

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 12****ADA DENTAL CLAIM FORM AND INSTRUCTIONS**

The most current 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 2019 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, Diagnostic, 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	<p>Required -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.</p> <p>Situational – Check box marked “EPSDT Title XIX” if patient is Medicaid eligible and under 21 years of age.</p> <p>If block is not checked, the claim will be processed as an adult claim.</p>	
2	Predetermination / Preauthorization Number	<p>Situational – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.</p>	
3	Company / Plan Name, Address, City, State, Zip Code	<p>Situational – Enter the primary payer information if applicable.</p>	

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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	<p>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.</p> <p>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.</p>	
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	<p>Required -- Enter the beneficiary's last name, first name, and middle initial exactly as verified through REVS or MEVS.</p> <p>Beneficiary's address is optional.</p>	

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Locator #	Description	Instructions	Alerts
13	Date of Birth (MM/DD/CCYY)	Required -- Enter the 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 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 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.	

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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. <u>If a tooth number or letter is required by Medicaid, do not enter an oral cavity designator in Block 25.</u>	
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.	

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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	Required – Total of all fees listed on the claim form.	

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33	Missing Teeth Information (Place an 'X' on each missing tooth)Total Fee	<p>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 “/”.</p> <p>In the following circumstances, this information is required:</p> <p>If the claim is for the Adult Denture Program.</p> <p>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.</p>	
34	Diagnosis Code List Qualifier (Place an 'X' on each missing tooth)	<p>Situational – Required if field 29a (diagnosis pointer) is completed.</p> <p>Diagnosis qualifier “AB” indicates an ICD-10 diagnosis will be entered in field 34a.</p> <p>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 “/”.</p> <p>In the following circumstances, this information is required:</p> <p>If the claim is for the Adult Denture Program.</p> <p>If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy.</p>	
34a	Diagnosis Code(s)	<p>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.</p> <p>Supports up to 4 diagnosis codes per dental procedure. The primary diagnosis should be noted in line A.</p>	

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Locator #	Description	Instructions	Alerts
35	Remarks	<p>Situational – If block 9 is complete, enter the amount paid by the primary payor.</p> <p>Write the words “Carrier Paid” and the amount that was paid by the carrier (including zero [\$0] payment) in this block.</p> <p>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).</p> <p>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 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.</p>	
36	Authorizations	Optional.	
37	Authorizations	Optional.	

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Locator #	Description	Instructions	Alerts
38	Place of Treatment	<p>Situational – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48.</p> <p>If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is required.</p>	
39	Number of Enclosures	<p>Situational – Enter 00 to 99 in applicable boxes.</p> <p>Claims submitted for prior authorization are required to contain the identified attachments.</p> <p>Claims submitted for payment should not contain any of the attachments listed in Block 39.</p>	
40	Is Treatment for Orthodontics?	<p>Situational – Complete if applicable.</p> <p>Claims requesting comprehensive orthodontic services are required to enter information in this block.</p> <p>Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.</p>	
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.	

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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	Additional Provider ID	Required – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	

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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.	

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																				
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSOT / 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? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U		8. Policyholder/Subscriber ID (Assigned by Plan)																
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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		
33. Missing Teeth Information (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-10 = AB)										31a. Other Fee(s)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16										34a. Diagnosis Code(s) A _____ C _____										
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17										(Primary diagnosis in "A") B _____ D _____										32. Total Fee
35. Remarks																				
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION										
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.										38. Place of Treatment <input type="checkbox"/> (e.g. 11-office; 22-QIP Hospital) 39. Enclosures (Y or N) <input type="checkbox"/> (Use "Place of Service Codes for Professional Claims")										
X Patient/Guardian Signature _____ Date _____										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										41. Date Appliance Placed (MM/DD/CCYY)										
X Subscriber Signature _____ Date _____										42. Months of Treatment 43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
										44. Date of Prior Placement (MM/DD/CCYY)										
										45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident										
										46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
48. Name, Address, City, State, Zip Code										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 _____										
49. NPI		50. License Number				51. SSN or TIN				54. NPI					55. License Number					
										56. Address, City, State, Zip Code										
										56a. Provider Specialty Code										
52. Phone Number () -					52a. Additional Provider ID					57. Phone Number () -					58. Additional Provider ID					

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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/>