2012 ADA Dental Claim Form Instructions

June 9, 2015

Change history

Date (mm/dd/yyyy)	Description of Changes	Impact
02/11/2014	Initial version	
07/16/2014	Updated instructions for fields 29a and 32	Pages 2 and 5
06/09/2015	Clarified current instructions for void and adjustment requests; updated requirements for fields 13 and 14; updated requirements and instructions for fields 16 and 17	Pages 1, 2 and 4

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Electronic claims

These instructions address Nevada Medicaid *paper* claim requirements. For questions on submitting an *electronic* claim or receiving an electronic remittance advice, contact your Service Center directly.

For EDI registration and other EDI questions, call the EDI coordinator at (877) 638-3472 or see the EDI page online at www.medicaid.nv.gov.

Claim mailing address

Keep the yellow (bottom) copy of the claim form for your records and mail the white (top copy) to:

Hewlett Packard Enterprise
ADA
PO Box 30042
Reno, NV 89520-3042

Third party liability

Paper claims with TPL must be submitted within 365 days from the date of service, and with one claim line per claim form. A copy of each EOB must be attached to *each* claim form.

TPL Example 1

To bill four procedures when there is a primary carrier *and* Medicaid coverage, submit four claim forms – each with *one* claim line completed. Attach the primary carrier's EOB to *each* ADA form. In this example, you would need four copies of the EOB.

TPL Example 2

To bill two procedures when there is a primary payer, a secondary payer and Medicaid coverage, submit two claim forms – both with one claim line completed. Attach a copy of each carrier's EOB to both ADA forms. You will need two copies of each EOB.

Void and adjustment requests

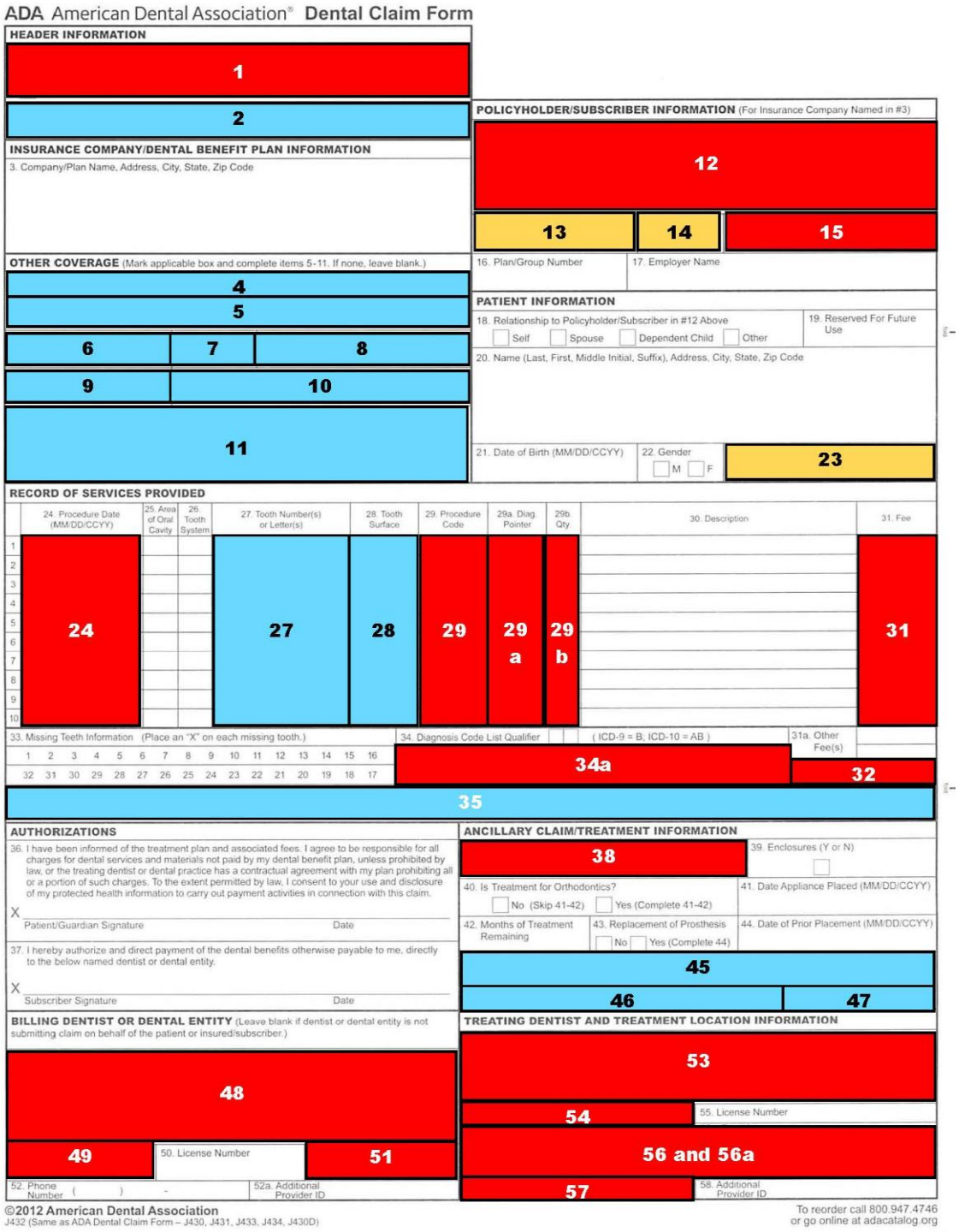
Submit void and adjustment requests on paper with a cover letter clearly explaining why the claim needs to be voided or adjusted. Include the ICN and a contact name and phone number. Mail to Hewlett Packard Enterprise at the address above to the attention of Customer Service. Adjustment requests must include an original, signed paper claim.

Questions

If you have questions, please call (877) 638-3472 to reach the Hewlett Packard Enterprise Customer Service Center. Hewlett Packard Enterprise offers provider and billing staff training free of charge. Check out web announcements at www.medicaid.nv.gov for dates and times.

Required and conditional claim fields

The 2012 ADA claim form is shown below with *required* fields shaded red, *conditional* fields shaded blue and *recommended* fields shaded yellow. On a black and white print, *required* fields will appear darkest. Note: The shaded claim form below is for claims only; it does not apply to prior authorization (PA) requests.



Hewlett Packard Enterprise

Claim form instructions

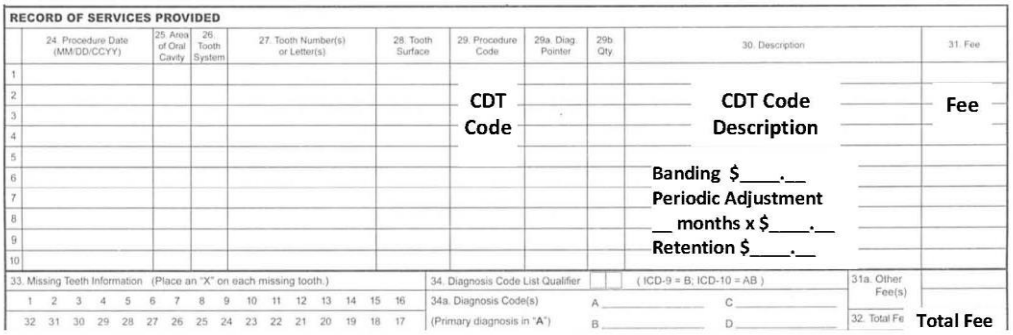
The following table provides requirements for submitting claims to Hewlett Packard Enterprise.

Prior authorization (PA) instructions

In the following table, fields marked with an asterisk (1, 12, 15, 27-29, 30, 31, 33, 35, 38, 40-46, 48, 54, 56 and 57) are *required* or *conditional* when requesting PA. Instructions for requesting PA are provided only when they differ from instructions for submitting a claim.

Field	Requirement	Field name and instructions
1*	**Required**	**Type of transaction:** Check *statement of actual services*. Also check *EPSDT/Title XIX* if this claim is for a recipient under age 21. **PA instructions:** Check *request for predetermination/preauthorization*. **Retrospective authorization is not available for non-emergency dental services. In the case of an emergency, a retrospective request may be submitted the next business day after service is rendered.**
2	**Conditional**	**Predetermination/Preauthorization number:** If you are submitting a claim for a service that was prior authorized, enter the 11-digit authorization number in this field. You may enter only one authorization number per claim form.
3	Not required	Company/Plan Name, Address, City, State, ZIP Code
4	**Conditional**	**Other coverage:** Mark the box after "Dental?" or "Medical?" when a patient has coverage under any other dental or medical plan. When either box is marked, complete fields 5 through 11 for the applicable benefit plan. If both "Dental" and "Medical" are marked, enter information about the dental benefit plan in fields 5 through 11.
5	**Conditional**	**Name of Policyholder/Subscriber with other coverage indicated in #4 (Last, First, Middle Initial, Suffix):** If the recipient has other coverage through a spouse, or if a child through both parents, enter the name of the policy holder of the other coverage.
6	**Conditional**	**Date of birth (MM/DD/YYYY):** If there is TPL, enter the birth date of the policy holder.
7	**Conditional**	**Gender:** If there is TPL, mark *M* for male or *F* for female to specify the policy holder's gender.
8	**Conditional**	**Policyholder/Subscriber identifier (SSN or ID#):** If there is TPL, enter the policy holder's unique identifier for that policy.
9	**Conditional**	**Plan/Group number:** Enter the group plan/policy number of the person named in Field 5.

Field	Requirement	Field name and instructions
10	**Conditional**	**Patient's relationship to person named in Field 5:** Mark the relationship of the recipient to the policy holder identified in Field 5.
11	**Conditional**	**Other insurance company/dental benefit plan Name, Address, City, State, and ZIP Code:** If the recipient has other insurance, enter the name and address of the other carrier.
12*	**Required**	**Subscriber/Policyholder name (Last, First, Middle Initial, Suffix), Address, City, State, and ZIP Code:** Enter the recipient's full name and complete address.
13	**Recommended**	**Date of birth (MM/DD/YYYY):** Enter the recipient's birth date in MM/DD/YYYY
14	**Recommended**	**Gender:** Mark *M* for male or *F* for female to specify the recipient's gender.
15*	**Required**	**Policyholder/Subscriber identifier (SSN or ID#):** Enter the recipient's 11-digit recipient ID as it appears on their Medicaid card.
16	Not required	Plan/Group number: This field is not currently available.
17	Not required	Employer name: This field is not currently available.
18	Not required	Relationship to policyholder/subscriber in Field 12 above
19	Not required	Reserved for future use
20	Not required	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code
21	Not required	Date of Birth (MM/DD/YYYY):
22	Not required	Gender
23	**Recommended**	**Patient ID/Account # (Assigned by Dentist):** Enter the provider's in-house account number for the recipient. Although not required, completing this field is highly recommended for future tracking purposes. The account number entered in this field will also appear on your remittance advice.
24	**Required**	**Procedure date (MM/DD/YYYY):** Enter the date the service was provided (MM/DD/YYYY format).
25	Not required	Area of oral cavity
26	Not required	Tooth system
27*	**Conditional**	**Tooth number(s) or letter(s):** When the procedure directly involves a tooth or range of teeth, enter tooth number(s) 1-32 for permanent dentition, 51-82 for supernumerary teeth, A-T for primary dentition or AS-TS for primary supernumerary teeth. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. When reporting a range of teeth, use a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4, 7-10, 22-27), or use commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). To report a quadrant, enter UL, UR, LL or LR.

Field	Requirement	Field name and instructions
28*	**Conditional**	**Tooth surface:** When applicable, enter a tooth surface code. The following single letter codes are used to identify surfaces: *B* for Buccal, *D* for Distal, *F* for Facial, *I* for Incisal, *L* for Lingual, *M* for Mesial and *O* for Occulusal.
29*	**Required**	**Procedure code:** Enter the appropriate procedure code for the service provided. Refer to the *Code on Dental Procedures and Nomenclature* book that was in effect on the Procedure Date entered in Item 24. **PA instructions:** Enter the procedure code of the requested service.
29a	**Required**	**Diagnosis Code Pointer:** Enter the letter(s) from **Field 34a** that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29b	**Required**	**Quantity:** Enter the number of times (01-99) the procedure identified in Field 29 is delivered to the patient on the date of service shown in Field 24. The default value is "01."
30*	Not required for claims, **conditional for PA**	**Description** **PA instructions:** To request orthodontic services, enter a price breakdown in the Description column as described/shown below: • *Banding*, followed by your usual and customary charge for banding • *Periodic Adjustment*, the number of months in the treatment, x (the multiplication sign), and your usual and customary charge per visit. • *Retention*, followed by your total charge for retainers. 
31*	**Required**	**Fee:** Enter your usual and customary charge for each procedure.
31a	Not Required	Other fee(s)
32*	**Required**	**Total Fee:** When Medicaid is the primary payer, add all rows in Field 31 and enter the total here. If the recipient has TPL, enter the recipient's legal obligation to pay. Do not include write-off or contractual adjustment amounts. **PA instructions:** To request orthodontic services, enter the total fee for banding, periodic adjustment and retention. The total fee should match the amount entered in the Fee column for Field 31.

Field	Requirement	Field name and instructions
33	Not required for claims; required for PA	Missing Teeth Information: **PA instructions:** Field 33 is required when requesting prior authorization.
34	Not Required	Diagnosis Code List Qualifier:
34a	**Required**	**Diagnosis Code(s):** Enter up to four applicable diagnosis codes after each letter (A – D). The primary diagnosis code is entered adjacent to the letter "A."
35*	**Conditional**	**Remarks:** If the recipient has other coverage, enter the words, *TPL Amount* followed by the total payment received from the other carrier. Attach a copy of the other carrier's EOB. Do not enter previous payment from Medicaid in this field. List only payments received by carriers other than Medicaid. When submitting TPL, submit only one dental code per claim. **PA instructions:** Describe the medical necessity for the procedure.
36	Not required	Patient/Guardian Signature, Date
37	Not required	Subscriber Signature, Date
38*	**Required**	**Place of treatment:** Enter the 2-digit Place of Service Code for Professional Claims. Frequently used codes are 11 = office; 12 = home; 21 = inpatient hospital; 22 = outpatient hospital; 31 = skilled nursing facility; 32 = nursing facility. **PA instructions:** Specify where the services will be performed.
39	Not required	**Number of enclosures**
40*	Not required for claims, **conditional for PA**	Is treatment for orthodontics? **PA instructions:** If the request is for orthodontics, check *Yes*. Otherwise, check *No*.
41*	Not required for claims, **conditional for PA**	Date appliance placed (MM/DD/YYYY) **PA instructions:** When orthodontic treatment was initiated by another dentist or orthodontist, enter the date the appliance was placed.
42*	Not required for claims, **conditional for PA**	Months of treatment remaining **PA instructions:** When orthodontic treatment was initiated by another dentist or orthodontist, enter the number of months of treatment remaining.
43*	Not required for claims, **conditional for PA**	Replacement of prosthesis? **PA instructions:** Check *Yes* if requesting replacement for an existing prosthesis. Otherwise, check *No*.

Field	Requirement	Field name and instructions
44*	Not required for claims, **conditional for PA**	Date prior placement (MM/DD/YYYY) **PA instructions:** If requesting a replacement for an existing prosthesis, enter the date of prior placement.
45*	**Conditional**	**Treatment resulting from**: If treatment/services were provided as a result of an occupational illness/injury, auto accident or other accident, check the appropriate box and complete Item 46. If treatment is a result of an auto accident, also complete Item 47.
46*	**Conditional**	**Date of accident (MM/DD/YYYY):** Enter the date on which the accident noted in Item 45 occurred.
47	**Conditional**	**Auto accident state:** Enter the state in which the auto accident noted in Item 45 occurred.
48*	**Required**	**Address, City, State, ZIP Code:** Enter the name and address of the billing provider. **The full, 9-digit ZIP code is required to process the claim.**
49	**Required**	**NPI (National Provider Identifier):** Enter the 10-digit NPI of the billing provider or group.
50	Not required	License number
51	**Required**	**SSN or TIN:** Enter the federal tax ID number of the billing provider or entity. If a billing provider does not have a federal tax ID number, a Social Security Number may be used.
52	Not required	Phone number
52a	Not required	Additional provider ID
53	**Required**	**Certification:** The provider who rendered the service(s) must sign and date this field. Rubber-stamped and electronic signatures are acceptable. The provider's license number is not required in this field.
54*	**Required**	**NPI (National Provider Identifier):** Enter the NPI of the servicing provider.
55	Not required	License number
56*	**Required**	**Address, City, State, ZIP Code:** Enter the address at which the services were rendered. **The full, 9-digit ZIP code is required to process the claim.** **PA instructions**: Enter the address at which services will be rendered.
56a	**Required**	**Treating provider specialty:** Enter the servicing provider's taxonomy code.
57*	**Required**	**Phone number:** Enter the servicing provider's phone number.
58	Not required	Additional provider ID