4.0 Dental Claim Form Instructions

This section explains the procedures for obtaining reimbursement for dental services submitted to Medicaid. Mississippi Medicaid accepts both electronic and paper dental claims. **Dentists are strongly encouraged to bill electronic claims to reduce the potential for error 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:/ / ms-medicaid.com/ msenvision/ index.do. If you have questions, please contact the fiscal agent's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222.

Provider Types

The following provider types should bill using the Dental claim form:

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

Before You Bill Medicaid

- Check the beneficiary's eligibility for Medicaid.
- Check the beneficiary's eligibility for dental services.
- Check the beneficiary's service limits.
- Check the procedure code on the dental fee schedule to determine if prior authorization is needed.
- Check for other dental insurance coverage.
- Check the procedure code on the fee schedule to see if Mississippi Medicaid covers that code.
- Check the current version of the ADA's Current Dental Terminology code book for correct procedure codes.
- Check to see if the procedure code requires tooth, surface, or quadrant indicators.
- Check to see if co-payment is required.

Electronic Dental Claims

Electronic dental claims may be submitted to Mississippi Medicaid by these methods:

- Using the Web Portal Claims Entry feature
- Using WINASAP (free software available from the fiscal agent)
- 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 Dental claim standard.

Paper Dental Claims

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Complete an original ADA American Dental Association Dental Claim form. Mississippi Medicaid will only accept the ADA American Dental Association Dental Claim form; no other versions will be accepted.
- No photocopied claims will be accepted.
- Use blue or black type or ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc., print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.

Multi-Page Paper Claims

When submitting ADA American Dental Association Dental claims form with multiple pages, please follow these guidelines:

- If the number of procedures reported exceeds the number of lines available on one claim (10 lines per claim), the remaining procedures must be listed on a separate, fully completed claim form.
- Do not total the first form.
- Staple or clip the 2 pages together.
- If reporting TPL payment, indicate in field #35 on the **first claim**.
- Only one copy of an attachment (e.g. EOB, EOMB, Consent Form) is required.

Paper Claims with Attachments

When submitting attachments with the ADA American Dental Association Dental claim form, please follow these guidelines:

- Do not staple attachments more than once.
- 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.

Billing Tip

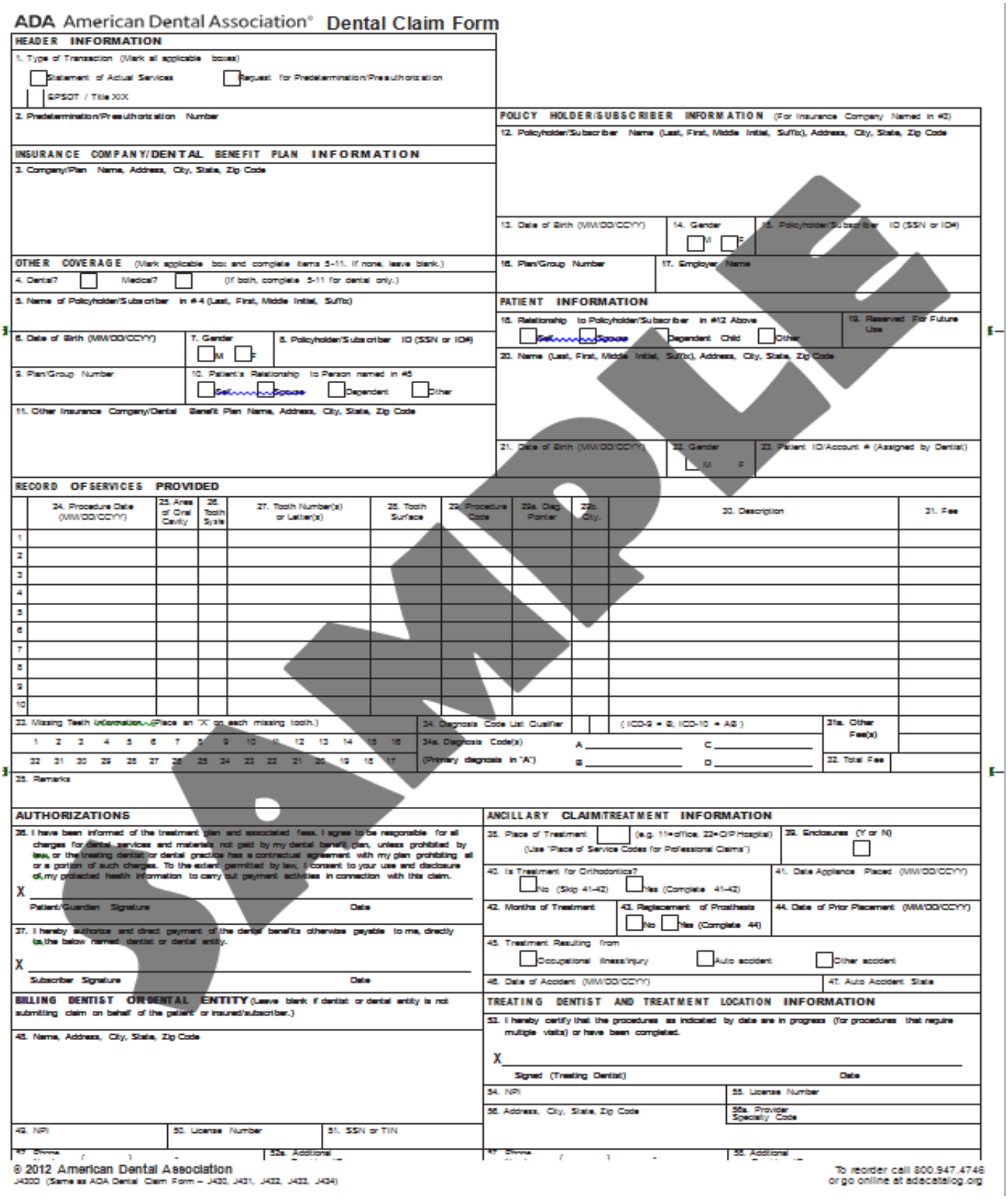
Be sure to include Treatment Authorization Number (TAN), timely filing Transaction Control Number (TCN), proper procedure codes, modifiers, units, etc. to prevent your claim from denying inappropriately.

Claim Mailing Address

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

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076

ADA American Dental Association Dental Claim Form



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

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 ☐Dependent ☐Other

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

POLICY HOLDER/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 ☐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 | 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										

32. 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 = 9; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ 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.)

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

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

47. Phone ( ) | 52a. Additional

ANCILLARY CLAIM/TREATMENT INFORMATION

39. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. 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 ( ) | 58. Additional

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

To reorder call 800.947.4746 or go online at adacatalog.org

ADA American Dental Association Dental Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
1	Not Required	Type of Transaction: Not Required.
2	**Required if Applicable**	**Predetermination/Preauthorization Number**: Enter TAN number for services that require PA and approval by the UM/ QIO. Refer to the Administrative Code and Dental Fee Schedule at http:/ / www.medicaid.ms.gov for specific instructions about services that require PA.
3	**Required**	**Company/Plan Name, Address, City, State, and Zip Code**: Enter the name and address for the insurance company that is the third party payer receiving the claim. For Mississippi Medicaid, enter Mississippi Medicaid Program, P. O. Box 23076, Ridgeland, MS 39225-3076. If the beneficiary has more than one dental insurance plan and Medicaid is the secondary payer, enter the Medicaid address in this field and complete fields 4 through 11 and field 17.
4	**Required**	**Other Dental or Medical Coverage?** Check "NO" if the patient does not have dental coverage under any other dental or medical benefit plan and do not complete fields 5-11. Check "YES" if the patient has dental coverage under any other dental or medical plan.
5	**Required if Applicable**	**Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix)**: If "yes" is checked in field #4, enter the name of the policyholder for the other dental or medical plan. If the patient has other coverage through a spouse, domestic partner or, if a child, through a parent, the name of the person who has other coverage is reported here.
6	**Required if Applicable**	**Date of Birth (MM/DD/CCYY):** If "yes" is checked in field #4, enter the date of birth of the person listed in field #5. The date must be entered with two digits for the month and day, and four digits for the year of birth.
7	**Required if Applicable**	**Gender:** If "yes" is checked in field #4, mark the gender of the person who is listed in field #5. Mark "**M" for male** or "**F" for female** as applicable.
8	**Required if Applicable**	**Policyholder/Subscriber Identifier (SSN or ID#):** If "yes" is checked in field #4, enter the Social Security Number or the identifier for the person listed in field #5. The identifier number is a number assigned by the payer/ insurance company to this individual.
9	**Required if Applicable**	**Plan/Group Number:** If "yes" is checked in field #4, enter the group plan or policy number for the person identified in field #5.
10	**Required if Applicable**	**Patient's Relationship to Person Named in Field #5:** If "yes" is checked in field #4, check the box corresponding to the patient's relationship to the other insured named in field #5.
11	**Required if Applicable**	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**: If "yes" is checked in field #4, enter the complete information of the additional payer, benefit plan or entity for the insured named in field #5.

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
12	**Required**	**Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code:** Enter the complete name, address and zip code of the Medicaid beneficiary receiving treatment.
13	**Required**	**Date of Birth (MM/DD/CCYY)**: Enter the Medicaid beneficiary's date of birth with two digits for the month and day and four digits for the year.
14	**Required**	**Gender:** Mark "**M" for male** or "**F" for female** as applicable for the beneficiary's gender.
15	**Required**	**Policyholder/Subscriber Identifier (SSN or ID#)**: Enter the full 9-digit Medicaid ID number for the beneficiary as indicated on the beneficiary's Medicaid ID card.
16	Not Required	Plan/ Group Number: Not required.
17	**Required if Applicable**	**Employer Name:** Required if the beneficiary has other dental insurance in addition to Medicaid. Enter the name of the policyholder/ subscriber's employer.
18	**Required**	**Relationship to Policyholder/Subscriber in #12 Above:** Mark the relationship of the patient to the person identified in field #12 who has the primary insurance coverage. For Medicaid beneficiaries, mark the box titled "Self" and skip to field #24.
19	Not Required	Student Status: Not required.
20	Not Required	Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code: Not required.
21	Not Required	Date of Birth (MM/ DD/ CCYY): Not required.
22	Not Required	Gender: Not required.
23	Not Required	Patient ID/ Account# (Assigned by Dentist): Not required.
24	**Required**	**Procedure Date (MM/DD/CCYY)**: Enter the procedure date for actual services performed. The date must have two digits for the month, two for the day, and four for the year.
25	**Required if Applicable**	**Area of Oral Cavity:** Enter the area of the oral cavity designated by a two-digit code as follows: 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
26	Not Required	Tooth System: Not required.

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
27	**Required if Applicable**	**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. 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. 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 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. See **Figure 4-2** for a list of procedure codes that require either a tooth number or a quadrant code.
28	**Required if Applicable**	**Tooth Surface:** Enter a tooth surface code when the procedure performed by tooth involves one or more tooth surfaces. See **Figure 4-2** for a list of procedure codes that require a surface code.
29	**Required**	**Procedure Code:** Enter the appropriate procedure code from the current version of the American Dental Association (ADA) Current Dental Terminology Manual.
29a	**Required**	**Diag Pointer: ("A" through "D": as applicale from Item 34a)**
29b	Not Required	Qty
30	**Required**	**Description:** Enter a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).
31	**Required**	**Fee:** Report the dentist's full fee or usual and customary charge. Do not deduct co-payment from your usual and customary charge.
31a	Not Required	Other Fee(s): Not required
32	**Required**	**Total Fee:** Enter the sum of all fees from lines in field #31.
33	**Required if Applicable**	**Missing Teeth Information:** Report a missing tooth/ teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant procedures.

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
34	**Required**	Diagnosis Code List Qualifier: (B for ICD-9-CM; AB for ICD-10-CM)
34a	**Required**	Diagnosis Code(s)/ A, B, C, D (up to four, with the primary adjacent to the letter "A")
35	**Required if Applicable**	**Remarks**: If submitting a claim that was originally submitted within twelve (12) months from the date of service, but is now over twelve (12) months old, enter the 17-digit transaction control number (TCN). If the beneficiary has dental insurance other than Medicaid, and Medicaid is the secondary payer, enter the payment amount received from the primary dental insurance in this field.
36	**Required**	**Patient Consent:** The beneficiary must sign his/ her name indicating he/ she 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. If the beneficiary cannot write his/ her name, he/ she should sign by a mark and have a witness sign his/ her name and indicate by whom the name was entered. If the beneficiary is a minor or is otherwise unable to sign, any responsible person such as a parent or guardian must enter the beneficiary's name and write "By," sign his/ her own name in the space, show his/ her relationship to the beneficiary, and explain briefly why the beneficiary cannot sign. 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 will allow 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 available must be specified.
37	Not Required	Insured's Signature**:** Not required.
38	**Required**	**Place of Treatment:** Check the appropriate box to indicate the place where services were provided. **Provider's Office** Service provided in the dentist office **Hospital** Service provided in the inpatient or outpatient hospital **ECF** Service provided in an extended care facility, e.g., nursing home, PRTF, ICF/ MR **Other** Service provided in a location other than those listed.
39	Not Required	Number of Enclosures (00 to 99): Not required.
40	Not Required	Is Treatment for Orthodontics? Not required.
41	Not required	Date Appliance Placed (MM/ DD/ CCYY): Not required.
42	Not Required	Months of Treatment Remaining: Not required.
43	Not Required	Replacement of Prosthesis? Not required.
44	Not Required	Date of Prior Placement (MM/ DD/ CCYY): Not required.

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
45	Not Required	Treatment Resulting From: Not required.
46	Not Required	Date of Accident (MM/ DD/ CCYY): Not required.
47	Not Required	Auto Accident State: Not required.
48	**Required**	**Billing Dentist Name, Address, City, State, and Zip Code:** Enter the name and complete address of the billing dentist, dental group, FQHC, or RHC.
49	**Required**	**Billing Dentist NPI (National Provider Identifier):** Enter the appropriate NPI number for the billing dentist, dental group, FQHC, or RHC. 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.
50	Not Required	License Number: Not required.
51	Not Required	SSN or TIN: Not required.
52	Not Required	Phone Number: Not required.
52A	**Optional**	**Additional Provider ID:** Enter the Medicaid provider number for the billing provider, i.e., dentist, dental group, FQHC, or RHC.
53	**Required**	**Certification:** 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 not acceptable. If anyone other than the provider is designated to sign the provider's name, a power of attorney must be on file and available on request. The provider is certifying that it is understood that payment and satisfaction of the claim will be from federal or state funds, and that any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable federal and state laws.
54	**Required**	**Treating Dentist NPI:** (National Provider Identifier): Enter the appropriate 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.
55	Not Required	License Number: Not required.
56	Not Required	Address, City, State, Zip Code: Not required.
56A	**Required**	**Provider Specialty Code:** 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 the Dental Service Providers section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions. The current full list of provider taxonomy codes is posted at www.wpc-edi.com/ codes/ codes.asp.
57	Not Required	Phone Number: Not required.
58	**Optional**	**Additional Provider ID:** Enter the Medicaid provider number for the treating or rendering dentist.

Figure 4-1. Checklist of Required ADA Dental Claim Form Fields

Dental Claim Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
1 Type of Transaction				✓
2 Predetermination/ Preauthorization Number		✓		
3 Company/Plan Name, Address, City, State, Zip Code	✓			
4 Other Dental or Medical Coverage?	✓			
5 Name of Policyholder/Subscriber with Other Coverage Indicated in Field #4		✓		
6 Date of Birth		✓		
7 Gender		✓		
8 Policyholder/Subscriber Identifier (SSN or ID#)		✓		
9 Plan/Group Number		✓		
10 Patient's Relationship to Person Named in Field #5		✓		
11 Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, Zip Code		✓		
12 Policyholder/Subscriber Name, Address, City, State, Zip Code	✓			
13 Date of Birth	✓			
14 Gender	✓			
15 Policyholder/ Subscriber Identifier (SSN or ID#)	✓			
16 Plan/Group Number				✓
17 Employer Name		✓		
18 Relationship to Policyholder/Subscriber in #12 Above	✓			
19 Student Status				✓
20 Name, Address, City, State, Zip Code				✓
21 Date of Birth				✓
22 Gender				✓
23 Patient ID/Account#				✓
24 Procedure Date	✓			
25 Area of Oral Cavity		✓		
26 Tooth System				✓
27 Tooth Number(s) or Letter(s)		✓		
28 Tooth Surface		✓		

Dental Claim Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
29 Procedure Code	✓			
29a Diag Pointer	✓			
29b Qty				✓
30 Description	✓			
31 Fee	✓			
31a Other Fee(s)				✓
32 Total Fee	✓			
33 Missing Teeth Information		✓		
34 Diagnosis code List Qualifier	✓			
34a Diagnosis Code	✓			
35 Remarks		✓		
36 Patient Consent	✓			
37 Insured's Signature				✓
38 Place of Treatment	✓			
39 Number of Enclosures				✓
40 Is Treatment for Orthodontics?				✓
41 Date Appliance Placed				✓
42 Months of Treatment Remaining				✓
43 Replacement of Prosthesis?				✓
44 Date of Prior Placement				✓
45 Treatment Resulting From				✓
46 Date of Accident				✓
47 Auto Accident State				✓
48 Billing Dentist Name, Address, City, State, Zip Code	✓			
49 Billing Dentist NPI	✓			
50 License Number				✓
51 SSN or TIN				✓
52 Phone Number				✓
52A Additional Provider ID			✓	
53 Certification	✓			
54 Treating Dentist NPI	✓			
55 License Number				✓
56 Address, City, State, Zip Code				✓
56A Provider Specialty Code	✓			
57 Phone Number				✓
58 Additional Provider ID			✓	

Figure 4-2. Required Fields for Certain Dental Procedure Codes

Code	Surface	Tooth Number	Quadrant
D1351		X	
D2140	X	X	
D2150	X	X	
D2160	X	X	
D2161	X	X	
D2330	X	X	
D2331	X	X	
D2332	X	X	
D2335	X	X	
D2390	X		
D2391	X	X	
D2392	X	X	
D2393	X	X	
D2394	X	X	
D2750		X	
D2751		X	
D2752		X	
D2930		X	
D2931		X	
D2933		X	
D2934		X	
D2940		X	
D3220		X	

Code	Surface	Tooth Number	Quadrant
D3310		X	
D3320		X	
D3330		X	
D4210			X
D4211			X
D4240			X
D4241			X
D4260			X
D4261			X
D4341			X
D4342			X
D7140		X	
D7210		X	
D7220		X	
D7230		X	
D7240		X	
D7241		X	
D7250		X	
D7280		X	
D7310			X
D7311			X
D7320			X
D7321			X