ADA 2012 Dental Claim Form

Effective April 1, 2014, the West Virginia Medicaid and WVCHIP Program's claims processing system will begin accommodating the national version of the ADA 2012 Dental Claim Form. For Dental claim filing purposes, deviations from the standard national claim form coding instructions are indicated by comments in the claim form directions on the following pages. A sample copy of the ADA 2012 Dental Claim Form Gainwell Technologies will accept is at the end of these billing instructions. Different versions of this claim form ***will not be accepted*** and ***will be rejected***. [Please note there are differences in blocks 31, 31a, 32, 33 and 38 onthe different claim form versions.]

ADA 2012 Instructions
Dental and Orthodontic Services must be billed on the ADA 2012 Dental Claim Form.

Required Field: Blank = Not Required
C = Conditionally Required
R = Required Field

**Note – All requirements will be enforced on January 1, 2015. Failure to comply could result in claim rejections.

Form Locator	Required Field	Field Name	Comments
1		Type of Transaction	
2	C	Predetermination/Prior Authorization	Enter predetermination number if applicable.
3	C	Insurance Company	Enter Primary Payer Information. If the Patient has a Primary Insurance, then an attached EOB is required.
4	C	Other Dental or Medical Coverage	Check 'Yes' to indicate other Insurance coverage. If yes, complete 5-11.
5	C	Name of Policy Holder / Subscriber	Enter Name of Subscriber - Last, First, Middle Initial and suffix if applicable
6	C	Date of Birth	Enter Subscriber date of birth. - Format = MM/DD/CCYY
7	C	Gender	Enter Subscriber gender. - M = Male - F = Female - U = default
8	C	Policyholder/Subscriber ID	Enter Subscriber ID/Social Security Number.
9	C	Plan/Group Number	Enter Plan/Group Number of Subscriber.

Form Locator	Required Field	Field Name	Comments
11	C	Other Insurance Company/Dental Benefit Plan	Enter other insurance co/dental benefit plan name and address.
12	R	Policyholder/Subscriber Name	Enter Member's Name and Address. - Last, First, Middle Initial and suffix if applicable - Member Street Address - Member City - Member State - Member Zip (must be 9 digit zip code)
13	R	Date of Birth	Enter Member's Date of Birth in this format: - MM/DD/CCYY
14	R	Gender	Select the correct gender for member. Check the M (male) or F (female) box
15	R	Policyholder/Subscriber ID	Enter Member's 11-digit Medicaid ID or 10-digit CHIP PIN.
16		Plan/Group Number	No entry required.
17		Employer Name	No entry required.
18		Relationship to Primary Subscriber	No entry required.
19		Student Status	No entry required.
20		Patient Name and Address	No entry required.
21		Patient Date of Birth	No entry required.
22		Patient/Member's Gender	No entry required.
23	R	Patient ID/Account #	Enter Account Number, or Last Name First Name as assigned by the dentist's office.
24	R	Procedure Date	Enter the date of service in this format. - MMDDCCYY.
25	C	Area of Oral Cavity or Quadrant	Valid values for arches and quadrants are: UA = Upper or Maxillary Arch LA = Lower or Mandibular Arch UL = Upper Left Quadrant LL = Lower Left Quadrant UR = Upper Right Quadrant LR = Lower Right Quadrant
26		Tooth System	No entry required.

Form Locator	Required Field	Field Name	Comments
27	C	Tooth Number(s) or Letter(s)	List in order by tooth number or letter. Valid tooth values are: 1-32 or A-T. Permanent Supernumerary Teeth are 50-82 Primary Supernumerary is AS - TS For permanent teeth or deciduous teeth add 50 to the tooth number. Example – Permanent tooth number 1 would be 51, tooth 12 would be 62. For Primary teeth add 'S' to the tooth number. Example: Primary tooth would be AS. **Note: Leading 0's are not valid or allowed.
28	C	Tooth Surface	Enter surface if applicable. Valid values for surface are: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal
29	R	Procedure Code	Enter Procedure Code (ADA 5-character code starting with the letter D).
29a		Diagnosis Code Pointer	Enter the letters from block 34 that identify the diagnosis codes. Applicable to the dental procedure billed on the line. Specific reference letters A, B, C, D are required if diagnosis is present. - List pointer for primary diagnosis first.
29b	R	Quantity	Enter the number of times the procedure for which you are billing was performed. - Default is '01'.
30		Description	Enter the description of the procedure code.

Form Locator	Required Field	Field Name	Comments
31	R	Fee	Enter charges for that procedure code. - 0.00 amount is acceptable. - Decimal amounts will only be captured if present. Examples - 100 will be captured as 100.00 - 10.00 will be captured as 10.00 - 10.10 will be captured as 10.10
31a		Other Fee(s)	No entry required.
32	R	Total Fee	Enter total charges. - 0.00 amount is acceptable. - Decimal amounts will only be captured if present. Examples - 100 will be captured as 100.00 - 10.00 will be captured as 10.00 - 10.10 will be captured as 10.10
33		Missing Teeth Information	No entry required.
34	C	Diagnosis Code List Qualifier	Enter B for ICD-9, enter AB for ICD-10 Please note that ICD-10 is only effective with dates of services 10/1/2015 and after. **Required when a diagnosis code is entered.
34a		Primary Diagnosis	Enter up to four applicable diagnosis codes after each letter. (A-D). Note: Letters are vertically aligned on the claim. (Down then across).
35	C	Remarks	Can be used to indicate Service Facility Location; use NPI followed by a dash then the 3 digit service location &/or can be used for Claim Adjustment Resubmission codes and Original reference number (ICN). Valid format and order are as followed: Service Facility Location If present should equal the 10 digit NPI followed by dash 3 digit service location ID or 10 digit Medicaid ID followed by dash 3 digit service location. Resubmission Code and Original ICN. Enter Resubmission Code 7 or 8 then a space, followed by Original Reference Number (ICN)
36		Patient/Guardian Signature	No entry required.
37		Subscriber Signature	No entry required.

Form Locator	Required Field	Field Name	Comments
38	R	Place of Treatment	Enter the appropriate two digit Place of Service indicator in the box. For example: 11 - Office 12 - Home 21 - Inpatient Hospital 22 - Outpatient Hospital 31 - Skilled Nursing Facility 32 - Nursing Facility The full list of POS Codes is available at www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf
39		Number of Enclosures	No entry required.
40	C	Is Treatment for Orthodontics?	Required when reporting the date orthodontic appliances were placed.
41	C	Date Appliance Placed	Required if box 40 is checked yes. Valid date format = MM/DD/CCYY
42	C	Months of Treatment Remaining	Required if box 40 is checked yes.
43	C	Replacement of Prosthesis	Only required to indicate the placement status of the Prosthesis.
44	C	Date Prior Placement	Only required if box 43 is checked yes. Must be valid format MM/DD/CCYY.
45	C	Treatment Resulting From	Check appropriate box(es) for occupational illness/Injury, auto accident, and other accident.
46	C	Date of Accident	Required if box for Auto Accident or Other Accident is checked in Block 45
47	C	Auto Accident State	Required if box for Auto Accident is checked in Block 45. Enter state abbreviation.
48	R	Billing Dentist Name, Address, Phone Number	Enter required information as follows: Provider Name Address City, State & 9 digit zip code Phone
49	R	NPI	Enter the Provider or Group Practice NPI.
50		License Number	Enter the Dentist’s License number.
51	R	SSN or TIN	Enter the Dentist’s 9 numeric Federal Tax ID.
52	R	Phone Number	Enter the Dentist’s office phone number

Form Locator	Required Field	Field Name	Comments
52A	C	Additional Provider ID	Enter the qualifier and provider's legacy Medicaid if NPI is missing in box 49. **Only 'G2' qualifier is valid. **Required if NPI is missing in box 49.
53	R	Treating Dentist's Signature	Signature of person authorized to certify this claim. By signing the Provider Enrollment Agreement (included in the Enrollment/Re-enrollment Packet) you have certified that all information listed on a claim for reimbursement from Medicaid is true, accurate and complete. Therefore, you may endorse your claim with a computer-generated, manual or stamped signature.
54	R	NPI	Enter the Treating Dentist's NPI
55		License Number	No entry required.
56	C	Treating Provider Address	Required if Service Facility Location indicated in Block 35. Address City, State & 9 digit zip code
56A	C	Provider Specialty Code	Enter the taxonomy code of the individual dentist (if applicable). **Note: 56A is REQUIRED when:** - A Rendering provider is used. - The billing dentist is a One-To-Many. Enter qualifier 'ZZ' or 'PXC' followed by taxonomy code. *As of September 1, 2015 'ZZ' qualifier will no longer be allowed.*
57		Treating Provider Phone #	No entry required.
58	C	Additional Provider ID	If NPI is not present in box 54 then enter Medicaid ID.

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

INSURANCE COMPANY/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
8. Policyholder/Subscriber ID (SSN or ID#)
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 (For Insurance Company 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
15. Policyholder/Subscriber ID (SSN or ID#)
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
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-9 = B; 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

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 Remaining
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

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

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

SAMPLE