6. Dental Claim Form Instructions (Version 2012 American Dental Association)

This section explains the procedures for obtaining reimbursement for dental services submitted to Medicaid on the 2012 American Dental Association (ADA) claim form. Mississippi Medicaid accepts both electronic and paper dental claims. Dental providers are strongly encouraged to bill electronic claims to reduce the potential for errors and speed reimbursement. This section only addresses billing procedures and must be used in conjunction with the Administrative Code Title 23 Part 204. The Dental Fee Schedule is available on the Medicaid web site at http://www.medicaid.ms.gov or on the Web Portal at https://portal.ms-medicaid-mesa.com/MS/Provider. For questions, contact Gainwell's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222.

6.1. Provider Types

The instructions for the 2012 ADA claim form are to assist the following providers:

- Dentists
- Federally Qualified Health Center (FQHC) dentists
- Rural Health Clinic (RHC) dentists

6.2. Electronic Dental Claims

Electronic dental claims may be submitted to Mississippi Medicaid by:

- Using the Web Portal Claims Entry feature
- Using other proprietary software purchased by the dental provider.

Electronic dental claims must be submitted in a format that is HIPAA compliant with the ANSI X12 837D claim standards.

6.3. Paper Dental Claims Guidelines

To facilitate processing and minimize the chances of rejection, providers should follow the guidelines below:

- An original 2012 ADA claim form must be completed.
- No photocopied or fax claims are accepted.
- Do not include handwritten information on the claim form.
- Blue or black ink must be used to fill out the form.
- The information on the form must be legible.
- No highlighters should be used.
- Correction fluid or correction tape should not be used.
- Names, codes, numbers, etc. must print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.

6.4. Multi-Page Paper Claims

When submitting American Dental Association Dental (ADA) claims form with multiple pages, the below guidelines should be followed:

- Multi-page claims are limited to five pages with a maximum of 50 claim lines.
- If the number of procedures reported exceeds the number of lines available on one claim (ten lines per claim), the remaining procedures must be listed on a separate, fully completed claim form.
- The first form should not be totaled.
- Multiple pages should be clipped together.
- Indicate Page X of 5 in the white space at the bottom of the claim form.
- FL 31 (Figure 139) should be used to indicate a TPL payment on last page, if applicable.
- Only one copy of an attachment (e.g., EOB, EOMB, Consent Form) is required.

6.5. Paper Claims with Attachments

When submitting attachments with the ADA Dental claim form, the below guidelines should be followed:

- Attachments must be clipped to the claim.
- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.

Be sure to include Treatment Authorization Number (TAN), timely filing ICN or TCN, proper procedure codes, modifiers, units, etc. to prevent claims from denying inappropriately.

6.6. Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program

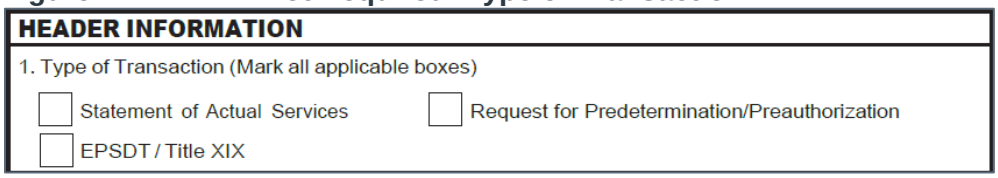
PO Box 23076

Jackson, MS 39225-3076

6.7. 2012 ADA American Dental Association Dental Claim Form

The field instructions are as follows:

Figure 127. FL 1 Not Required: Type of Transaction

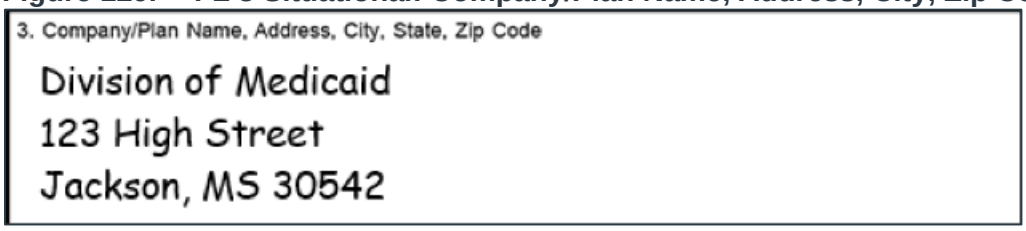


Instructions: Leave this field blank.

Figure 128. FL 2 Situational: Predetermination/Prior Authorization Number (Treatment Authorization Number)

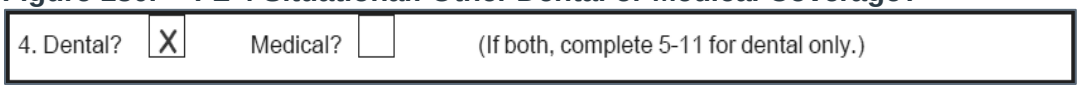
Instructions: Enter an authorization number without hyphens, dashes, spaces, etc. if entering a pre-authorized claim. Enter only one authorization per one claim form.

Figure 129. FL 3 Situational: Company/Plan Name, Address, City, Zip Code



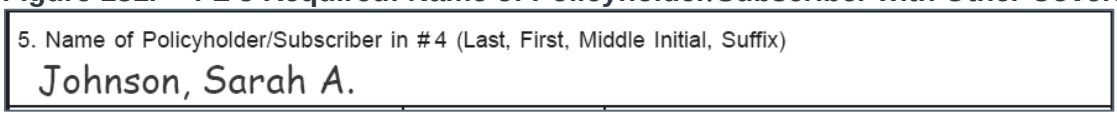
Instructions: Enter the name and address for the insurance company or dental benefit plan that is receiving the claim.

Figure 130. FL 4 Situational: Other Dental or Medical Coverage?



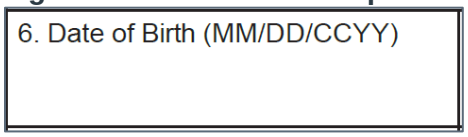
Instructions: Mark the box after “Dental?” or “Medical?” whenever a patient has coverage under any other dental or medical plan, regardless of whether the dentist or the patient is submitting a claim to collect benefits under the other coverage. If either box is marked, complete FL 5-11.

Figure 131. FL 5 Required: Name of Policyholder/Subscriber with Other Coverage in #4



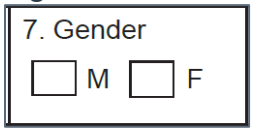
Instructions: Enter the name of the policyholder for the other dental or medical plan. If the patient has other coverage through spouse, domestic partner, or if a child, through a parent, the name of the person who has the other coverage is reported here.

Figure 132. FL 6 Not Required: Date of Birth (MM/DD/CCYY)



Instructions: Leave this field blank.

Figure 133. FL 7 Not Required: Gender

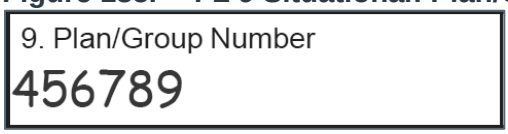


Instructions: Leave this field blank.

Figure 134. FL 8 Situational: Policyholder/Subscriber ID (SSN or ID#)

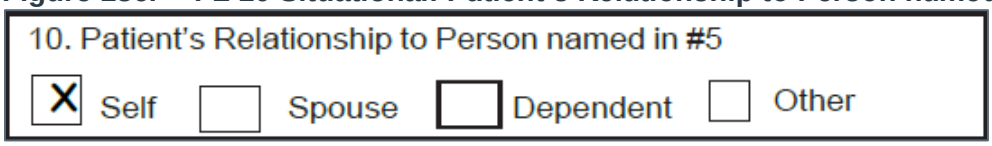
Instructions: Enter the unique identifying number assigned by the third-party payer (e.g., insurance company) to the person named in FL 5 (Figure 131), which is on the identification card.

Figure 135. FL 9 Situational: Plan/Group Number



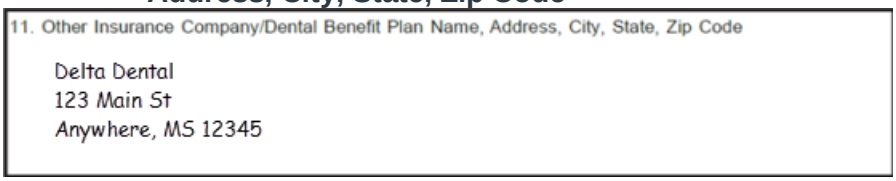
Instructions: Enter the group plan or policy number of the person identified in FL 5 (Figure 131).

Figure 136. FL 10 Situational: Patient's Relationship to Person named in #5



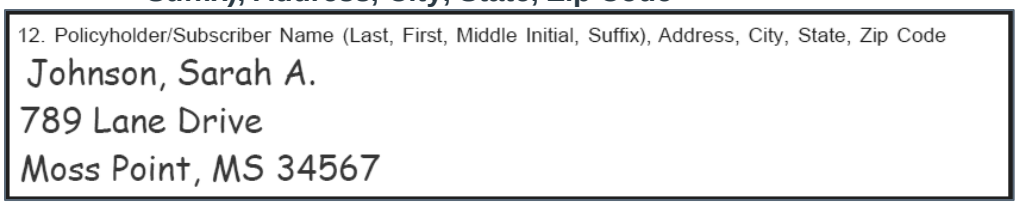
Instructions: Mark the box corresponding to the patient's relationship to the other insured name in FL 5 (Figure 131).

Figure 137. FL 11 Situational: Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code



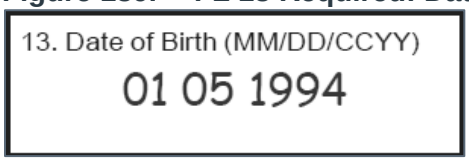
Instructions: Enter the complete information of the additional payer, benefit plan, or entity for the insured named in FL 5 (Figure 131).

Figure 138. FL 12 Required: Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code



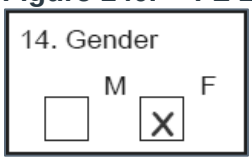
Instructions: Enter the complete name, address, and zip code of the Medicaid beneficiary receiving treatment.

Figure 139. FL 13 Required: Date of Birth (MM/DD/CCYY)



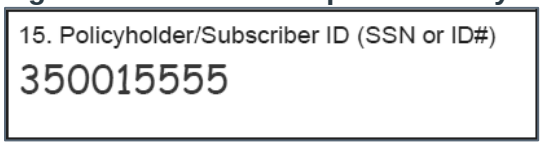
Instructions: Enter the Medicaid beneficiary's [from FL 12 (Figure 138)] date of birth with two digits for month and day and four digits for the year.

Figure 140. FL 14 Required: Gender



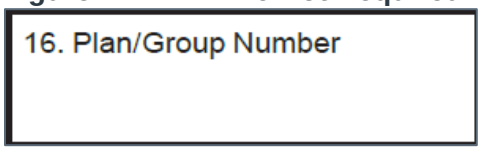
Instructions: Mark "M" for male, or "F" for female

Figure 141. FL 15 Required: Policyholder/Subscriber ID (SSN or ID#)



Instructions: Enter the full nine-digit identification number as listed on the policy holder's Medicaid card.

Figure 142. FL 16 Not Required: Plan/Group Number

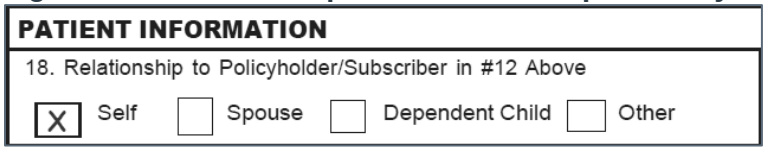


Instructions: Leave this field blank.

Figure 143. FL 17 Situational: Employer Name

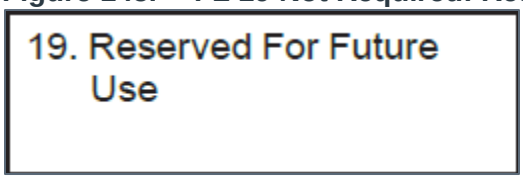
Instructions: Enter the name of the policyholder/subscriber's employer.

Figure 144. FL 18 Required: Relationship to Policyholder/Subscriber in #12



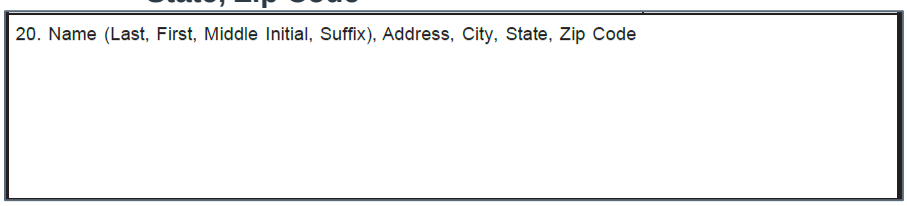
Instructions: Mark the relationship of the patient to the person in FL 12 (Figure 138) who has the primary insurance coverage. For Medicaid beneficiaries, mark the box titled "Self" and skip to FL 24 (Figure 150).

Figure 145. FL 19 Not Required: Reserved for Future Use



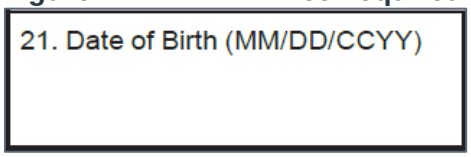
Instructions: Leave this field blank.

Figure 146. FL 20 Not Required: Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code



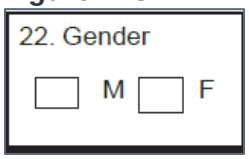
Instructions: Leave this field blank.

Figure 147. FL 21 Not Required: Date of Birth (MM/DD/CCYY)



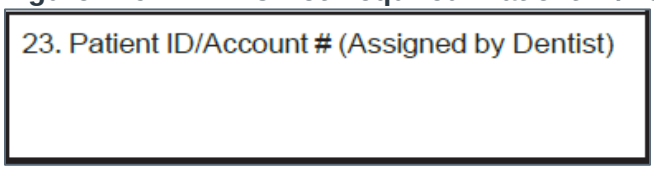
Instructions: Leave this field blank.

Figure 148. FL 22 Not Required: Gender



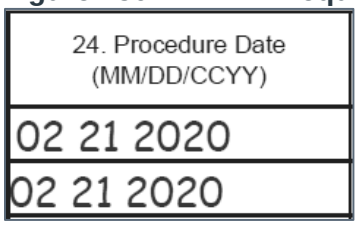
Instructions: Leave this field blank.

Figure 149. FL 23 Not Required: Patient ID/Account # (Assigned by Dentist)



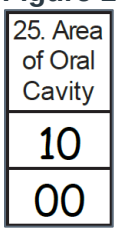
Instructions: Leave this field blank.

Figure 150. FL 24 Required: Procedure Date (MM/DD/CCYY)



Instructions: Enter the procedure date for actual services performed. A total of eight digits are required; two for month, two for the day of the month and four for the year.

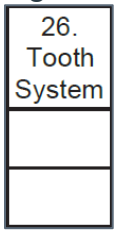
Figure 151. FL 25 Situational: Area of Oral Cavity



Instructions: Enter the area of the oral cavity designated by a two-digit code from the following list:

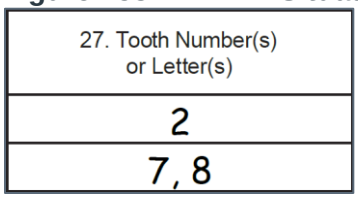
- 00 – Entire oral cavity
- 01 – Maxillary arch
- 02 – Mandibular arch
- 10 – Upper right quadrant
- 20 – Upper left quadrant
- 30 – Lower left quadrant
- 40 – Lower right quadrant

Figure 152. FL 26 Not Required: Tooth System



Instructions: Leave this field blank.

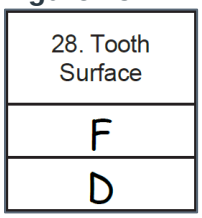
Figure 153. FL 27 Situational: Tooth Number(s) or Letter(s)



Instructions: Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank.

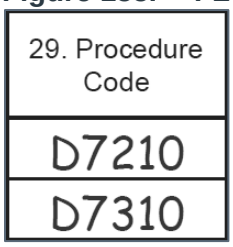
If the same procedure is performed on more than a single tooth on the same date of service, report each procedure code and tooth involved on separate lines on the claim form. Supernumerary teeth in the permanent dentition are identified by tooth numbers 51 through 82; for primary dentition, supernumerary is identified by placement of the letter “S” following the letter identifying the adjacent primary tooth.

Figure 154. FL 28 Situational: Tooth Surface



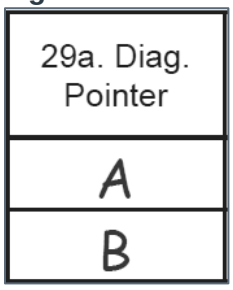
Instructions: Enter a tooth surface code.

Figure 155. FL 29 Required: Procedure Code



Instructions: Enter the appropriate procedure code from the current version of the ADA Current Dental Terminology Manual, Code on Dental Procedure and Nomenclature (CDT Code).

Figure 156. FL 29a Required: Diag. Pointer (Diagnosis Code Pointer)



Instructions: Enter the letter(s) from FL 34 (Figure 163) that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

Figure 157. FL 29b Situational: Qty. (Quantity)

29b. Qty.
1
1

Instructions: Enter the number of times (01-99) the procedure identified in FL 29 (Figure 155) is delivered to the patient on the date of service shown in FL 24 (Figure 150). The default value is "01".

Figure 158. FL 30 Not Required: Description

30. Description

Instructions: Leave this field blank.

Figure 159. FL 31 Required: Fee

31. Fee
145 00
200 00

Instructions: Enter the dentist's full fee or usual and customary charge. Do not deduct co-payment from the usual and customary charge.

Figure 160. FL 31a Situational: Other Fee(s)

31a. Other Fee(s)	10 00

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

Figure 161. FL 32 Required: Total Fee

32. Total Fee	345 00

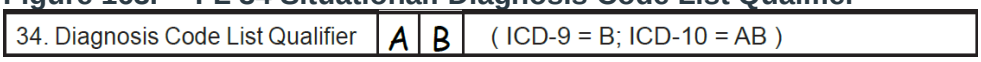
Instructions: Enter the sum of all fees from lines in FL 31 (Figure 159) and FL 31a (Figure 160).

Figure 162. FL 33 Situational: Missing Teeth Information

33. Missing Teeth Information (Place an "X" on each missing tooth.)															
X	2	3	4	X	6	7	8	9	X	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

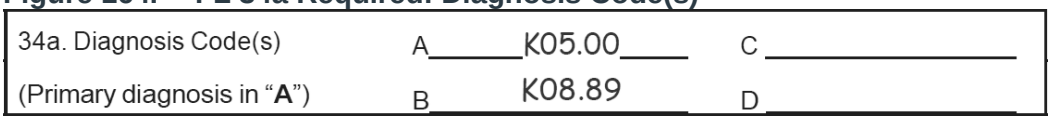
Instructions: Mark an "X" on the number of the missing tooth for identifying missing permanent dentition only. Report a missing tooth/teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant procedures.

Figure 163. FL 34 Situational: Diagnosis Code List Qualifier



Instructions: Enter the appropriate code to identify the diagnosis code source: AB= ICD-10 CM

Figure 164. FL 34a Required: Diagnosis Code(s)

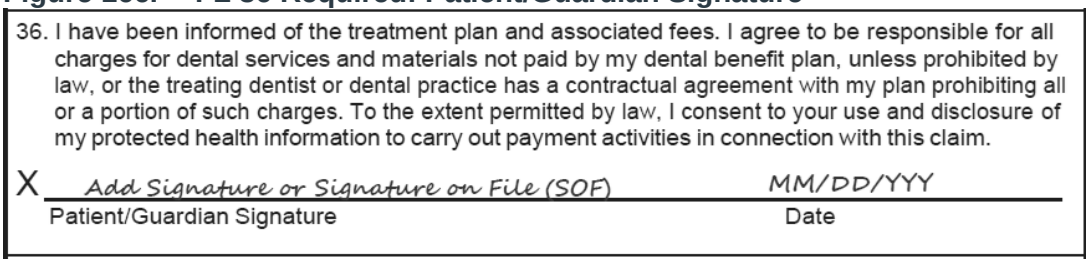


Instructions: Enter up to four applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".

Figure 165. FL 35 Situational: Remarks (Used for submitting Adjustments/Replacements and Voids)

Instructions: Enter a 7 to indicate an adjustment/replacement or enter an 8 to indicate a void preceding the ICN or TCN to be adjusted

Figure 166. FL 36 Required: Patient/Guardian Signature



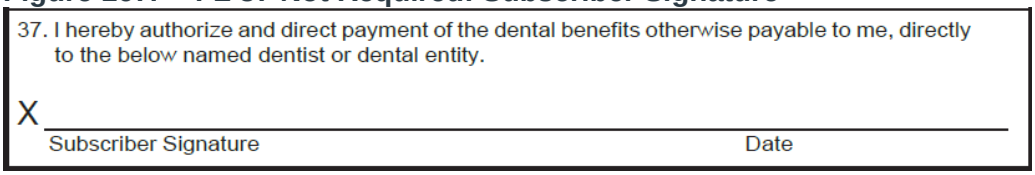
Instructions: By signing in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.

In lieu of having the beneficiary sign a claim form on each visit, the provider may retain a copy of a statement of release signed by the beneficiary or his/her guardian. Medicaid allows a beneficiary signature for a lifetime when the provider has a signature authorization on file. On the claim form, the provider would enter "Signature on File" to satisfy the signature guidelines. If the beneficiary is unable to sign, the billing clerk may sign the beneficiary's name and indicate "By: (name of office person signing)". In addition, the reason the beneficiary is not able to sign must be specified.

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

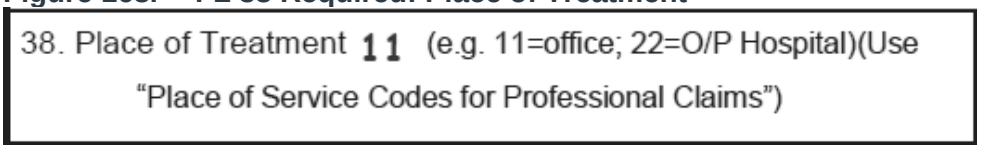
Note: Red ink should not be used for the signature.

Figure 167. FL 37 Not Required: Subscriber Signature



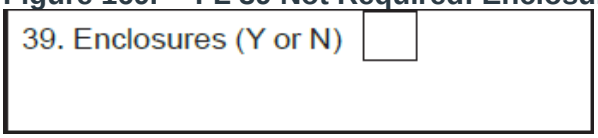
Instructions: Leave this field blank.

Figure 168. FL 38 Required: Place of Treatment



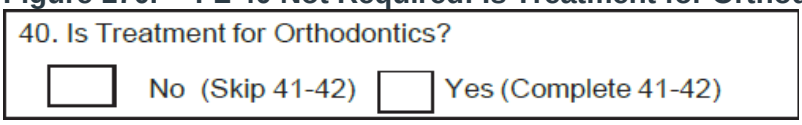
Instructions: Enter the two-digit Place of Service Code for Professional Claims; this is a HIPAA standard. A complete list of the Place of Service Codes is available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Figure 169. FL 39 Not Required: Enclosures



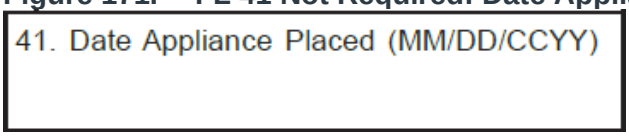
Instructions: Leave this field blank.

Figure 170. FL 40 Not Required: Is Treatment for Orthodontics?



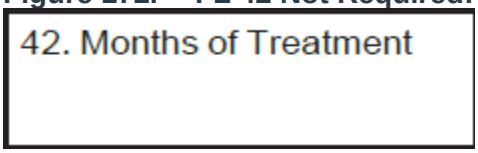
Instructions: Leave this field blank.

Figure 171. FL 41 Not Required: Date Appliance Placed (MM/DD/CCYY)



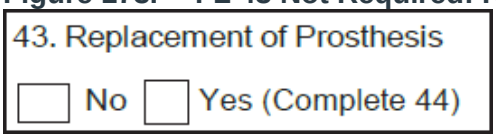
Instructions: Leave this field blank.

Figure 172. FL 42 Not Required: Months of Treatment



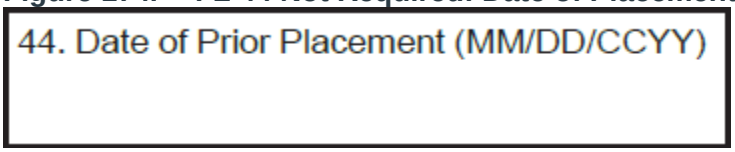
Instructions: Leave this field blank.

Figure 173. FL 43 Not Required: Replacement of Prosthesis



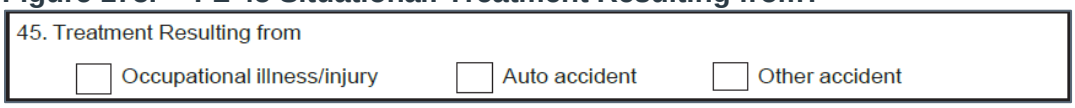
Instructions: Leave this field blank.

Figure 174. FL 44 Not Required: Date of Placement (MM/DD/CCYY)



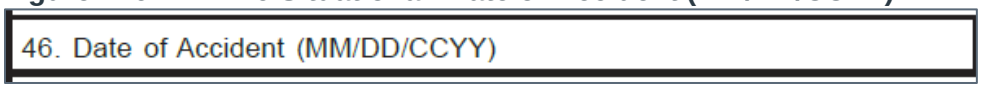
Instructions: Leave this field blank.

Figure 175. FL 45 Situational: Treatment Resulting from?



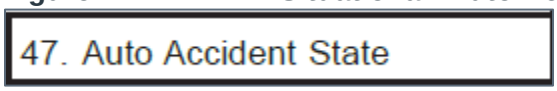
Instructions: If dental treatment is listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to FL 46 (Figure 176) and FL 47 (Figure 177). If the services you are providing are not the result of an accident, this field does not apply; skip to FL 48 (Figure 178).

Figure 176. FL 46 Situational: Date of Accident (MM/DD/CCYY)



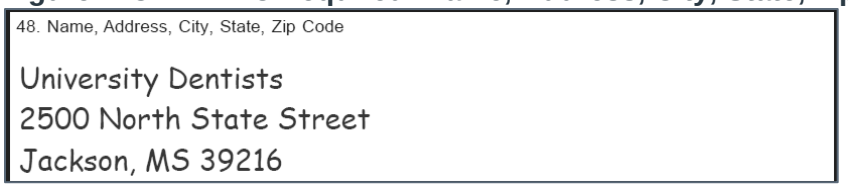
Instructions: Enter the date on which the accident noted in FL 45 (Figure 175) occurred. Otherwise, leave blank.

Figure 177. FL 47 Situational: Auto Accident State



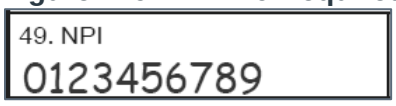
Instructions: Enter state where the auto accident occurred.

Figure 178. FL 48 Required: Name, Address, City, State, Zip Code



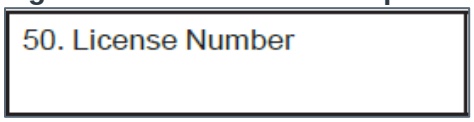
Instructions: Enter the name and complete address of the billing dentist or dental entity (group, corporation, etc.)

Figure 179. FL 49 Required: NPI



Instructions: Enter the appropriate ten-digit NPI number for the billing entity. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.

Figure 180. FL 50 Not Required: License Number

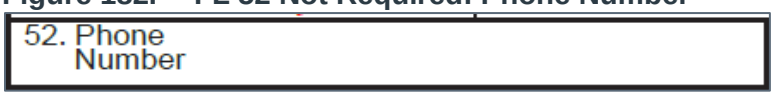


Instructions: Leave this field blank.

Figure 181. FL 51 Not Required: SSN or TIN

Instructions: Leave this field blank.

Figure 182. FL 52 Not Required: Phone Number

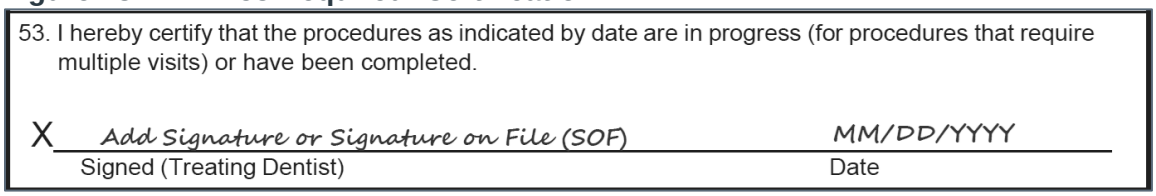


Instructions: Leave this field blank.

Figure 183. FL 52a Situational: Additional Provider ID

Instructions: Enter the qualifier ZZ followed by the Taxonomy code, if the NPI was used in FL 49 (Figure 179). Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number. The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the dental provider.

Figure 184. FL 53 Required: Certification



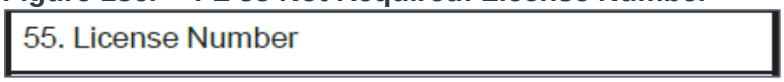
Instructions: Enter the signature of the treating or rendering dentist and the date the form was signed. The provider must sign and date the claim form; a rubber stamp signature is acceptable. The provider is certifying that it is understood that payment and satisfaction of the claim is from federal or state funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted und applicable federal and state laws. Claim forms prepared by the dentist's management software may insert the treating dentist's printed name in this item.

Note: Red ink should not be used for the signature.

Figure 185. FL 54 Required: NPI

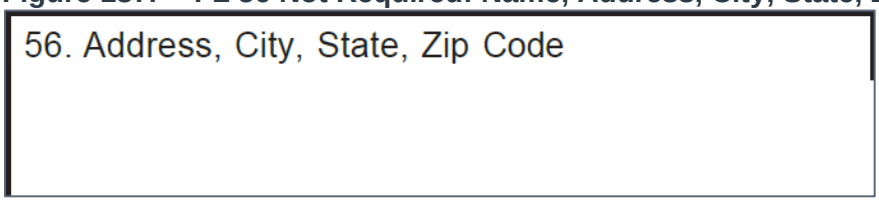
Instructions: Enter the appropriate ten-digit NPI number for the treating dentist. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.

Figure 186. FL 55 Not Required: License Number



Instructions: Leave this field blank.

Figure 187. FL 56 Not Required: Name, Address, City, State, Zip Code



Instructions: Leave this field blank.

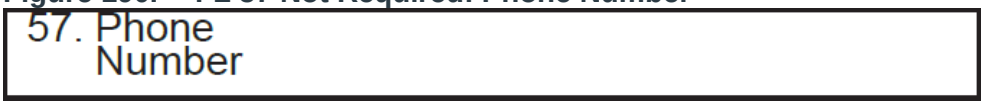
Figure 188. FL 56a Required: Provider Specialty Code

Instructions: Enter the code that indicates the type of dental professional who delivered the treatment. Provider specialty codes, also known as "provider taxonomy codes," come from Dental Service Provider section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions. The valid values for the specialty code are in the following figure.

Figure 189. Provider Specialty Codes

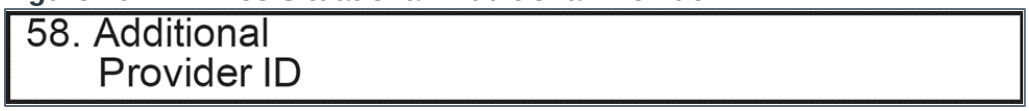
Source	Description
Dentist	122300000X
General Practice	1223G0001X
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Figure 190. FL 57 Not Required: Phone Number



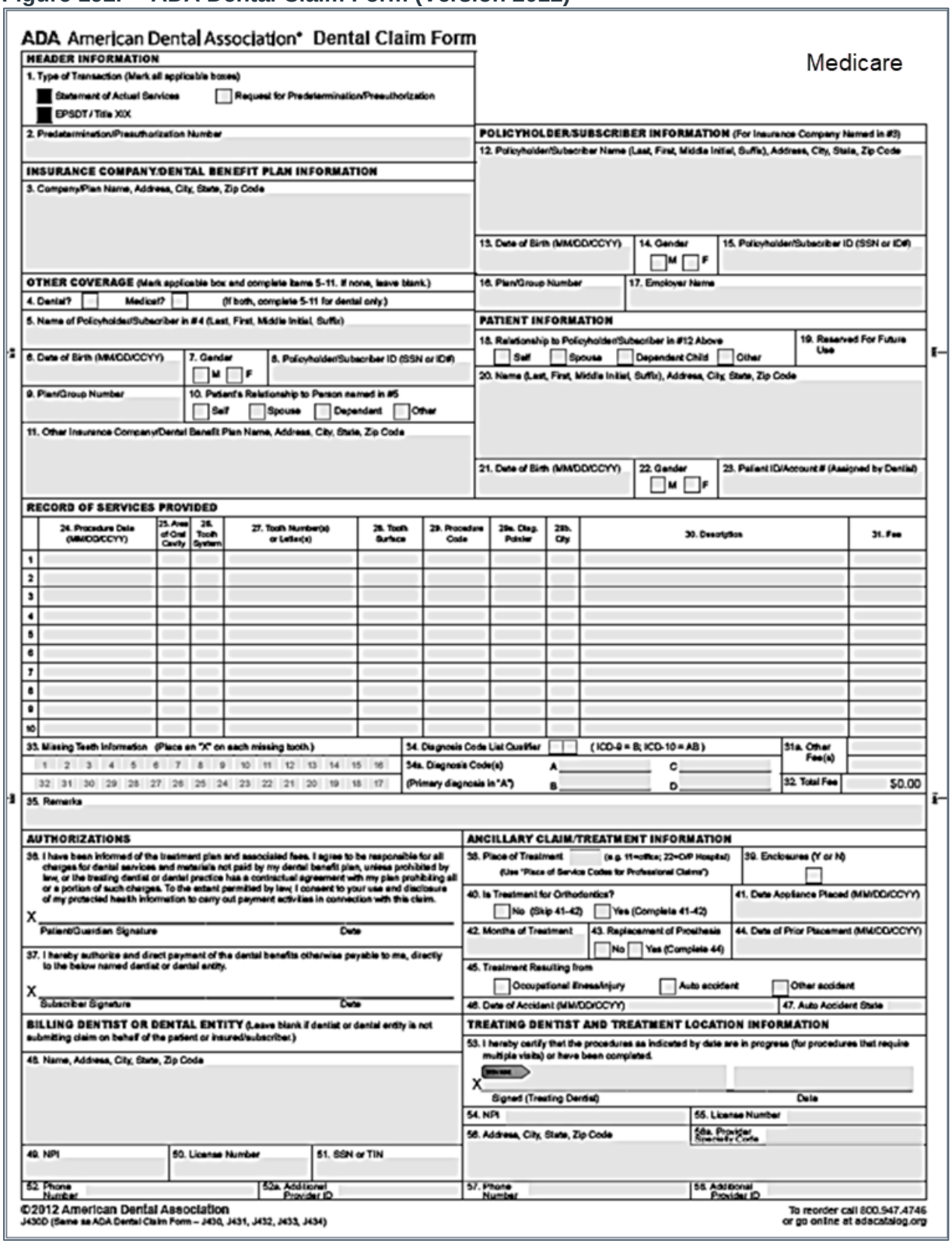
Instructions: Leave this field blank.

Figure 191. FL 58 Situational: Additional Provider ID



Instructions: Enter the qualifier (0B, G2, and LU) identifying the non-NPI number followed by the ID number.

Figure 192. ADA Dental Claim Form (Version 2012)



ADA American Dental Association* Dental Claim Form

Medicare

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

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 | 8. Policyholder/Subscriber ID (SSN or ID#)

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

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

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company 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 | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependant 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 | 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-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A B C D

51a. Other Fee(s)
32. Total Fee $0.00

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

58. Place of Treatment (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 59. Enclosures (Y or N) ☐

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

54. NPI | 55. License Number

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

57. Phone Number | 58. Additional Provider ID

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J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

6.8. Filing Medicare Part, A Crossover Claims on the Dental Claim Form

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. Complying with the following instructions expedites claims adjudication:

- The word "Medicare" should be indicated the white space of the upper right hand corner of the claim form as shown in Figure 192.

- The beneficiary's Medicare number should be entered in FL 12 (Figure 138).
- The beneficiary's nine-digit Medicaid number should be entered in FL 15 (Figure 141).
- The ten-digit NPI number should be entered in FL 49 (Figure 179).
- Optional: The nine-digit Medicaid provider number should be entered in FL 52A (Figure 183).
- The claim detail information should match the individual EOMB detail level information.
- The corresponding claim information should be circled on the EOMB and the EOMB attached to the back of the claim.
- Any prior payer payments should be reported in FL 31a (Figure 160) of the UB-04.

The Medicare EOMB must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out patient data not applicable to the claim submitted.
- The provider may line out any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).
- The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled and never highlighted.

Note: The MISSISSIPPI CROSSOVER CLAIM FORM is no longer accepted.