

Item 4 Sex (OPTIONAL)

Enter the appropriate letter, F (female) or M (male)

Item 5 Resource Code (MUST, IF APPLICABLE)

Enter the appropriate one digit code to indicate the resource(s), other than Medical Assistance, which are available to the recipient for dental services.

PROVIDER INFORMATION

Items 6 through 14 are to be completed using the information found on the provider's Medical Assistance "Provider Notice Information Form."

Item 6 Provider's Name (MUST)

Enter the provider's last name, first name, and middle initial.

Item 7 Provider Type (PREPRINTED)

The Provider Type for a dentist is always **03**. This information is preprinted on the MA 98.

Item 8 M.A. I.D. Number (MUST)

Enter the provider's seven digit MA ID Number.

Item 9 Address Code (MUST)

Enter the two digit code for the office where the service will be provided.

Item 10 Provider's Own Reference No. (OPTIONAL)

Enter your own reference number of recipient's name to comply with the provider's filing system.

Items 11 through 14 will only be completed if the payment for services will be sent to someone other than the dentist providing the services. A payee must be enrolled with the Department. Payees are issued an MA ID Number that is different from the dentist's MA ID Number.

Item 11 Payee Name (MUST, IF APPLICABLE)

Enter the name of the person, group or organization designated to receive payment.

Item 12 Payee Type (MUST, IF APPLICABLE)

Enter the two-digit payee type.

Item 13 Payee M.A. I.D. Number (MUST, IF APPLICABLE)

Enter the payee's seven digit MA ID Number.

NOTE: The MA ID Number entered in Item 13 should *never* be identical to the MA ID number entered in Item 8.

Item 14 Payee Address Code (MUST, IF APPLICABLE)

Enter the two-digit payee address code.

REQUESTED PRIOR AUTHORIZED SERVICES

When requesting a single service, complete Items 15A through 15G as follows:

Item 15A Procedure Name (MUST)

Enter the procedure terminology found in the Medical Assistance Program Fee Schedule.

Item 15B Tooth No./Letter (MUST, IF APPLICABLE)

Enter the tooth number or tooth letter that identifies the permanent or primary tooth involved. Only one tooth number or letter may be entered on each line.

When requesting prior authorization for multiple extractions, indicate the appropriate teeth to be extracted in 15B through 21B. Up to seven (7) separate teeth and procedures can be identified on each MA98. Extractions require separate lines for each tooth to be extracted.

This item must be completed when requesting authorization for periodontal procedures **D4210** (gingivectomy or gingivoplasty – per quadrant) and **D4341** (periodontal scaling and root planing – per quadrant). Enter the appropriate code to identify the quadrant on which the service will be provided:

UR – Upper right
UL – Upper left

LR – Lower right
LL – Lower left

For reimbursement purposes, a quadrant is defined as 5 to 8 teeth. For individuals with less than 5 teeth present in the mouth, Procedure Code **D4341** will not be approved.

Item 15C Type Service (LEAVE BLANK)

Item 15D Procedure Code (MUST)

Enter the five-character CDT-4 procedure code for the service requested. The procedure code can be found on the Medical Assistance Program Fee Schedule.

Items 15 E & 15F Modifier (LEAVE BLANK)

Item 15 G Visit Code (MUST, IF APPLICABLE)

If applicable, enter the appropriate visit code number from the following list:

- 02 – County Assistance Office (CAO) Referral
- 04 – Vehicle Accident (includes all types of vehicles covered by insurance)
- 05 – Accident (other than vehicle)
- 09 – Services rendered to a pregnant woman
- 10 – Services rendered to a resident of a medical facility as defined in Chapter 1101, §1101.63(b)(2)(iii).

Items 16A through 21G are available for additional requested services and must be completed as described in Items 15A through 15G above.

Item 22 Treatment Plan (MUST)

This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½" X 11".

Prior authorization of dental services must be performed as a part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

1. pertinent dental history;
2. pertinent medical history, if applicable;
3. the strategic importance of the tooth;
4. the condition of the remaining teeth;
5. the existence of all pathological conditions;
6. preparatory services performed and completion date(s);
7. documentation of all missing teeth in the mouth;
8. the oral hygiene of the mouth;
9. all proposed dental work;
10. identification of existing crowns, periodontal services, etc.
11. identification of the existence of full and/or partial denture(s), with the date of initial insertion;
12. the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis;
13. identification of abutment teeth by number;
14. for periodontal services, include a comprehensive periodontal evaluation.

NOTE: For those HealthCare Benefits Packages where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided.

Item 23 Tooth Chart (MUST)

Indicate all missing teeth by marking an "X" on the chart.

Use a slash (/) to indicate any teeth requiring extraction.

Check Appropriate Block Below (MUST)

Place an "X" in the appropriate block to indicate if this is an initial prior authorization request for the service or if it is a resubmission of a previously denied request. If the resubmission block is checked, please include the denied Prior Authorization Reference Number from the original submission.

Item 24 Number of Attachments Other Than X-rays (MUST, IF APPLICABLE)

Indicate the number of attachments, excluding X-rays, that are being submitted with the MA 98. For example, if you attached two additional pages to include additional treatment plan information, you would enter a "2". Identify each individual attachment in the "Remarks" section of the MA 98.

Item 25 X-ray Envelope Number (MUST, IF APPLICABLE)

Place the seven-digit number appearing on the left side of the X-ray envelope (ENV 98) in this item.

Use the following procedure to submit X-rays with the MA 98:

1. Place your return address on the ENV 98 so the X-rays can be returned to you.
2. Place the X-rays in the ENV 98. The radiographs must be:
 - a. properly mounted;
 - b. clearly readable;
 - c. free from defects;
 - d. the clarity must be such that interpretation can be made without difficulty by using a conventional view box;
 - e. taken in a manner that all clinical crowns and roots are observable; and
 - f. labeled with the recipient's name, the recipient number, the provider's name, and the date the radiograph was taken.
3. Use one ENV 98 for each recipient.
4. Be sure that your return address is placed on the ENV 98 in the white block labeled "Provider Return Address". This envelope will be used by the Department when returning X-rays to you. DO NOT USE TAPE OR STAPLES TO SEAL THE ENV 98.
5. Place the ENV 98 with the completed MA 98 in an MA 320 envelope and mail to the Department.

Item 26 Provider's Signature (MUST)

The dentist requesting the prior authorized service must sign the MA 98. His/her signature indicates that the prior authorized service will be performed in accordance with Medical Assistance regulations.

A signature stamp is acceptable if the provider authorizes its use and assumes responsibility for the request.

NOTE: ALL UNSIGNED PRIOR AUTHORIZATION REQUESTS WILL BE RETURNED TO THE PROVIDER WITHOUT BEING PROCESSED.

Item 27 Date (MUST)

Enter the month, day and year the MA 98 was completed. Use an eight digit format for the date (mmddyyyy).

F. How to Complete the ADA Claim Form – Version 2000 for a Prior Authorization Request

Item 1 Dentist's pre-treatment estimate/Dentist's statement of actual services and Specialty (MUST)

Please check the "Dentist's pre-treatment estimate" box

Item 2 Medicaid Claim/EPSTD and Prior Authorization # (LEAVE BLANK)

Items 3 - Carrier Name/Carrier Address/City/State/Zip (OPTIONAL)
7

PATIENT INFORMATION

Items 8 through 14 are to be completed using information obtained from the Eligibility Verification System (EVS)

Item 8 Patient Name (Last, First, Middle) (MUST)

Enter the recipient's last name, first name, and middle initial exactly as they appear on the recipient's Pennsylvania ACCESS Card.

Items 9 - Address/City/State (LEAVE BLANK)
11

Item 12 Date of Birth (MM/DD/YYYY) (MUST)

Enter the recipient's date of birth in eight digit format (mmdyyy)

Item 13 Patient ID # (MUST)

Enter the ten digit recipient number obtained from the recipient's Pennsylvania ACCESS Card.

Item 14 Sex (OPTIONAL)

Enter the appropriate letter, F (female) or M (male)

Items 15- (LEAVE BLANK)
18

SUBSCRIBER/EMPLOYEE

Items 19- (LEAVE BLANK)
30

OTHER POLICIES

Item 31 Is patient covered by another dental plan? (MUST, IF APPLICABLE)

Indicate if the recipient has another resource(s), other than Medical Assistance, that is available to the recipient for dental services.

Item 32 Policy Number (MUST, IF APPLICABLE)

Complete this item if the available resource is not on the recipient's EVS record or is a Resource Code 7 (Other).

Items 33- (LEAVE BLANK)
35

Item 36 Plan/Program Name (MUST, IF APPLICABLE)

Complete this item only if the available resource is not on the recipient's EVS record or is a Resource Code 7 (Other).

Items 37-41 (LEAVE BLANK)

BILLING DENTIST

Items 42 through 57 are to be completed using the information found on the provider’s Medical Assistance Enrollment Notice.

Item 42 Name of Billing Dentist or Dental Entity (MUST, IF APPLICABLE)

Enter the name of the enrolled group, corporation or organization designated to receive payment for the service to be provided. The payee must be enrolled with the Department and must be listed as payee on the individual dentist’s Provider Notice Information Form.

Item 43 Phone Number (LEAVE BLANK)

Item 44 Provider ID# (MUST)

If you are enrolled with a group, corporation or organization other than the individual provider of service, enter the seven-digit ID number assigned to the designated group or payee, followed by the two-digit code to identify the payee location. The group or payee identification number and address code are found on the “Provider Notice Information Form” sent to you by the Department. You will notice that the “Provider Notice Information Form” lists an eight-digit ID number. Please drop the leading zero when completing this block.

If you are enrolled as an individual dentist *without* a group or payee, enter your seven-digit Medical Assistance ID number followed by the two-digit address code for the office where the service will be provided.

Items 45-56 (LEAVE BLANK)

Item 57 Is treatment result of auto accident?/other accident?/neither (MUST, IF APPLICABLE)

Mark the appropriate box to identify that the requested service is the result of an auto accident or other type of accident.

If the requested service is not the result of an auto accident or other type of accident, leave this item BLANK.

Item 58 Diagnosis Code Index (LEAVE BLANK)

ITEM 59 – EXAMINATION AND TREATMENT PLAN

Item 59 identifies the requested prior authorized services.

Date (MUST, IF APPLICABLE)

For endodontic therapy and gingival debridement, enter the date the service was performed.

Tooth (MUST, IF APPLICABLE)

Enter the tooth number or tooth letter that identifies the permanent or primary tooth involved. Only one tooth number or letter may be entered on each line.

When requesting prior authorization for multiple extractions, indicate the appropriate teeth to be extracted. **Up to seven (7) separate teeth and procedures can be identified on each ADA Claim Form – Version 2000.** Extractions require separate lines for each tooth to be extracted.

This item must be completed when requesting authorization for periodontal procedures **D4210** (gingivectomy or gingivoplasty – per quadrant) and **D4341** (periodontal scaling and root planing – per quadrant). Enter the appropriate code to identify the quadrant on which the service will be provided:

UR – Upper right
UL – Upper left

LR – Lower right
LL – Lower left

For reimbursement purposes, a quadrant is defined as 5 to 8 teeth. For individuals with less than 5 teeth present in the mouth, Procedure Code **D4341** will not be approved.

Surface (LEAVE BLANK)

Diagnosis Index# (LEAVE BLANK)

Procedure Code (MUST)

Enter the five-character procedure code for the service requested. The procedure code can be found on the Medical Assistance Program Fee Schedule.

Qty (LEAVE BLANK)

Description (MUST)

Enter the procedure terminology found in the Medical Assistance Program Fee Schedule.

Fee (LEAVE BLANK)

Total Fee (LEAVE BLANK)

Payment by other plan (LEAVE BLANK)

Max. Allowable (LEAVE BLANK)

Deductible (LEAVE BLANK)

Carrier % (LEAVE BLANK)

Carrier pays (LEAVE BLANK)

Patient pays (LEAVE BLANK)

Admin. Use
Only (LEAVE BLANK)

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

Indicate all missing teeth by marking an "X" on the chart.

Use a slash (/) to indicate any teeth requiring extraction.

REMARKS AND DENTIST'S SIGNATUREItem 61 Remarks for unusual services (MUST)

This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½" X 11".

Prior authorization of dental services must be performed as a part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

1. pertinent dental history;
2. pertinent medical history, if applicable;
3. the strategic importance of the tooth;
4. the condition of the remaining teeth;
5. the existence of all pathological conditions;
6. preparatory services performed and completion date(s);
7. documentation of all missing teeth in the mouth;
8. the oral hygiene of the mouth;
9. all proposed dental work;
10. identification of existing crowns, periodontal services, etc.
11. identification of the existence of full and/or partial denture(s), with the date of initial insertion;
12. the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis;
13. identification of abutment teeth by number;
14. for periodontal services, include a comprehensive periodontal evaluation.

NOTE: For those HealthCare Benefits Packages where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided.

If this is a resubmission of a previously denied prior authorization request, enter "Resubmission of a previously denied request" and the denied P.A. Reference Number in this item.

Also, place the seven-digit number appearing on the left side of the X-ray envelope (ENV 98) and the words "X-Ray Envelope Number" in this item.

Use the following procedure to submit X-rays with the ADA Claim Form, Version 2000:

1. Place your return address on the ENV 98 so the X-rays can be returned to you.
2. Place the X-rays in the ENV 98. The radiographs must be:
 - a. properly mounted;
 - b. clearly readable;
 - c. free from defects;
 - d. the clarity must be such that interpretation can be made without difficulty by using a conventional view box;
 - e. taken in a manner that all clinical crowns and roots are observable; and
 - f. labeled with the recipient's name, the recipient number, the provider's name, and the date the radiograph was taken.
3. Use one ENV 98 for each recipient.