ITEM 59 – EXAMINATION AND TREATMENT PLANS

Item 59 of the ADA Claim Form – Version 2000, identifies the services you have provided to the recipient. Only those procedure codes listed in the Medical Assistance Program Fee Schedule are compensable.

Date (MM/DD/YYYY) (MUST)

Enter the date the service was provided. Use an eight-digit format for all dates. Enter a zero to the left of all one-digit numbers.

Claims for space maintainers, crowns and dentures should show the date the appliance was inserted. In the event the recipient loses eligibility before the service was completed, indicate the date the impression was taken in the Date field. (Enter the date the appliance was inserted in Item 61 (Remarks for unusual services)).

Tooth (MUST, IF APPLICABLE)

Enter only one tooth number or letter per claim line. This item must be completed whenever a particular tooth or tooth area is involved.

Use numerical identification **1 through 32** for permanent teeth; use capital letter identification **A through T** for primary teeth.

For supernumerary teeth, use numerical identification **51 through 82** for permanent teeth; use capital letter identification **AS through TS** for primary teeth.

You must identify the tooth involved when the claim is for a restoration, tooth extraction, root canal, crown, or dentition related surgical excision. If the claim is not for a specific tooth (e.g., oral examination), leave this item BLANK.

When billing for periodontal services (procedure codes D4210 and D4341), enter the appropriate code to identify the quadrant on which the service was provided:

10 – Upper Right Quadrant	30 – Lower Left Quadrant
20 – Upper Left Quadrant	40 – Lower Right Quadrant

Surface (MUST, IF APPLICABLE)

Indicate the surface or surfaces of the tooth/teeth that were treated. Only the surface identification letters listed below are to be used in completing the invoice::

M – Mesial	L – Lingual
O – Occlusal	F – Facial
D – Distal	I – Incisal

Diagnosis Index # (LEAVE BLANK)

Procedure Code (MUST)

Enter the code for the procedure performed. Only those codes listed in the Medical Assistance Program Fee Schedule are covered by the Medical Assistance Program.

Qty (MUST)

Enter the number of times the service was provided on the date of service.

Description (MUST, IF APPLICABLE)

Enter the terminology to describe the service provided.

Fee (MUST)

Enter your usual charge to the self-paying public for the service(s) provided in dollars and cents.

If you are billing for multiple units of service, be sure to multiply your usual charge by the number of units billed and enter that amount.

Total Fee (OPTIONAL)

Enter the sum of all fees charged in dollars and cents.

Payment by other plan (OPTIONAL)

Max. Allowable (OPTIONAL)

Deductible (OPTIONAL)

Carrier % (OPTIONAL)

Carrier pays (OPTIONAL)

Patient pays (LEAVE BLANK)

Admin. Use Only (LEAVE BLANK)

This area for Department use only. *DO NOT COMPLETE.*

Item 60 Identify all missing teeth with "X" (OPTIONAL)