

ADA Claim Form – Version 2012 Completion Aid for Dentists

Claims Submission

Purpose of the document The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the ADA claim form-Version 2012:

Dentists – Provider Type 27

Document format The document is divided into thirteen sections that correspond to the sections of the ADA claim form. They are:

- Header Information (Items 1-2)
- Insurance Co/Dental Benefit Plan Information (Item 3)
- Other Coverage (Items 4-11)
- Policy Holder/Subscriber Information (Items 12-17)
- Patient Information (Items 18-23)
- Record of Services Provided (Items 24-32)
- Missing Teeth Information (Item 33)
- Diagnosis Code Information (Items 29a, 34-34a)
- Remarks (Item 35)
- Authorizations (Items 36-37)
- Ancillary Claim/Treatment Information (Items 38-47)
- Billing Dentist or Dental Entity (Items 48-52A)
- Treating Dentist and Treatment Location Information (Items 53-58)

Each section contains a table with four columns. Each column provides a specific piece of information as explained below:

Item Number – Provides the item number as it appears on the claim form.

Item Name – Provides the item name as it appears on the claim form.

Item Code – Lists one of four codes that denote how the claim form item should be treated. They are:

- **M** – Indicates that the item **m**ust be completed.
- **A** – Indicates that the item must be completed, if **a**pplicable.
- **O** – Indicates that the item is **o**ptional.
- **LB** – Indicates that the item should be **l**eft **b**lank.

Notes – Provides important information specific to completing the item.

Item No.	Item Name	Item Code	Notes
Header Information			
1.	Type of Transaction	M	<p>Check the Request for Predetermination/Preauthorization box if this is a prior authorization; benefit limit exception request or post-operative review request.</p> <p>Check the Statement of Actual Services box if this is a claim for completed services.</p> <p>Check the Statement of Actual Services box if this is a claim adjustment to correct a previously approved (or paid) claim.</p> <p>It is not necessary to submit claim adjustments to the Department for amounts less than one dollar (\$1.00).</p>
2.	Predetermination/Preauthorization Number	A	<p>If the service was prior authorized, approved through a Benefit limit Exception or an 1150 Administrative Waiver (MA 97) enter the appropriate 10-digit prior authorization number.</p>
Insurance Company/Dental Benefit Plan Information			
3.	Name, Address, City, State, Zip Code	O	<p>MA does not require that you complete this item.</p>
Other Coverage			
4.	Other Dental or Medical Coverage	A	<p>If there is other dental coverage, check the Yes box and complete items 5–11 below.</p>
5.	<p>Name of Policyholder/Subscriber in #4</p> <p>Name (Last, First, Middle Initial, Suffix)</p>	A	<p>MA does not require that you complete this item unless you have answered Yes to Item No. 4 above.</p> <p>Note: If the beneficiary has another resource available to pay for the service, bill the other resource before billing MA. The available resource(s) is/are obtained through EVS. Also, ask the beneficiary if he/she has any medical/dental resources not listed on EVS.</p> <p>If the beneficiary has Medicare or another resource available to pay for the service, attach a copy of the Explanation of Medicare Benefits</p>

Item No.	Item Name	Item Code	Notes
			<p>(EOMB) statement or other insurance plan’s Explanation of Benefits (EOB) statement to the claim with a paperclip. Verify that the EOB/EOMB contains the approved amount, deductible and coinsurance information, when applicable, the amount paid, and the date of service. Attach the EOB/EOMB to the claim form with a paper clip. Do Not Use Staples.</p> <p>Note: If the beneficiary’s other resource has denied the service or benefits have been exhausted, enter “AT-11” in Block 35 (Remarks).</p>
6.	Date of Birth (MM/DD/CCYY)	O	MA does not require that you complete this item.
7.	Gender	O	MA does not require that you complete this item.
8.	Policyholder/ Subscriber ID # (SSN or ID#)	O	MA does not require that you complete this item.
9.	Plan/Group Number	A	Complete this item ONLY if the available resource is not on the beneficiary’s EVS record.
10.	Patient’s Relationship to Person Named in #5	O	MA does not require that you complete this item.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	A	Complete this item only if the available resource is not on the beneficiary’s EVS record or is a Resource Code 7 (Other Insurance).
Policyholder/ Subscriber Information			
12.	Policyholder/ Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	O	MA does not require that you complete this item.

Item No.	Item Name	Item Code	Notes
13.	Date of Birth (MM/DD/CCYY)	O	MA does not require that you complete this item.
14.	Gender	O	MA does not require that you complete this item.
15.	Policyholder/ Subscriber ID# (SSN or ID#)	O	MA does not require that you complete this item.
16.	Plan/Group Number	O	MA does not require that you complete this item.
17.	Employer Name	O	MA does not require that you complete this item.
Patient Information			
18.	Relationship to Policyholder/ Subscriber in #12 above	O	MA does not require that you complete this item.
19.	Student Status	O	MA does not require that you complete this item.
20.	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	O*	Enter the beneficiary's last name, first name, and middle initial (if any). *If submitting a claim for a newborn under the mother's beneficiary number, you must enter the name of the newborn in this field. If the name is not available, you may use Baby Boy or Baby Girl with the last name.
21.	Date of Birth (MM/DD/CCYY)	O	MA does not require that you complete this item.
22.	Gender	O	MA does not require that you complete this item.
23.	Patient ID/Account Number	M	Enter the beneficiary's 10-digit identification number as it appears on the beneficiary's ACCESS Card. If the beneficiary number is not available, access EVS by using the beneficiary's Social Security Number (SSN) and date of birth

Item No.	Item Name	Item Code	Notes
			(DOB). The EVS response will then provide the 10-digit beneficiary number to complete this item. Eligibility of dental benefits must be verified at each visit.
Record of Services Provided			
24.	Procedure Date (MM/DD/CCYY)	M	<p>Enter the date the service was provided. Use an 8-digit format for all dates (for example, 03012004). Enter a zero to the left of all single-digit numbers.</p> <p>Claims for space maintainers, crowns, and dentures should show the date the appliance was inserted. In the event the beneficiary loses eligibility after the service has been prior authorized and 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 35 — Remarks).</p>
25.	Area of Oral Cavity	A	<p>Enter only one quadrant per claim line.</p> <p>When billing for periodontal services (Procedure Codes D4210 and D4341), enter the appropriate code to identify the quadrant on which the service was provided:</p> <p style="text-align: center;">10 or UR – Upper Right Quadrant 20 or UL – Upper Left Quadrant 30 or LL – Lower Left Quadrant 40 or LR – Lower Right Quadrant</p>
26.	Tooth System	O	MA does not require that you complete this item.

Item No.	Item Name	Item Code	Notes
27.	Tooth Number(s) or Letter(s)	A	<p>Enter only one tooth number or letter per claim line. This item must be completed whenever a particular tooth is involved.</p> <p>Use numerical identification 1 through 32 for permanent teeth; use capital letter identification A through T for primary teeth.</p> <p>For permanent supernumerary teeth, use numerical identification 51 through 82.</p> <p>For primary supernumerary teeth; use capital letter identification AS through TS.</p> <p>You must identify the tooth involved when the claim is for a restoration, tooth extraction, root canal, crown, or dentition related surgical excision.</p> <p>Note: Do not enter quadrant in this block. Quadrant should be entered in Block 25 Area of Oral Cavity.</p>
28.	Tooth Surface	A	<p>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 claim form:</p> <ul style="list-style-type: none"> M – Mesial O – Occlusal D – Distal L – Lingual F – Facial I – Incisal

Item No.	Item Name	Item Code	Notes
29.	Procedure Code	M	<p>Enter the code for the procedure performed. Only those codes listed in the MA Program Fee Schedule are covered by the MA Program.</p> <p>When billing a Primary code with additional related (add-on) codes, the Primary code and the additional add-on code(s) must appear on the same claim. The Primary code MUST appear on the claim first preceding the add-on codes, regardless of where the primary code appears on the claim.</p> <p>Note: Failure to follow this Billing procedure will result in the denial of your claim on edit 5529 “Related Procedures Must be Billed Together”, 5535 “Primary Code Must be Billed Before Add-on Code”, or 5536 “Primary Must be Billed Before Add-on Code (Different)”.</p> <p>Note: Billing for Orthodontic Services Procedure Code D8080 is to be billed in conjunction with first quarter of treatment. Procedure Code D8670 is to be billed for each quarter treatment. Only one treatment quarter may be submitted per line.</p> <p>When billing procedure code D5630 and D5660, the tooth number must be reported in Block 27.</p>

Item No.	Item Name	Item Code	Notes
29a.	Diagnosis Pointer	A	<p>Enter the letter(s) that identify the diagnosis code(s) applicable to the dental procedure in Block 29 Procedure Code.</p> <p>If the service was provided for the primary diagnosis (in Block 34a), enter A. If provided for the secondary diagnosis, enter B. If provided for the third diagnosis, enter C, and for the fourth diagnosis, enter D.</p> <p>Note: The primary diagnosis pointer must be entered first.</p> <p>If you complete Block 29a Diagnosis Pointer, you must also complete Block 34 Diagnosis Qualifier and Block 34a Diagnosis Code(s).</p>
29b.	Quantity	A	Enter the number of services provided.
30.	Description	O	MA does not require that you complete this item.
31	Fee	M	<p>Enter your usual and customary charge to the general public for the service(s) provided in dollars and cents. Example: \$25.00, \$150.00</p> <p>Enter the dollar amount followed by a decimal point and then the cents amount.</p> <p>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.</p>
31a.	Other Fee(s)	O	MA does not require that you complete this item.
32.	Total Fee	O	MA does not require that you complete this item.
Missing Teeth Information			
33.	(Place an 'X' on each missing)	O	MA does not require that you complete this item when billing.
Diagnosis Code List Qualifier			
34.	Diagnosis Qualifier	A	<p>Enter only one value in this Block.</p> <p>Enter B when billing ICD-9 codes.</p>

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			Enter AB when billing ICD-10 codes. If you complete Block 34 Diagnosis Qualifier, you must also complete Block 29a Diagnosis Pointer and Block 34a Diagnosis Code(s).
34a.	Diagnosis Code(s)	A	Enter one valid diagnosis code after each letter (A – D). Enter the primary diagnosis code adjacent to the letter “A”. Enter subsequent diagnosis codes adjacent to the letters “B”, “C” and “D” in sequential order. If you complete Block 34a Diagnosis Code(s), you must also complete Block 29a Diagnosis Pointer and Block 34 Diagnosis Qualifier.
Remarks			
35.	Remarks	A	This item is for additional information relevant to the beneficiary, provider, or service(s) provided. This section may also be used if additional space is needed to explain unusual circumstances or conditions relative to services reported on the claim or as required in any other section of the handbook. If additional space is required, use another 8.5” by 11” sheet of paper and attach it to the claim with a paperclip. Include the beneficiary’s name and 10-digit beneficiary identification number in the upper right-hand corner of each additional sheet. Item 35 MUST be used to report the following information: Services exempt from beneficiary copayment: <ol style="list-style-type: none"> 1. If the service provided was on an emergency basis, enter Emergency. If the service was provided to a pregnant woman, enter Pregnancy . If the service was provided to a resident of a long term care facility, enter Long Term Care Resident . Please refer to the Copayment Desk Reference for a complete listing of all services exempt

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			<p>from beneficiary copayment</p> <p>http://dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005972.pdf</p> <p>Do not enter the Place of Treatment in this Block. Place of Treatment should be entered in Block 38.</p> <p>Resubmission of rejected claims/ Submission of claim adjustments:</p> <ol style="list-style-type: none"> 1. When resubmitting a rejected claim, enter the 13- digit internal control number (ICN) of the original rejected claim and the words Resubmission of Rejected ICN (for example, 1234567890123 Resubmission of Rejected ICN). 2. When submitting a claim adjustment of a previously approved claim, enter the 13- digit ICN of the last approved claim and the letters ADJ (for example, ADJ 1000345689001 01). 3. When submitting a claim adjustment for a previously approved claim adjustment, enter the 13-digit ICN of the last approved adjustment and the letters ADJ (for example, ADJ 1000445689001) <p>When submitting a claim adjustment, always submit the adjustment as the original claim should have been submitted (do NOT remove any information or claim lines from the adjustment claim). Enter the reason for the adjustment. If additional space is required, use a separate 8.5” by 11” sheet of paper and attach it to the claim form with a paper clip.</p> <p>Third Party Insurance Denial: If there is third party insurance denial or benefits are exhausted, enter AT-11 in this block.</p>

Item No.	Item Name	Item Code	Notes
Authorizations			
36.	Patient/Guardian signature and Date	M	<p>All claims must have either the beneficiary’s signature or the words Signature Exception appearing in this item. If utilizing signature exception, the beneficiary’s signature must be obtained on the Encounter Form (MA 91).</p> <p>The purpose of the beneficiary’s signature is to certify that the beneficiary received the service from the provider indicated on the claim and that the person listed on the Pennsylvania ACCESS Card is the individual who received the service provided.</p> <p>Note: Please refer to Section 6 of the Provider Handbook for additional information on obtaining beneficiary’s signatures.</p>
37.	Subscriber signature and Date	LB	Do not complete this item.
Ancillary Claim/Treatment Information			
38.	Place of Treatment	M	<p>Enter the 2-digit Place of Treatment Code for Dental Claims to identify where the service was provided.</p> <p>11 = Office 12 = Home 21 = Inpatient Hospital 22 = Outpatient Hospital 23 = Emergency Room 24 = Ambulatory Surgical Center/Short Procedure Unit 31 = Skilled Nursing Facility 32 = Nursing Facility 99 = Community</p> <p>Note: All claim lines must be provided in the same place of treatment.</p>

Item No.	Item Name	Item Code	Notes
39.	Number of Enclosures	O	MA does not require that you complete this item.
40.	Is Treatment for Orthodontics?	O	MA does not require that you complete this item.
41.	Date Appliance Placed (MM/DD/CCYY)	O	MA does not require that you complete this item.
42.	Months of Treatment Remaining	O	MA does not require that you complete this item.
43.	Replacement of Prosthesis?	O	MA does not require that you complete this item.
44.	Date Prior Placement (MM/DD/CCYY)	O	MA does not require that you complete this item.
45.	Treatment Resulting from	A	<p>Mark the Occupational Illness/injury box to indicate that the treatment is the result of an occupational illness or injury.</p> <p>Mark the Auto accident box to indicate that the treatment is the result of an automobile accident.</p> <p>Mark the Other accident box to indicate that the treatment is the result of non-auto accident.</p> <p>If the treatment is not the result of occupational illness/injury, auto or other type of accident, leave blank.</p>
46.	Date of Accident (MM/DD/CCYY)	A	Enter the date of the accident if the treatment is the result of an accident.
47.	Auto Accident State	A	If the treatment was the result of an automobile accident, enter the two-character State code indicating where the accident occurred.
Billing Dentist Or Dental Entity			
48.	Name, Address, City, State, Zip Code	O	Enter the name of the enrolled group, corporation, or organization DESIGNATED TO RECEIVE PAYMENT. THIS MAY BE the same or a different provider RENDERING the SERVICE for the service provided. The

Item No.	Item Name	Item Code	Notes
			<p>payee must be enrolled with the Department and must be listed as payee on the individual dentist’s Provider Notice Information Form.</p>
49.	NPI Number	M	<p>Please enter the NPI number of the enrolled group, corporation, or organization DESIGNATED TO RECEIVE PAYMENT for the service provided. THIS MAY BE the same as or different from the provider RENDERING the SERVICE.</p> <p>Note: When submitting a claim for payment of a prior authorized service, the NPI number entered in this Block must match the corresponding Block on the approved prior authorization for payment.</p>
50.	License Number	O	<p>MA does not require that you complete this item.</p>
51.	SSN or TIN	O	<p>MA does not require that you complete this item.</p>
52.	Phone Number	O	<p>Enter the telephone number of the enrolled group, corporation, or organization other than the individual provider of the service, designated to receive payment for the service provided.</p>
52A.	Additional Provider ID	M	<p>Enter the 9-digit PROMISe™ ID number and the 4-digit service location code of the enrolled group, corporation OR organization designated to receive payment. This may be the same as or different from the provider rendering the service. Do not use slashes, hyphens or spaces.*Payment will be made to the ID number appearing in this item.</p> <p>Note: When submitting a claim for payment of a prior authorized service, the 9-digit PROMISe™ ID number and the 4-digit service location code entered in this Block must match the corresponding Block on the approved prior authorization for payment.</p>

Item No.	Item Name	Item Code	Notes
Treating Dentist and Treatment Location Information			
53.	Signature (Treating Dentist) and Date (MMDDYYYY)	M	<p>The provider requesting payment for the service must sign and date the claim. The signature certifies that the service has been provided in accordance with MA regulations. A signature stamp is acceptable if the provider authorizes its use and assumes responsibility for the information on the claim.</p> <p>If submitting by computer-generated pin-fed claim forms, diskette, or magnetic tape, the Dentist's signature field can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claims.</p>
54.	NPI Provider ID	M	Please enter the NPI number of the treating dentist.
55.	License Number	M	<p>Enter the complete alpha numeric license number of the dentist rendering the service.</p> <p>Example: DS-012345L</p> <p>Do Not Enter the PROMISe™ ID Number.</p> <p>Note: When submitting a claim for payment of a prior authorized service, the complete alpha numeric license number entered in this Block must match the corresponding Block on the approved prior authorization for payment.</p>
56.	Address, City, State, Zip Code	M	Enter the address (Street Address, City, State, and ZIP Code) where the service was performed.
56a.	Provider Specialty Code	O	MA does not require that you complete this item
57.	Phone Number	O	Enter the telephone number of the rendering/treating dentist that provided the service.
58.	Additional Provider ID	O	MA does not require that you complete this item.