471-000-88 Nebraska Medicaid Dental Program completion instructions for the 2024 American Dental Association (ADA) Dental Claim Form

Throughout these instructions, the term Department is used to mean the Department of Health and Human Services, 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 2012 American Dental Association (ADA) form are on page 5 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 American Dental Association (ADA) claim form. Send ONE copy of the American Dental Association (ADA) claim form and required documentation to:

Division of Medicaid and Long-Term Care
Department of Health and Human Services
P. O. Box 95026
Lincoln, NE 68509-5026

Payment: To claim payment for completed services, complete the American Dental Association (ADA) claim form. Send ONE copy of the American Dental Association (ADA) claim form to:

Medicaid Claims Unit
Division of Medicaid and Long-Term Care
Department of Health and Human Services
P. O. Box 95026
Lincoln, NE 68509-5026

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 American Dental Association (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 10 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:

- The client's permanent Nebraska Medicaid Identification Card or temporary Nebraska Medicaid Presumptive Eligibility Application. For explanation and examples, see 471-000-123;
- The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
- The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

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 Department 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.

Encounter Visits: Tribal/IHS dental clinics submit code T1015 when billing an encounter. The claim must also contain the American Dental Association (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.

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 the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. 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 prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) | 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

To reorder call 800.947.4746 or go online at ADAstore.org

ADA Dental Claim Form Completion Instructions Version 2024 © American Dental Association.

DATA ELEMENT SPECIFIC INSTRUCTIONS
Form completion instructions are provided for each data item, which is indicated by a number. Please note that data items are in groups of related information. These instructions explain the reasons for such groupings, and the relationships (if any) between groups.

Header Information
The 'header' provides information about the type of submission being made. This information applies to the entire transaction.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

Type of Transaction: There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box marked "Request for Predetermination / Preauthorization". If the claim is through the **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment **P**rogram, mark the box marked EPSDT/Title XIX'.

Predetermination/Preauthorization Number: If you are submitting a claim for a procedure that has been pre-authorized by a third-party payer, enter the preauthorization or predetermination number provided by the insurance company.

Insurance Company/Dental Benefit Plan Information

DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code
3a. Payer ID

Company/Plan Name, Address, City, State, Zip Code: **This Item is always completed**. Enter the information for the insurance company or dental benefit plan that is the third-party payer receiving the claim.

- If the patient is covered by more than one plan, enter the primary insurance company information here for the initial claim submission.
- When submitting a separate claim to the secondary carrier, place the secondary carrier's company/plan name and address information here.

Payer ID: Enter the Payer Identification Number for the Company/Plan specified in "3." above. (Leave blank if not known.)

Note: This identifier may be found on the patient's insurance card or in the provisions of a participating provider contract. It is intended to provide additional routing information for claims which may be sent to a centralized mailing address.

Other Coverage

This area of the claim form provides information on the existence of additional dental or medical insurance policies. This is necessary to determine if multiple coverages are in effect, and the possibility of coordination of benefits.

- When the claim form is being prepared for submission to the primary carrier the information in "Other Coverage" applies to the secondary carrier.
- When the claim form is being prepared for submission to the secondary carrier the information in "Other Coverage" applies to the primary carrier.

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		
4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F ☐U	8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		
11a. Other Payer ID		

Other Dental or Medical Coverage?: Mark the box after “Dental?” or “Medical?” whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage.

- Leave blank when the dentist is not aware of any other coverage(s).
- When either box is marked, complete Items 5 through 11 in the “Other Coverage” section for the applicable benefit plan.
- If both Dental and Medical are marked, enter information about the dental benefit plan in Items 5 through 11.

Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix): If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.

Date of Birth (MM/DD/CCYY): Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.

Gender: Mark the gender of the person who is listed in Item #5. Mark “M” for Male, “F” for Female, or “U” for Unknown as applicable.

Policyholder/Subscriber Identifier (Assigned by Plan): Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in Item #5, which is on their identification card.

Plan/Group Number: Enter the group plan or policy number of the person identified in Item #5.

Patient’s Relationship to Person Named in Item #5: Mark the patient’s relationship to the other 30 insured named in Item #5.

Other Insurance Company/Dental Benefit Plan Name, Address, City, 1 State, Zip Code: Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

Payer ID: Enter the Payer Identification Number for the Other Insurance Company/Dental Benefit Plan specified in “11.” above. (Leave blank if not known.)

Note: This identifier may be found on the patient’s insurance card or in the provisions of a participating provider contract. It is intended to provide additional routing information for claims which may be sent to a centralized mailing address.

Policyholder/Subscriber Information (For Insurance Company Named in Item #3)

This section documents information about the insured person who may or may not be the patient.

- When the claim form is being prepared for submission to the primary carrier the information.

supplied applies to the person insured by the primary carrier.

- When the claim form is being prepared for submission to the secondary carrier the information entered applies to the person insured by secondary carrier.

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender ☐M ☐F ☐U	15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number	17. Employer Name	

Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Enter the complete name, address and zip code of the policyholder/subscriber with coverage from the company/plan named in #3.

Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year.

Gender: This applies to the primary insured, who may or may not be the patient. Mark “M” for Male, “F” for Female, or “U” for Unknown as applicable.

Policyholder/Subscriber Identifier (Assigned by Plan): Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in Item #12, which is on their identification card.

Plan/Group Number: Enter the policyholder/subscriber’s group plan/policy number.

Employer Name: If applicable, enter the name of the policyholder/subscriber’s employer.

Patient Information

The information in this section of the claim form pertains to the patient.

PATIENT INFORMATION			
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other			19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code			
21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F ☐ U	23. Patient ID/Account # (Assigned by Dentist)	

Relationship to Policyholder/Subscriber in #12 Above: Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. **If the patients also the primary insured, mark the box titled 'Self' and skip to item #23.**

Reserved For Future Use: Leave blank and skip to Item #20. (#19 was previously used to report "Student Status.")

Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Enter the complete name, address and zip code of the patient.

Date of Birth (MM/DD/CCYY): A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.

Gender: This applies to the patient. Mark "M" for Male, "F" for Female, or "U" for Unknown as applicable.

Patient ID/Account # (Assigned by Dentist): Enter if the dentist's office has assigned a number to identify the patient. This is not required to process claim.

Record Of Services Provided

This section contains information regarding the proposed treatment (predetermination/preauthorization), or treatment performed (actual services).

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

NOTE: Items 24 through 31, following, apply to each of the 10 available 1 lines on the claim form for reporting dental procedures provided to the patient. **The remaining Items in this section of the form (33-35) do not repeat**.

Procedure Date (MM/DD/CCYY): Enter procedure date for actual services performed or leave blank if the claim is for preauthorization/predetermination. The date, if included, must have two digits for the month, two for the day, and four for the year.

NOTE: The presence or absence of a Procedure Date should be consistent with the type of transaction(s) marked in Item #1 (e.g., actual services; predetermination / preauthorization).

Area of Oral Cavity: **Use of this field is conditional**. Always report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. For example:

- Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as D4263 bone replacement graft – first site in quadrant.
- Do not report the applicable area of the oral cavity when the procedure either: 1) incorporates a specific area of the oral cavity in its nomenclature, such as D5110 complete denture – maxillary; or 2) does not relate to any portion of the oral cavity, such as D9222 deep sedation/general anesthesia – first 15 minutes.

NOTE: Detailed guidance on reporting Area of the Oral Cavity, Tooth Numbers and Tooth Surfaces by CDT code is posted on the ADA Dental Claim Form web page. Area of the oral cavity is designated by a two-digit code, selected from the following code list:

Code Area
00 entire oral cavity
01 maxillary arch
02 mandibular arch
10 upper right quadrant
20 upper left quadrant
30 lower left quadrant
40 lower right quadrant

Tooth System: Enter "JP" to indicate that teeth are being designated using the ADA's Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition).

Tooth Number(s) or Letter(s): **Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank.**

NOTE: Numbers or letters reported are based on tooth morphology, not anatomic position. This is the traditional and important concept to understand for accurate documentation and reporting. For instance, a tooth may migrate into an edentulous space, but that movement does not change its morphology. Similarly, placement of an implant body need not be in an anatomic tooth position, but the prosthesis placed is the morphological equivalent of a missing tooth or range of teeth.

If the same procedure is performed on more than a single tooth on the same date of service, there are two options for reporting –

- Report each procedure, the tooth involved, and the fee on separate service lines.
- Report the procedure on a single service line with the teeth involved in #27, the number of times the procedure was delivered in the #29b (Quantity), and the total fee for all in #31 (Fee).

When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10; 3-5, 22-27).

Supernumerary teeth in the **permanent** dentition are identified in the ADA's Universal/National Tooth Designation System ("JP") by the numbers 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). This enumeration is illustrated in the following chart:

Upper Arch (commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
'Super' #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Arch

Tooth "#"	T	S	R	Q	P	O	N	M	L	K
Super "#"	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

Tooth Surface: This Item is necessary when the procedure performed by tooth involves one or more tooth surfaces. Otherwise leave blank. The following single letter codes are used to identify surfaces:

Surface	Code
Buccal	B
Distal	D
Facial (or labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

Do not leave any spaces between surface designations in multiple surface restorations (e.g., 2 MOD).

NOTE: The Incisal ("I") surface of an anterior tooth (analogous to the Occlusal surface of posterior teeth for reporting purposes) may incorporate the Incisal Angle. A restoration involving the incisal angle will include multiple surfaces. The size of the affected area and the anatomy of the tooth will dictate the number of surfaces involved in this restoration.

For example, a small fracture involving the angle could be perceived clinically as two surface restoration (e.g., M-I; D-I). A larger fracture involving the angle that requires restoring a greater portion of the tooth would require a multi-surface restoration (e.g., M-I-F-L; D-I-F-L). The clinician determines what type of restoration was placed, and the code to report the procedure delivered to the patient.

Procedure Code: Enter the appropriate procedure code found in the version of the *Code on Dental Procedures and Nomenclature* in effect on the "Procedure Date" (Item #24).

NOTE: Additional guidance concerning reporting select CDT codes (e.g., Teledentistry; Sales Tax) are in Coding Education and the ADA Claim Form content linked to the CDT Code Portal web page – www.ada.org/cdt.

Diagnosis Code Pointer: Enter the letter(s) from Item 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

Quantity: Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01."

Description: Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).

Fee: Report the dentist's full fee for the procedure. Resolution 44-2009 Statement on Reporting Fees on Dental Claims adopted by the ADA House of Delegates, as follows, provides guidance on the appropriate entry for this item.

> **Statement on Reporting Fees on Dental Claims**
> 1) A full fee is the fee for a service that is set by the dentist, which reflects the costs of providing the procedure and the value of the dentist's professional judgment.
> 2) A contractual relationship does not change the dentist's full fee.
> 3) It is always appropriate to report the full fee for each service reported to a third-party payer.

(Note: Item 31 above is the last of the repeating 'service line' items.)

Other Fee(s): When other charges applicable to dental services 1 provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.

Total Fee: The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a.

Missing Teeth Information: Mark an "X" on the number of the missing tooth – for identifying missing permanent dentition only. Report missing teeth when pertinent to Periodontal, Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim

NOTE: Numbers marked are based on tooth morphology, not anatomic position.

Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source: **AB** = ICD-10-CM.

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."

NOTE: #34 and #34a are required when a) the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions; or b) when required by state regulation (e.g., Medicaid) or third-party payer contract provisions. Detailed guidance on reporting ICD-10-CM diagnosis codes is posted on the Coding Education | American Dental Association (ada.org).

Remarks: This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim (e.g., for a secondary claim, the amount the primary carrier paid).

Remarks should be concise and pertinent to the claim submission. Claimants should note that an entry in "Remarks" may prompt review by a person as part of claim adjudication, which may affect overall time required to process the claim.

NOTE: When the claim is for a multi-unit implant supported prosthesis the supporting implant body locations may not correlate to the anatomic location of a natural tooth. An appropriate notation in "Remarks" may avoid a misunderstanding when the claim is submitted to a third-party payer.

Authorizations

This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.

AUTHORIZATIONS

36. 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 prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

Patient Consent: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.

By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.

Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.

Authorize Direct Payment: The signature and date (or "Signature on File" notice) are required when the Policyholder/Subscriber named in Item #12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company.

Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.

Ancillary Claim/Treatment Information

This section of the claim form provides additional information to the third-party payer regarding the claim.

ANCILLARY CLAIM/TREATMENT INFORMATION (alll dates in MM/DD/CCYY format)		
38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N)
		39a. Date Last SRP
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident		
46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State

Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard. Frequently used codes are:

11 = Office; **12** = Home; **21** = Inpatient Hospital; **22** = Outpatient Hospital;
31 =Skilled Nursing Facility; **32** = Nursing Facility; **02** = Telehealth (aka Teledentistry)

All current codes are available online from the Centers for Medicare and Medicaid Services in 6 PDF format for download – CMS Place of Service Code Set 8 39.

Number of Enclosures (00 to 99): Enter a "**Y**" or "**N**" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).

Date Last SRP: Enter the date of service for the last Scaling and Root Planning procedure (e.g., D4341) delivered to the patient in the space immediately to the right of this data element caption; date format is MM/DD/CCYY. (Leave blank if not applicable to claim or if not known.).

Is Treatment for Orthodontics?: **If no, skip to Item #43**. If yes, answer Items 41 & 42.

Date Appliance Placed (MM/DD/CCYY): Indicate the date an orthodontic appliance was placed. 16 This information should also be reported in this section for subsequent orthodontic visits.

Months of Treatment: Enter the total number of months required to complete the orthodontic treatment, from the beginning to the end of the treatment plan.

Replacement of Prosthesis?: This Item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures).
Please review the following three situations in order to determine how to complete this Item.

a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to Item 45.

b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Item 45.

c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete section 44.

Date of Prior Placement (MM/DD/CCYY): Complete if the answer to Item #43 was "YES."

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 in this item, and proceed to Items #46 and #47. **If the services you are providing are not the result of an accident, this Item does not apply; skip to Item #48**.

Date of Accident (MM/DD/CCYY): Enter the date on which the accident noted in Item #45 occurred. Otherwise, leave blank.

Auto Accident State: Enter the state in which the auto accident noted in Item #45 occurred. Otherwise, leave blank.

Billing Dentist Or Dental Entity

The 'Billing Dentist' or 'Dental Entity' section provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist. **If the patient is submitting the claim directly, do not complete Items 48-52a**.

<table>
<tr><td colspan="4">48. Name, Address, City, State, Zip Code</td></tr>
<tr><td colspan="2">49. NPI</td><td>50. License Number</td><td>51. SSN or TIN</td></tr>
<tr><td>52. Phone Number</td><td>( ) -</td><td colspan="2">52a. Additional Provider ID</td></tr>
</table>

Name, Address, City, State, Zip Code: Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).

NPI (National Provider Identifier): Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.

NOTE: The NPI is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation.

An NPI is unique to an individual dentist or dental entity, and has no intrinsic meaning. There are two types of NPI available to dentists and dental practices:

- Type 1 Individual Provider - All individual dentists are eligible to apply for Type 1 NPIs, regardless of whether they are covered by HIPAA.
- Type 2 Organization Provider - A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.

On paper, there is no way to distinguish a type 1 from a type 2 in the absence of any associated data; they are identical in format. Additional information on NPI and enumeration can be obtained from the CMS' Internet Web Site – National Provider Identifier (NPI).

License Number: If the billing dentist is an individual, enter the dentist's license number. If a billing entity (e.g., corporation) is submitting the claim, leave blank.

SSN or TIN: Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.

Phone Number: Enter the business phone number of the billing dentist or dental entity.

Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; federal government). Some Legacy IDs have an intrinsic meaning.

Treating Dentist And Treatment Location Information

This section must be completed for all claims. Information that is specific to the dentist or practitioner 10 acting within the scope of their state licensure who has provided treatment is entered in this section.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X_____ Signed (Treating Dentist) Date		
53a. Locum Tenens Treating Dentist? ☐		
54. NPI		55. License Number
56. Address, City, State, Zip Code		56a. Provider Specialty Code
57. Phone Number	( ) -	58. Additional Provider ID

Certification: Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form.

Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this Item.

Locum Tenens Dentist: Mark box if the treating dentist is providing services in a locum tenens capacity. (Leave blank if not applicable.).

NPI (National Provider Identifier): Enter the treating dentist's Type 1 – Individual Provider NPI in Item # 54. (See Item #49 for more NPI information.)

NOTE: This will be the "locum tenens" dentist's NPI when applicable.

License Number: Enter the license number of the treating dentist. This may vary from the billing dentist.

NOTE: This will be the "locum tenens" dentist's license number when applicable.

Address, City, State, Zip Code: Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.

NOTE: For teledentistry encounters the treatment location is the dentist's practice location, not the patient's location.

Provider Specialty Code: Enter the code that indicates 1 the type of dental professional who delivered the treatment. Available codes describing treating dentists follow. The general code listed as "Dentist" may be used instead of any other dental practitioner codes.

NOTE: This will be the “locum tenens” dentist’s specialty when applicable.

Category / Description	Code
Dentist / a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice / a dentist who provides a variety of dental services to address patient needs.	1223G0001X
Dental Specialty / a practitioner in one of the nine specialty areas recognized by the ADA.	See following list
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223x0008X
Oral & Maxillofacial Surgery	1223S0112X

These codes are from the “Dental Service Providers” section of the Healthcare Providers Taxonomy code list, a HIPAA standard, and are a subset of the full list that includes codes for other types of practitioners including dental assistants, dental hygienists, denturists, and dental lab technicians. The current full list is posted online –Health Care Provider Taxonomy Code Set.

Phone Number: Enter the business telephone number of the treating dentist.

NOTE: This will be the “locum tenens” dentist telephone number, when applicable.

Additional Provider ID: This is an identifier assigned to the treating dentist other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider’s NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

NOTE: This will be the “locum tenens” dentist’s Additional Provider ID when applicable.