
tal pain
 D9220 \$ _____ Deep sedation/general anesthesia first 30
minutes
 D9221 \$ _____ Deep sedation/general anesthesia each
additional 15 minutes
 D9230 \$ _____ Analgesia, anxiolysis, inhalation of
nitrous oxide

Additional codes

_____ \$ _____
 _____ \$ _____
 _____ \$ _____

*** If you practice at more than one office, you must submit fee filings for each location.***

Please print or type

Name _____
 Office Address _____
 TIN # _____

License Number _____
 City _____ Zip _____
 Telephone _____
 Fax # _____

I certify that these are the fees I intend to charge my patients. I agree these fees and any future fees will not be used on treatment forms until I have received notification from ODS of acceptance of all fees listed on this form.

Signature _____ Date _____ Specialty _____