ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
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TO: **Arkansas Medicaid Health Care Providers – Dental**

DATE: **April 1, 2014**

SUBJECT: **Provider Manual Update Transmittal DENTAL-7-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
215.000	8-1-13	215.000	4-1-14
226.400	8-1-13	226.400	4-1-14
262.400	7-1-07	262.400	4-1-14

Explanation of Updates

Section 215.000 is updated to link to the new American Dental Association (ADA) claim form, ADA-J430.

Section 226.400 is updated to link to ADA-J430. It is also updated to remove Dental Unit contact information that is found in Section V of the provider manuals.

Section 262.400 is updated to link to ADA-J430. It is also updated with instructions for completing the new form.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

TOC not required

215.000 Child Health Services (EPSDT) Dental Screening 4-1-14

The Child Health Services (EPSDT) periodic and interperiodic dental screening exams consist of an inspection of the oral cavity by a licensed dentist. The purpose of the dental screening exams is to check for obvious dental abnormalities and to assure access to needed dental care. Regular screening exams should be performed in accordance with the recommendations of the Child Health Services (EPSDT) periodicity schedule.

The Child Health Services (EPSDT) periodic dental screening exam is limited to two screening exams every six (6) months plus one (1) day for individuals under age 21. These benefits may be extended if documentation is provided that verifies medical necessity. See Section 262.100 to view the procedure code for periodic dental screening exams.

Individuals under age 21 enrolled in the EPSDT Program may receive an interperiodic dental screening exam twice per SFY. Extension of benefits is available in cases of medical necessity. **View or print form ADA-J430.** See Section 262.100 for the interperiodic dental screening exam procedure code.

NOTE: ARKids First-B beneficiaries may also receive an interperiodic dental screening exam twice per SFY. There is no extension of benefits for ARKids First-B beneficiaries.

Extension of benefits requests, in addition to a narrative and any supporting documentation, should be submitted to the Division of Medical Services Dental Care Unit – ATTN Dental Extension of Benefits. **View or print the Division of Medical Services Dental Care Unit contact information**.

Infant oral health care examinations must be based on the recommendations of the American Academy of Pediatric Dentistry. Essential elements of an infant oral health care visit are a thorough medical and dental history, oral examination, parental counseling, preventive health education and determination of appropriate periodic re-evaluation. See Section 201.500 for information regarding the dentist's role in the EPSDT Program.

226.400 Prior Authorization for Orthodontics 4-1-14

When requesting prior authorization for orthodontic services, the provider *must* complete and submit the Request for Orthodontic Treatment form (Form DMS-32-0), the ADA-J430 claim form for the orthodontic records and a written treatment plan along with the orthodontic records. **View or print form DMS-32-0. View or print form ADA-J430.**

Mail the requested information to the Division of Medical Services Dental Care Unit. For electronic submissions options, contact the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

262.400 Billing Instructions - ADA Claim Form - Paper Claims Only 4-1-14

Dental providers must complete the ADA claim form when:

A. Billing for services when using the ADA procedure codes

B. Requesting prior authorization

C. Approving prior authorization

D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the "Request for Payment for Services Provided" portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. **View or print the Division of Medical Services Dental Unit contact information**.

Completed claim forms should be forwarded to the HP Enterprise Services Claims Department. **View or print the HP Enterprise Services Claims Department contact information**.

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. **View or print form ADA-J430.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Dental? Medical?	Check the applicable box and complete items 5-11. If none, leave blank. (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.

Field Number and Name	Instructions for Completion
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 Above.	Check one of the following: Self Spouse Dependent Child Other
19. Reserved for Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter last name, first name, middle initial, suffix, address, city, state and Zip code.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist)	Enter the patient ID/Account # assigned by the dentist.

Field Number and Name	Instructions for Completion
RECORD OF SERVICES PROVIDED	
24. Procedure Date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial
29. Procedure Code	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
29a. Diag. Pointer	Diagnosis Code Pointer. Enter A-D as applicable from item 34a.
29b. Qty.	Quantity. Indicates the number of units of the procedure code(s) listed in field 29.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.
31a. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
32. Total Fee	Required for Medicaid. Enter the total fee charged.
33. Missing Teeth Information (Place an 'X' on each missing tooth)	Draw an X through the number of each missing tooth.
34. Diagnosis Code List Qualifier	Enter B for ICD-9-CM or AB for ICD-10-CM.
34a. Diagnosis Code(s) (Primary diagnosis in "A")	Enter up to four diagnosis codes in A-D. Enter the primary diagnosis in A.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	

Field Number and Name	Instructions for Completion
38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	Enter the two-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 **http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf**.
39. Enclosures (Y or N)	If there are enclosures such as radiographs, oral images or models, enter Y for Yes. If there are no enclosures, enter N for No.
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42. If Yes, complete items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis	Check No or Yes. If Yes, complete item 44.
44. Date of Prior Placement	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
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	Enter the name and address of the billing dentist or dental entity.
49. NPI	Not required.
50. License Number	Optional.
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.

Field Number and Name	Instructions for Completion
52a. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	Not required.
55. License Number	Optional.
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56a. Provider Specialty Code	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. For a complete list of codes, see the Provider Specialty table in the instructions accompanying the ADA-J430 claim form. **View or print form ADA-J430**.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52a is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.

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TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **April 1, 2014**

SUBJECT: **Provider Manual Update Transmittal SecV-1-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
500.000	—	500.000	—
ADA-J400	2006	—	—
—	—	ADA-J430	2012

Explanation of Updates

Section 500.000 is updated to replace discontinued American Dental Association (ADA) claim form ADA-J400 with ADA-J430.

Form ADA-J400 has been discontinued.

Form ADA-J430 has been added to all provider manuals.

This transmittal and the enclosed form are for informational purposes only. **Please do not complete the enclosed form.**

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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Andrew Allison, PhD
Director

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J430	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adverse Effects Form	DMS-2704

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485

Form Name	Form Link
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet
Quarterly Monitoring Form	AAS-9506
Referral for Audiology Services – School-Based Setting	DMS-7783
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630

Form Name	Form Link
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request for Molecular Pathology Laboratory Services	DMS-841
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9506
AAS-9559
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-841
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit
Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit
Arkansas Department of Human Services, Children's Services

HP Enterprise Services Provider Assistance Center (PAC)

HP Enterprise Services Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

ICD-9-CM, CPT, and HCPCS Reference Book Ordering

Immunizations Registry Help Desk

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Partners Provider Certification

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

QSource of Arkansas

Select Optical

Standard Register

Table of Desirable Weights

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

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

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 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

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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America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

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 CDT manual's instructions.

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.

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). There are additional detailed completion instructions in the CDT manual.

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 (B for ICD-9-CM; 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 "www.cms.gov/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 "www.wpc-edi.com/codes/taxonomy"