2006 ADA CLAIM FORM INSTRUCTIONS

Effective January 1, 2007, Medicaid will begin accepting the new 2006 American Dental Association (ADA) Claim Form from providers who submit hardcopy claims to Medicaid for prior authorization and payment of dental services. In addition, Medicaid will continue to accept the 2002 ADA Claim Form and the 2002, 2004 ADA Claim Form through April 1, 2007.

Effective April 2, 2007, the 2006 ADA Claim Form will be required when submitting hardcopy claims to Medicaid and will be the only dental claim form accepted for prior authorization and payment of dental services. Effective April 2, 2007, all 2002 ADA Claim Forms and all 2002, 2004 ADA Claim Forms received by the Medicaid Dental Prior Authorization Unit or Unisys will be returned to the provider unprocessed. **All providers who submit hardcopy dental claims will be responsible for submitting the 2006 ADA Claim Form effective April 2, 2007. No exceptions will be made.**

The numbered line-by-line billing instructions below correspond with the same numbered block of the 2006 American Dental Association 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.

EPSDT Dental Program and Adult Denture Program **claims for payment** should be submitted to:

Molina
P. O. Box 91022
Baton Rouge, LA 70821

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.	
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	**Situational.**	

Locator #	Description	Instructions	Alerts
	Company / Dental Benefit Plan Name, Address, City, State, Zip Code		
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	**Required** -- Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS. Recipient's address is **optional**.	
13	Date of Birth (MM/DD/CCYY)	**Required** -- Enter the recipient'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'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's name is required to be entered in Block 12.	
21	Date of Birth (MM/DD/CCYY)	**Situational.**	
22	Gender	**Situational.**	

Locator #	Description	Instructions	Alerts
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.	
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	

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		the same tooth for most services. Refer to the Dental Services Manual for more information.	
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.	
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.	
32	Other Fee(s)	**Leave Blank**	
33	Total Fee	**Required** – Total of all fees listed on the claim form.	
34	(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.	
35	Remarks	**Situational** – 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	

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		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'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.**	
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.	

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		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 .	
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,	

Locator #	Description	Instructions	Alerts
		state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	**Optional.**	**The 2006 ADA form accommodates entry of the NPI for the billing dental provider. This block was formerly Medicaid Provider ID number, which is now Block 52A. Block 49 will become required when NPI becomes mandatory.**
50	License Number	**Optional.**	
51	SSN or TIN	**Optional.**	
52	Phone Number	**Required** -- Enter the phone number for the billing dental provider.	
52A	Additional Provider ID	**Required** – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	**New block. The Medicaid ID was formerly entered in Block 49.**
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.	

Locator #	Description	Instructions	Alerts
54	NPI	**Optional.**	**The 2006 ADA form accommodates entry of the NPI for the treating (attending) dental provider. This block was formerly Medicaid Provider ID number of the treating (attending) provider, which is now Block 58. Block 54 will become required when NPI becomes mandatory.**
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.**	**Formerly Block 58, "Treating Provider Specialty."**
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.	**Formerly "Treating Provider Specialty." The Medicaid ID of the treating (attending)**

Locator #	Description	Instructions	Alerts
			dental provider was formerly entered in Block 54.