

471-000-88 Nebraska Medicaid Dental Program completion instructions for the 2006, 2002, 1999 and 1994 ADA Dental Claim Forms

Throughout these instructions, the term Department is used to mean the Department of Health and Human Services Finance and Support, or effective July 1, 2007, the Department of Health and Human Services. Also effective July 1, 2007, the Division of Medicaid will become the Division of Medicaid and Long-Term Care. The address remains the same.

The instructions in this appendix apply when submitting a prior authorization request and when billing Nebraska Medicaid.

- Instructions for the 2006 ADA form are on page 5 of 19.
- Instructions for the 2002 ADA form are on page 9 of 19.
- Instructions for the 1999 ADA form are on page 13 of 19.
- Instructions for the 1994 ADA form are on page 17 of 19.
- Electronic Claims: Dental services may be billed to Nebraska Medicaid using the standard electronic Health Care Claim: Dental transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Prior Authorization: To request prior authorization, complete the data elements designated with one asterisk (*). Send TWO copies of the ADA claim form and required documentation to:

Medicaid Division
Department of Health and Human Services Finance and Support
P.O. Box 95026
Lincoln, NE 68509

- Electronic Submission: Dental prior authorization requests may be requested and issued using the standard electronic Health Care Service Review – Request for Review and Response (ASC X12N 278). For instructions, see Standard Electronic Transactions at 471-000-50.

Payment: To claim payment for completed services, complete the data elements designated with two asterisks (**) and one asterisk (*). Send ONE copy of the ADA claim form to:

Medicaid Claims Processing
Department of Health and Human Services Finance and Support
P.O. Box 95026
Lincoln, NE 68509

General Billing Instructions:

- Nebraska Medicaid accepts the Universal/National System tooth numbering system. Only one tooth number or letter will be processed per line.

Supernumerary teeth in the permanent dentition are identified in the ADA Universal/National Tooth Designation System by the number 51 through 82 beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to

the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32).

Supernumerary teeth in the primary dentition are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").

- Only one tooth number or letter will be processed per line.
- A MAXIMUM of 15 lines of service can be submitted on a claim. A second form must be completed if treatment exceeds 15 lines of service.
- Each page/claim must have a "Total Fee" for that page/claim. DO NOT carry forward a balance from a previous page/claim.
- When submitting a claim for payment, if some services listed on the page/claim were not completed cross out those items and correct the "Total Fee" for that page/claim.
- DO NOT list services that have a \$0.00 fee.

Eligibility: Medicaid eligibility and third party resources may be verified from:

1. The client's monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

Unborn-Ineligible Mother of an Eligible Unborn: The mother is eligible for dental services under the unborn-Medicaid number during and for a period of time after the pregnancy ends. Medicaid coverage on the unborn-Medicaid number ends on the last day of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. All prior authorization regulations apply.

Share of Cost: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

Presumptive Eligibility: Certain Medicaid clients are issued a Nebraska Medicaid Presumptive Eligibility Application at the time the client is determined eligible by a qualified presumptive eligibility provider. Presumptive eligibility may begin or end on any day of the month. For information regarding the Nebraska Medicaid Presumptive Eligibility document see 471-000-123.

Telehealth: The 1999 ADA dental claim form must be used when billing Telehealth services. See the instructions on page 12 of 19 for Telehealth billing instructions. Medicaid regulations for Telehealth services are in 471 NAC 1-006.

Encounter Visits: Tribal/IHS dental clinics and FQHC dental clinics – submit code T1015 when billing an encounter. The claim must also contain the ADA procedure code for service(s) provided.

Third Party Resources: Claims for services provided to clients with third party resources (that is, private health/casualty insurance) must be billed to the third party payor according to the payor's instructions. After the payment determination by the third party payor is made, the provider may submit the claim to Nebraska Medicaid. A copy of the explanation of benefits, remittance advice, denial, or other documentation from the third party resource must be submitted with the claim. Regulations for Third Party Resources (TPR) policy are in 471 NAC 3-004.

Medicaid Claim Status: The status of Nebraska Medicaid claims submitted for payment can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277), or by contacting Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln). Medicaid Inquiry hours are 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.

Medicaid Prior Authorization Status: The status of a prior authorization can be obtained by calling 402-471-9771.

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Medical and Surgical Services of a Dentist or Oral Surgeon: Medically necessary services not covered in 471 NAC 6-000 - Dental services may qualify for coverage as a Medicaid Physician service. Regulations for Physician services are in 471 NAC 18-000.

Services are billed on a CMS-1500, "Health Insurance Claim Form" (see 471-000-62) or electronically using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Physician services are billed with HCPCS/CPT procedure codes.

Client enrollment in Nebraska Health Connection managed care plans should be checked before providing services that will be billed as Physicians services. See 471-000-122 for a listing of managed care plans and vendors.

2006 ADA Dental Claim Form: Data elements not listed are not required by Nebraska Medicaid.

1. TYPE OF TRANSACTION: Check the appropriate box. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box "Request for Predetermination/Preauthorization."
- 4 – 11. Complete if the patient has other dental coverage in addition to Medicaid.

POLICYHOLDER/SUBSCRIBER INFORMATION:

- 12 – 14. Complete if the patient has other dental coverage in addition to Medicaid.
- *15. POLICYHOLDER/SUBSCRIBER IDENTIFIER (SSN OR ID#): Enter the patient's 11-digit Medicaid identification number (example: 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (See 471 NAC 1-002.02K3).

PATIENT INFORMATION:

- *20. NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX), ADDRESS, CITY, STATE, ZIP CODE: Enter the name of the patient.
- *21. DATE OF BIRTH (MM/DD/CCYY): Enter the patient's month, day and year of birth.
22. GENDER: This applies to the patient and is necessary for identification of the patient.
23. PATIENT ID/ACCOUNT # (ASSIGNED BY DENTIST): (Optional) You may enter the dental office patient account number. It will appear on the "Remittance Advice" report issued by the Department.

RECORD OF SERVICES PROVIDED:

- *24. PROCEDURE DATE (MM/DD/CCYY): Complete when the service has been performed. Leave blank if the claim is for preauthorization. Procedure codes listed without a date of service can not be processed for payment.
- *27. TOOTH NUMBER(S) OR LETTER(S): Enter the appropriate tooth number or letter when the procedure directly involves a tooth.
- *28. TOOTH SURFACE: Designate tooth surface(s) when procedure code reported on that line directly involves one or more tooth surfaces.
- *29. PROCEDURE CODE: Enter the appropriate 5-digit ADA procedure code.
- *30. DESCRIPTION: Use ADA dental procedure description for the service. For miscellaneous codes include a description of the service provided.

- *31. FEE: Report the dentist's full fee for the procedure except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of prior authorized orthodontic treatment, the fee must be the amount prior authorized on the MC-9D Dental Treatment and Prior Authorization document.
- **32. OTHER FEE: Enter any payment made, due, or obligated from other sources for services listed on the claim. Other sources include health insurance, liability insurance, share of cost, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the providers billed charge and the Medicaid fee in this data element.
- **33. TOTAL FEE: This total is the amount for all services listed on that claim less any amount listed in data element 32.
- *34. MISSING TEETH INFORMATION: Place an "X" on each missing tooth.
- 35. REMARKS: Convey additional information for a procedure code that requires a report, or additional information necessary to process the claim for payment. If space is inadequate, attach a separate sheet.

ANCILLARY CLAIM/TREATMENT INFORMATION:

- *38. PLACE OF TREATMENT: Check the appropriate place of treatment.
- *39. NUMBER OF ENCLOSURES (00 TO 99): Indicate the number of radiographs, oral image(s), or model(s) sent with the claim.
- *40. IS TREATMENT FOR ORTHODONTICS: Indicate whether prior authorization request is for orthodontics.
- *41. DATE APPLIANCE PLACED: Complete if orthodontic treatment was started prior to Medicaid eligibility.
- *42. MONTHS OF TREATMENT REMAINING: Complete if orthodontic treatment was started prior to Medicaid eligibility.
- *43. REPLACEMENT OF PROSTHESIS?: Complete when requesting prosthetic appliances.
- *44. DATE OF PRIOR PLACEMENT: Date of prior placement is needed to review prior authorization requests for replacement dentures or partials and when submitting for payment for dentures or partials.
- 45. TREATMENT RESULTING FROM: If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box.
- 46. DATE OF ACCIDENT: Enter the date on which the accident noted in data element #45 occurred.

47. AUTO ACCIDENT STATE: Enter the state in which the auto accident noted in data element #45 occurred.

BILLING DENTIST OR DENTAL ENTITY:

- *48. NAME, ADDRESS, CITY, STATE, ZIP CODE: Enter the individual dentist's name or the name of the group practice/corporation, street address, city, state and zip code. This address must be the same as the address on your Medicaid provider agreement.
49. NPI (NATIONAL PROVIDER IDENTIFIER): Optional. Enter the NPI number of the billing provider.
- *50. LICENSE NUMBER: If the billing dentist is a solo/individual practice, enter the dentist's license number. If a billing entity (e.g., corporation) is submitting the claim, leave blank.
- *52. PHONE NUMBER: Enter the business phone number.
- *52A. ADDITIONAL PROVIDER ID: Enter the 11-digit Nebraska Medicaid provider number as assigned by the Department (example 123456789-01)

TREATING DENTIST AND TREATMENT LOCATION INFORMATION:

- **53. CERTIFICATION: The dentist or authorized representative must sign and date the claim form. A signature stamp, computer generated or typed signature will be accepted, but the statement "signature on file" cannot be accepted. Unsigned claims can not be processed for payment.
- **55. LICENSE NUMBER: Enter the license number of the dentist providing the services listed on the claim.
- **56. ADDRESS, CITY, STATE, ZIP CODE: Enter the physical location where the treatment was rendered. If treatment was performed in a extended care facility, hospital, or ambulatory surgical center, include the name of the facility with the address. If the services were performed in the person's home, state "Person's Home," and provide the address.
- **58. ADDITIONAL PROVIDER ID: Complete if enrolled as a group provider. Enter the Social Security number of the dentist providing the services listed on the claim. Payment is made to the provider ID in data element 52A. (Optional if data element #55 has been completed.)

2002 ADA Dental Claim Form: Data elements not listed are not required by Nebraska Medicaid.

1. TYPE OF TRANSACTION: Check the appropriate box, "Statement of Actual Services", or "Request for Predetermination/Preauthorization."

- 4 – 11. Complete if the patient has other dental coverage in addition to Medicaid.

- *15. SUBSCRIBER IDENTIFIER: Enter the patient's 11-digit Medicaid identification number (example: 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (See 471 NAC 1-002.02K3).

- *20. NAME: Enter the full name (first, middle initial, last name) of the patient.

- *21. DATE OF BIRTH: Enter the patient's month, day, and year of birth.

- *22. GENDER: Necessary for identification purposes.

23. PATIENT ID/ACCOUNT #: (Optional) You may enter the dental office patient account number. It will appear on the "Remittance Advice" report issued by the Department.

- *24. PROCEDURE DATE: Complete when the service has been performed. Procedure codes listed without a date of service cannot be processed for payment.

- *27. TOOTH NUMBER(S) OR LETTER(S): Enter the appropriate tooth number or letter when the procedure directly involves a tooth.

- *28. TOOTH SURFACE: Designate tooth surface(s) when procedure code reported on that line directly involves one or more tooth surfaces.

- *29. PROCEDURE CODE: Enter the appropriate 5 digit ADA procedure code.

- *30. DESCRIPTION: Use ADA dental procedure descriptions for the service. For miscellaneous codes include a description of the service provided.

- *31. FEE: Report the dentist's full fee for the procedure except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of prior authorized orthodontic treatment the fee must be the amount prior authorized on the MC-9D, Dental Treatment and Prior Authorization document.

- **32. OTHER FEE(S): Enter any payment made, due, or obligated from other sources for services listed on this claim. Other sources include health insurance, liability insurance, excess income, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the providers billed charge and the Medicaid allowable fee in this data element.

- **33. TOTAL FEE: This total is the amount for all services listed less any amount listed in data element 32.
- *34. Place an "X" on each missing tooth.
- 35. REMARKS: Use to indicate any information which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, attach a separate sheet.
- 36 – 37. Completion not required. Medicaid payment is made to the dental provider. Payment can not be made to the Medicaid patient.
- *38. PLACE OF TREATMENT: Check the appropriate place of treatment.
- *39. NUMBER OF ENCLOSURES: Indicate the number of radiograph(s), oral image(s), or model(s) sent with the claim.
- *40. IS TREATMENT FOR ORTHODONTICS: Indicate whether prior authorization request is for orthodontics.
- *41. DATE APPLIANCE PLACED: Complete if orthodontic treatment was started prior to Medicaid eligibility.
- *42. MONTHS OF TREATMENT REMAINING: Complete if orthodontic treatment was started prior to Medicaid eligibility.
- *43. REPLACEMENT OF PROSTHESIS: Complete when requesting prosthetic appliances.
- *44. DATE PRIOR PLACEMENT: Date of prior placement is needed to review prior authorization requests for replacement dentures or partials, and when submitting for payment for dentures or partials.
- 45. TREATMENT RESULTING FROM: If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box.
- 46. DATE OF ACCIDENT: Enter the date on which the accident noted in data element #45 occurred.
- 47. AUTO ACCIDENT STATE: Enter the state in which the auto accident noted in data element #45 occurred.
- *48. BILLING DENTIST OR DENTAL ENTITY: Enter the individual dentist's name or the name of the group practice/corporation, street address, city, state, and zip code. This address must be the same as the address on your Medicaid provider agreement.
- *49. BILLING DENTISTS PROVIDER I.D.: Enter the eleven-digit Nebraska Medicaid provider number as assigned by the Department (example 123456789-01).

- **53. TREATING DENTIST - Signature: The dentist or authorized representative must sign and date the claim form. A signature stamp, computer generated or typed signature will be accepted, but the statement "signature on file" cannot be accepted. Unsigned claims can not be processed for payment.
- **54. TREATING DENTIST PROVIDER ID: Complete if enrolled as a group provider. Enter the Social Security number of the dentist providing the services listed on the claim. Payment is made to the provider I.D. in data element #49. ((Optional if data element 55 has been completed.))
- **55. TREATING DENTIST LICENSE NUMBER: Enter the license number of the dentist providing the services listed on the claim.
- **56. ADDRESS, CITY, STATE, ZIP CODE: Enter the full address where treatment was performed. If treatment was performed in a extended care facility, hospital, or ambulatory surgical center, include the name of the facility with the address. If the services were performed in the person's home, state "Persons Home," and provide the address.
- *57. PHONE NUMBER: Enter the treating dentist office telephone number, including the area code.

Dental Claim Form

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1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		Specialty (see backside)		3. Carrier Name	
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT		Prior Authorization #		4. Carrier Address	
				5. City	6. State
				7. Zip	

PATIENT	8. Patient Name (Last, First, Middle)		9. Address		10. City	11. State
	12. Date of Birth (MM/DD/YYYY) / /		13. Patient ID #		14. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
	15. Phone Number ()		16. Zip Code		17. Relationship to Subscriber/Employer: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
				18. Employer/School Name _____ Address _____		

SUBSCRIBER / EMPLOYEE	19. Subs./Emp. ID#/SSN#		20. Employer Name		21. Group #	
	22. Subscriber/Employer Name (Last, First, Middle)					
	23. Address			24. Phone Number ()		
	25. City		26. State	27. Zip Code		
	28. Date of Birth (MM/DD/YYYY) / /		29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		30. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
	31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical					
32. Policy #						
33. Other Subscriber's Name						
34. Date of Birth (MM/DD/YYYY) / /		35. Sex <input type="checkbox"/> M <input type="checkbox"/> F		36. Plan/Program Name		
37. Employer/School Name _____ Address _____						
38. Subscriber/Employer Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student						
39. 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 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 under applicable law, I authorize release of any information relating to this claim. X _____ Signed (Patient/Guardian) _____ Date (MM/DD/YYYY)						
40. Employer/School Name _____ Address _____						
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X _____ Signed (Employee/subscriber) _____ Date (MM/DD/YYYY)						

BILLING DENTIST	42. Name of Billing Dentist or Dental Entity		43. Phone Number ()		44. Provider ID #		45. Dentist Soc. Sec. or I.I.N.		
	46. Address				47. Dentist License #		48. First visit date of current series: Date		
	49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other		50. City		51. State	52. Zip Code		53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No	
	54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No				55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No		56. If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____		
	57. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes				58. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither				
	Brief description and dates _____				Brief description and dates _____				

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans - List teeth in order										Admin. Use Only																
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee																			
60. Identify all missing teeth with "X"																										
Permanent					Primary					Total Fee																
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	Payment by other plan
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable
61. Remarks for unusual services										Deductible																
										Carrier %																
										Carrier pays																
										Patient pays																

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. X _____ Signed (Treating Dentist) _____ License # _____ Date (MM/DD/YYYY)			63. Address where treatment was performed		
		64. City	65. State	66. Zip Code	

1999 ADA Dental Claim Form:

1. DENTIST'S PRE-TREATMENT ESTIMATE, OR DENTIST'S STATEMENT OF ACTUAL SERVICES: Check the appropriate box.
- * 8. PATIENT NAME: Enter the full name (first, middle initial, last name) of the patient.
- * 12. PATIENT DATE OF BIRTH: Enter the patient's month, day, and year of birth.
13. PATIENT ID#: (Optional) You may enter the dental office patient account number. It will appear on the "Remittance Advice" report issued by the Department.
- * 14. SEX: Necessary for identification purposes.
- * 19. SUBS/EMP. ID#/SS#: Enter the patient's 11-digit Medicaid identification number (example: 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (See 471 NAC 1 -002.02K3).
- 31-41. IS PATIENT COVERED BY ANOTHER PLAN: Complete if the patient has other dental coverage in addition to Medicaid.
- * 42. NAME OF BILLING DENTIST OR DENTAL ENTITY: Enter the individual dentist's name or the name of the group practice/corporation responsible for billing.
- * 43. PHONE NUMBER: Enter the office telephone number, including area code.
- * 44. PROVIDER ID#: Enter the 11-digit Nebraska Medicaid provider number as assigned by the Department (example 123456789-01).
- ** 45. DENTIST SOCIAL SECURITY OR T.I.N.: Complete if enrolled as a group provider. Enter the Social Security number of the dentist providing the services listed on the claim. Payment is made to the provider I.D. in data element #44. (Optional if data element #47 has been completed.)
- * 46. ADDRESS: Enter the provider's street address.
- ** 47. DENTIST LICENSE #: Enter the license number of the dentist providing the services listed on the claim.
48. FIRST VISIT DATE OF CURRENT SERIES: Enter the first date of treatment.
- * 49. PLACE OF TREATMENT, OFFICE, HOSPITAL, EXTENDED CARE FACILITY (ECF), OTHER: Check the appropriate place of treatment. IF BILLING TELEHEALTH SERVICES, CHECK "OTHER."
- * 50-52. CITY, STATE, ZIP CODE: Self-explanatory.

- * 53. RADIOGRAPHS OR MODELS ENCLOSED? Indicate whether radiograph(s) or models are enclosed and the number enclosed.
- * 54. IS TREATMENT FOR ORTHODONTICS? YES, NO. IF SERVICES ALREADY COMMENCED: DATE APPLIANCE PLACED, TOTAL MONTHS OF TREATMENT REMAINING: Complete if orthodontic treatment was started prior to Medicaid eligibility.
- * 55. IF PROSTHESIS (CROWN, BRIDGE, DENTURES), IS THIS INITIAL PLACEMENT? YES, NO: IF NO, REASON FOR REPLACEMENT: DATE OF PRIOR PLACEMENT: Complete when requesting prosthetic appliances. Date of prior placement is needed to review prior authorization requests for replacement dentures or partials, and when submitting for payment for dentures or partials.
- 56. IS TREATMENT RESULT OF OCUPATIONAL ILLNESS OR INJURY? NO, YES: Check the appropriate box. If answered YES, please explain.
- 57. IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT? NEITHER: Check the appropriate box. If answered YES, please explain.
- 59. EXAMINATION AND TREATMENT PLANS:
 - ** • Date: Complete when the service has been performed. Procedure codes listed without a date of service cannot be processed for payment.
 - * • Tooth: Enter the appropriate tooth number or letter when the procedure directly involves a tooth.
 - * • Surfaces: Designate tooth surface(s) when procedure code reported on that line directly involves one or more tooth surfaces.
 - * • Procedure Code: Enter the appropriate 5-digit ADA procedure code. If billing Telehealth transmission costs, use procedure code T1014, enter the number of minutes of transmission in the Quantity column.
 - * • Qty: List the quantity of services provided.
 - * • Description: Use ADA dental procedure descriptions for the service. For miscellaneous codes include a description of the service provided.
 - * • Fee: Enter the dentist's full fee for the procedure reported, except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of orthodontic treatment, the fee must be the amount prior authorized on the MC-9D Dental Treatment and Prior Authorization document.
 - ** • Total Fee: This total is the amount for all services listed.
 - ** • Payment By Other Plan: Enter any payment made, due, or obligated from other sources for services listed on this claim. Other sources include health insurance, liability insurance, share of cost, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the provider's billed charge and the Medicaid allowable fee in this data element.

- * 60. IDENTIFY ALL MISSING TEETH WITH "X": Place an "X" on each missing tooth.
- 61. REMARKS FOR UNUSUAL SERVICES: Use to indicate any information which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, attach a separate sheet.
- ** 62. DENTIST'S SIGNATURE BLOCK: The dentist or authorized representative must sign and date the claim form. A signature stamp, computer generated or typewritten signature will be accepted, but the statement "Signature on File" cannot be accepted. Unsigned claims can not be processed for payment.
- ** 63. ADDRESS WHERE TREATMENT WAS PERFORMED: Complete if the treatment was performed at a different location than the dentist office. If services were performed in an extended care facility, hospital or ambulatory surgical center, include the name of the facility with the address. If the services were performed in the person's home, state "Person's Home," and provide the address.

1994 ADA Dental Claim Form:

1. DENIST'S PRE-TREATMENT ESTIMATE OR STATEMENT OF ACTUAL SERVICES: Check the appropriate box.
- * PROVIDER IDENTIFICATION NUMBER: Enter the eleven-digit Nebraska Medicaid provider number as assigned by the Department of Health and Human Services (example 123456789-01).
- * 2. PATIENT I.D. NUMBER: Enter the patients eleven-digit Medicaid identification number (example 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (See 471 NAC 1-002.02K3).
- * 4. PATIENT NAME: Enter the full name (first, middle initial, last name) of the patient.
- * 6. SEX: Necessary for identification purposes.
- * 7. PATIENT BIRTHDATE: Enter the patients month, day and year of birth.
- 14-18. Complete if the patient has other dental coverage in addition to Medicaid.
- 17b. EMPLOYEE/SUBSCRIBER DENTAL PLAN I.D. NUMBER: (Optional) You may enter the dental office patient account number. It will appear on the "Remittance Advice" report issued by the Department of Health and Human Services.
- * 21. NAME OF BILLING DENTIST OR DENTAL ENTITY: Enter the provider's name.
- * 22-23. ADDRESS WHERE PAYMENT SHOULD BE REMITTED: Enter the providers address.
- ** 24. DENTIST SOC. SEC. OR T.I.N.: Complete if enrolled as a group provider. Enter the social security number of the dentist providing the services listed on the claim. Payment is made to the provider identification number in data element #1.
- ** 25. DENTIST LICENSE NO.: Enter the license number of the dentist providing the services listed on the claim.
- * 26. DENTIST PHONE NUMBER: Enter the treating dentist office telephone number, including the area code.
27. FIRST VISIT DATE CURRENT SERIES: Enter the first date of treatment.
- * 28. PLACE OF TREATMENT: Enter the place of treatment.
- * 29. RADIOGRAPHS OR MODELS ENCLOSED? Indicate whether x-rays and/or models are enclosed AND the number enclosed.

30. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?: Check the appropriate box. If answered YES, please explain in detail.
31. IS TREATMENT RESULT OF AUTO ACCIDENT?: Check the appropriate box. If answered YES, please explain in detail.
32. OTHER ACCIDENT?: Check the appropriate box. If answered YES, please explain in detail.
- * 33. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?: Complete when requesting prosthetic appliances.
- * 34. DATE OF PRIOR PLACEMENT: Complete when requesting prosthetic appliances as applicable to replacement prosthetic appliances.
35. IS TREATMENT FOR ORTHODONTICS?: Complete when orthodontic treatment was started prior to Medicaid eligibility and request is for completion of orthodontic treatment.
- * 36. IDENTIFY MISSING TEETH WITH "X": Put an "X" on each missing tooth.
37. EXAMINATION AND TREATMENT PLAN:
- * • Tooth # or Letter: Enter the appropriate tooth number or letter when the procedure directly involves a tooth.
 - * • Surface: Designate tooth surface(s) when procedure code reported on that line directly involves one or more tooth surfaces.
 - * • Description of Service: Use ADA dental procedure descriptions for the service. For miscellaneous codes include a description of the service provided.
 - ** • Date Service Performed MO/DAY/YEAR: Complete when the service has been performed. Procedure codes listed without a date of service cannot be processed for payment.
 - * • Procedure Number: Enter the appropriate 5 digit ADA procedure code.
 - * • Fee: Enter the dentist full fee for the procedure reported, except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of orthodontic treatment the fee should be the amount prior authorized on the MC-9D Dental Treatment and Prior Authorization document.
38. REMARKS FOR UNUSUAL SERVICES: Use to indicate any information, which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, attach a separate sheet.
- ** 39. DENTIST'S SIGNATURE BLOCK: The dentist or authorized representative must Sign and Date the claim form. A signature stamp, computer generated or typewritten signature will be accepted, but the statement "Signature on File" cannot be accepted. Unsigned claims can not be processed for payment.

- * 40. ADDRESS WHERE TREATMENT WAS PERFORMED: Complete if the treatment was performed at a different location than the dentist office. If services were performed in an extended care facility, hospital or ambulatory surgical center include the name of the facility with the address. If the services were performed in the person's home, state "Person's Home," and provide the address.
- ** 41. TOTAL FEE CHARGED: This total is the amount for all services listed.
- ** 42. PAYMENT BY OTHER PLAN: Enter any payment made, due, or obligated from other sources for services listed on this claim. Other sources include health insurance, liability insurance, excess income, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the provider's billed charge and the Medicaid allowable fee in this field.