~~2006~~ ADA DENTAL CLAIM FORM AND INSTRUCTIONS

The most current ~~2006~~ American Dental Association (ADA) Dental Claim Form is required when submitting hardcopy claims to Medicaid and will be the only dental claim form accepted for prior authorization and payment of dental services.

The numbered line-by-line billing instructions below correspond with the same numbered block of the 20~~06~~19 ADA Dental Claim Form. **Required** information must be entered to ensure claims processing. **Situational** information may be required only in certain situations as detailed in each instruction item. Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form. Only one tooth number/letter or oral cavity designator is allowed per claim line. Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Dental Program and Adult Denture Program **claims for payment** should be submitted to the fiscal intermediary (refer to Appendix J for contact information).

Locator #	Description	Instructions	Alerts
1	Type of Transaction	**Required** -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization. **Situational** – Check box marked "EPSDT Title XIX" if patient is Medicaid eligible and under 21 years of age. If block is not checked, the claim will be processed as an adult claim.	
2	Predetermination / Preauthorization Number	**Situational** – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.	
3	Company / Plan Name, Address, City, State, Zip Code	**Situational** – Enter the primary payer information if applicable.	

Locator #	Description	**Instructions**	**Alerts**
4	Other Dental or Medical Coverage?	**Situational** – If yes, complete Block 9.	
5	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	**Situational.**	
6	Date of Birth (MM/DD/CCYY)	**Situational.**	
7	Gender	**Situational.**	
8	Policyholder/Subscriber ID	**Situational.**	
9	Plan/Group Number	**Situational** – Enter the third party's carrier code if a third party is involved. A list of codes identifying various carriers may be obtained from the Louisiana Medicaid website, www.lamedicaid.com under the link **Forms/Files**. If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid.	
10	Patient's Relationship to Person Named in #5	**Situational.**	
11	Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code	**Situational.**	
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	**Required** -- Enter the ~~recipient~~beneficiary's last name, first name, and middle initial exactly as verified through REVS or MEVS. ~~Recipient~~Beneficiary's address is **optional**.	

Locator #	Description	**Instructions**	**Alerts**
13	Date of Birth (MM/DD/CCYY)	**Required** -- Enter the ~~recipient~~beneficiary's eight-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.	
14	Gender	**Optional** – Check appropriate block.	
15	Policyholder/Subscriber ID	**Required** -- Enter the thirteen-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the sixteen-digit Card Control Number (CCN) from the ~~recipient~~beneficiary's Medicaid card.	
16	Plan / Group Number	**Situational.**	
17	Employer Name	**Situational.**	
18	Relationship to Policyholder/Subscriber in #12 above.	**Situational.**	
19	Student Status	**Situational.**	
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	**Situational.** This field should be used only when other private insurance is primary. **Note:** The Medicaid ~~recipient~~beneficiary's name is required to be entered in Block 12.	
21	Date of Birth (MM/DD/CCYY)	**Situational.**	
22	Gender	**Situational.**	
23	Patient ID / Account # (Assigned by Dentist)	**Optional** – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice. The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.	

Locator #	Description	**Instructions**	**Alerts**
24	Procedure Date (MM/DD/CCYY)	**Required** -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. A service must have been performed/delivered before billing Medicaid for payment.	
25	Area of Oral Cavity	**Situational** – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific **requirements** regarding oral cavity designator. If an oral cavity designator is **required** by Medicaid, do not enter a tooth number or letter in Block 27.	
26	Tooth System	**Leave Blank**	
27	Tooth Number(s) or Letter(s)	**Situational** – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific **requirements** regarding tooth number or letter. If a tooth number or letter is **required** by Medicaid, do not enter an oral cavity designator in Block 25.	
28	Tooth Surface	**Situational –** Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: B = Buccal; D = Distal; F = Facial; I = Incisal; L = Lingual; M = Mesial; and O = Occlusal. Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.	

Locator #	Description	**Instructions**	**Alerts**
29	Procedure Code	**Required –** Enter the appropriate dental procedure code from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.	
29a	Diagnosis Code Pointer	**Situational –** This field is optional and is only utilized if diagnosis will be listed in 34a. If diagnosis codes are being used, enter the letter(s) from item 34 that identify the diagnosis code(s) applicable to the specific dental procedure. List primary diagnosis pointer first.	
29b	Quantity	**Required –** Enter the number of times (01-99) the procedure identified in block 29 was delivered to the beneficiary on the date of service shown in block 24. The default value for the field is "01".	
30	Description	**Required –** Enter the description of the service performed.	
31	Fee	**Required** -- Enter the dentist's full (usual and customary) fee for the dental procedure reported.	
31a	Other Fee(s)	**Leave Blank**	
32	Total Fee ~~Other Fee(s)~~	**Required** – Total of all fees listed on the claim form.~~**Leave Blank**~~	
~~33~~	~~Total Fee~~	~~**Required** – Total of all fees listed on the claim form.~~	

3334	Missing Teeth Information (Place an 'X' on each missing tooth)Total Fee(Place an 'X' on each missing tooth)	**Situational** – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/". In the following circumstances, this information is **required**: If the claim is for the Adult Denture Program. If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy. **Required** – Total of all fees listed on the claim form.~~**Situational** – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/".~~ ~~In the following circumstances, this information is **required**:~~ ~~If the claim is for the Adult Denture Program.~~ ~~If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy.~~	
34	Diagnosis Code List Qualifier (Place an 'X' on each missing tooth)	**Situational –** Required if field 29a (diagnosis pointer) is completed. Diagnosis qualifier "AB" indicates an ICD-10 diagnosis will be entered in field 34a.**Situational** – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/". In the following circumstances, this information is **required**:	

		If the claim is for the Adult Denture Program. If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy.	
34a	Diagnosis Code(s)	**Situational –** This information is only needed when the diagnosis may affect claim adjudication due to specific dental procedures being authorized to minimize risks associated with the connection between the patient's oral and systemic health conditions. Supports up to 4 diagnosis codes per dental procedure. The primary diagnosis should be noted in line A.	

Locator #	Description	**Instructions**	**Alerts**
35	Remarks	**Situational** – If block 9 is complete, ~~E~~enter the amount paid by the primary payor. ~~if block 9 is completed. If no TPL, leave blank. (RANDY – PLEASE DELETE)~~ Write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [$0] payment) in this block. Enter any additional information **required** by Medicaid regarding requested services (including description of the patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include). For prior authorization requests, if the information **required** in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the ~~recipient~~beneficiary's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record.	
36	Authorizations	**Optional.**	
37	Authorizations	**Optional.**	

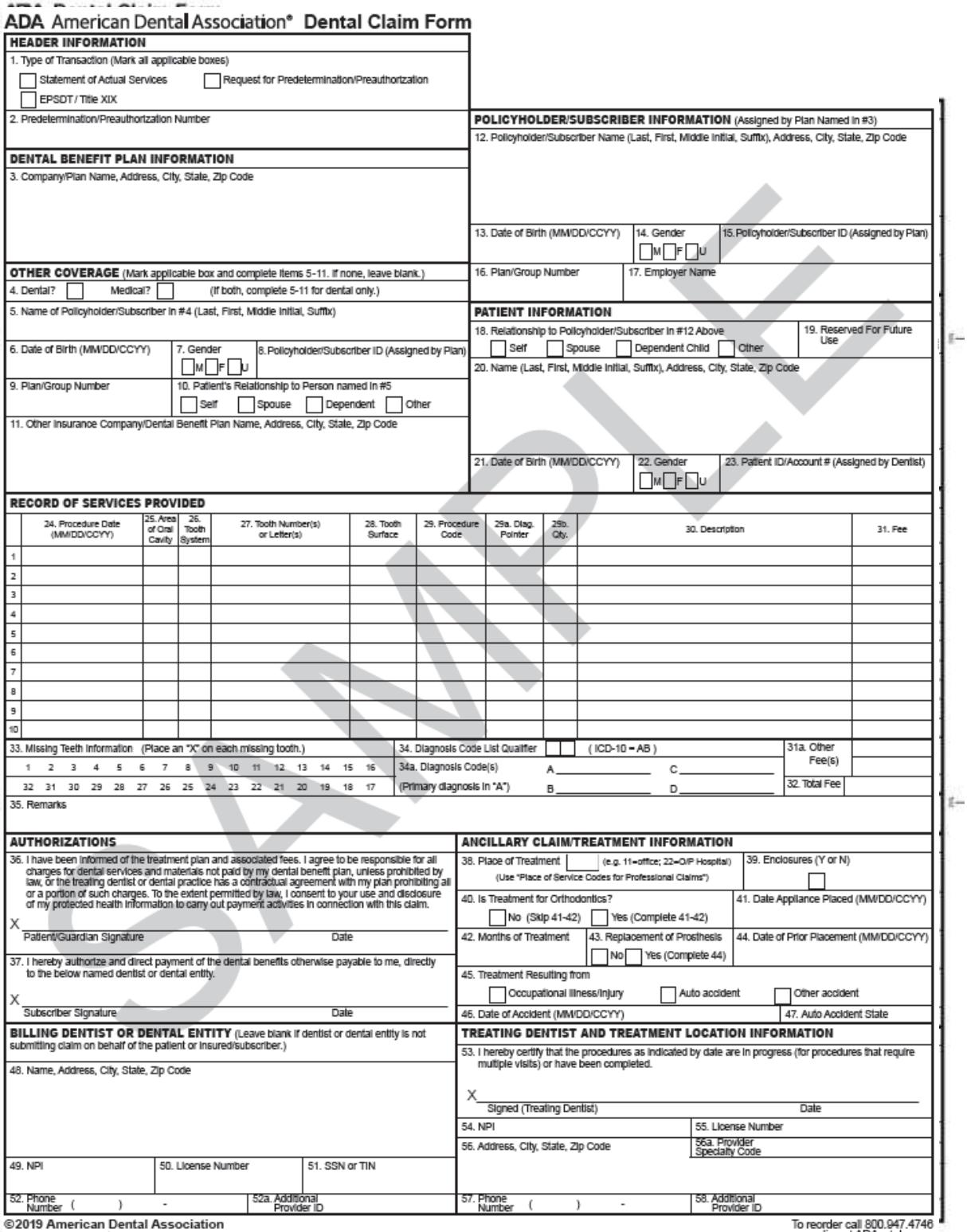
Locator #	Description	**Instructions**	**Alerts**
38	Place of Treatment	**Situational** – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48. If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is **required**.	
39	Number of Enclosures	**Situational** – Enter 00 to 99 in applicable boxes. Claims submitted for prior authorization are **required** to contain the identified attachments. Claims submitted for payment should not contain any of the attachments listed in Block 39.	
40	Is Treatment for Orthodontics?	**Situational** – Complete if applicable. Claims requesting comprehensive orthodontic services are **required** to enter information in this block. Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.	
41	Date Appliance Placed	**Situational.**	
42	Months of Treatment Remaining.	**Situational.**	
43	Replacement of Prosthesis	**Situational** – Check appropriate box if applicable; if checked, complete Block 44 if known.	

Locator #	Description	**Instructions**	**Alerts**
44	Date Prior Placement	**Situational** – If Block 43 is checked and if known, enter the appropriate eight-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	**Situational** – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is **required**. Check the appropriate box.	
46	Date of Accident (MM/DD/CCYY).	**Situational**. If Block 45 is completed, then this block is **required**. Enter the eight-digit date in month, day and year (MM/DD/CCYY).	
47	Auto Accident State	**Situational**. If Auto Accident is checked in Block 45, this block is **required**. Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	**Required**. Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group. Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	**Required – Enter the 8-digit NPI of the billing dental provider.**	
50	License Number	**Optional.**	
51	SSN or TIN	**Optional.**	
52	Phone Number	**Required --** Enter the phone number for the billing dental provider.	
52a~~A~~	Additional Provider ID	**Required** – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	

Locator #	Description	**Instructions**	**Alerts**
53	Signature	**Required** – Enter the signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider's assistant.	
54	NPI	**Required – Enter the 8-digit NPI of the treating dental provider.**	
55	License Number	**Required** – Enter the license number of the treating (attending) dental provider.	
56	Address, City, State, Zip Code	**Situational** – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48.	
56a~~A~~	Provider Specialty Code	**Optional.**	
57	Phone Number	**Situational** – Enter the phone number for the treating (attending) dental provider, if different from Block 52.	
58	Additional Provider ID	**Required** – Enter the 7-digit Medicaid ID of the treating (attending) dental provider.	

~~Locator #~~	~~Description~~	~~**Instructions**~~	~~**Alerts**~~
~~53~~	~~Signature~~	~~**Required** – Enter the signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider's assistant.~~	
~~54~~	~~NPI~~	~~**Required – Enter the 8-digit NPI of the treating dental provider.**~~	

~~55~~	~~License Number~~	~~**Required –** Enter the license number of the treating (attending) dental provider.~~	
~~56~~	~~Address, City, State, Zip Code~~	~~**Situational –** Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48.~~	
~~56A~~	~~Provider Specialty Code~~	~~**Optional.**~~	
~~57~~	~~Phone Number~~	~~**Situational –** Enter the phone number for the treating (attending) dental provider, if different from Block 52.~~	
~~58~~	~~Additional Provider ID~~	~~**Required –** Enter the 7-digit Medicaid ID of the treating (attending) dental provider.~~	



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

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) | 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

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

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 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

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee

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 _____
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 _____
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

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of 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

TREATING 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 _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

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J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

SAMPLE

ADA American Dental Association®
America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35).

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

SAMPLE