ADA 2012 Claim Form Instructions

This document is intended to provide Alaska Medicaid-specific instructions for completion of the ADA 2012 claim form.

Each number listed in the instructions corresponds to a field on the ADA 2012 claim form; additional fields may be required for providers billing electronically in a HIPAA-compliant format.

These claim form instructions are intended for dental services providers.

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 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 ☐ Dependent ☐ 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 ☐ 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										

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 _____

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

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) ☐

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

42. Months of Treatment Remaining | 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

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

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or go online at adacatalog.org

Sample ADA 2012 Claim Form

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
1.	Type of Transaction	M	Select **Statement of Actual Services**.
2.	Predetermination/Preauthorization Number	C	Enter the applicable Alaska Medicaid service authorization number.
Insurance Company/Dental Benefit Plan Information			
3.	Company/Plan Name, Address, City, State, Zip Code	M	Conduent State Healthcare, LLC P.O. Box 240769 Anchorage, AK 99524-0769
Other Coverage			
4.	Dental? Medical?	C	Select whether patient's other coverage is dental or medical. If marked, complete boxes 5-11. If none, leave blank. **NOTE**: If you selected both, complete fields 5-11 for dental coverage only.
5.	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	C	
6.	Date of Birth (MM/DD/CCYY)	C	
7.	Gender	C	
8.	Policyholder/Subscriber ID (SSN or ID#)	C	
9.	Plan/Group Number	C	
10.	Patient's Relationship to Person named in #5	C	
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	C	
Policyholder/Subscriber Information			
12.	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip code	M	Enter patient's full name and address.
13.	Date of Birth (MM/DD/CCYY)	M	Enter patient's DOB.

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
14.	Gender	M	Mark patient's gender.
15.	Policyholder/Subscriber ID (SSN or ID#)	M	Enter patient's Alaska Medical Assistance ID number.
16.	Plan/Group Number	B	
17.	Employer Name	O	Enter name of patient's employer.
Patient Information			
18.	Relationship to Policyholder/Subscriber in #12 Above	O	If used, select **Self**.
19.	Reserved for Future Use	B	
20.	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	B	
21.	Date of Birth (MM/DD/CCYY)	B	
22.	Gender	B	
23.	Patient ID/Account # (Assigned by Dentist)	O	Enter patient's record or account number used for provider record keeping purposes only. This number will appear after the claim control number on your remittance advice.
Record of Services Provided			
24.	Procedure Date (MM/DD/CCYY)	M	Enter the date services were rendered; no more than 10 lines per claim.
25.	Area of Oral Cavity	C	Always report, if applicable. **Code** **Area** **Code** **Area** **00** Entire Oral Cavity **20** Upper Left Quadrant **01** Maxillary Arch **30** Lower Left Quadrant **02** Mandibular Arch **40** Lower Right Quadrant **10** Upper Right Quadrant
26.	Tooth System	O	

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
27.	Tooth Number(s) and Letter(s)	C	Enter the appropriate tooth number/letter when the procedure directly involves a tooth, otherwise leave blank. If the same procedure is performed on more than one tooth on the same date, report each procedure and tooth as a separate line item.
28.	Tooth Surface	C	If the procedure involves one or more tooth surfaces, annotate all that apply with no spaces between surface designators. **B** – Buccal **F** – Facial (Labial) **L** – Lingual **O** – Occlusal **D** – Distal **I** – Incisal **M** – Mesial
29.	Procedure Code	M	
29a.	Diagnosis Pointer	C	If a diagnosis code is entered in field 34a, enter the corresponding line's letter (**A**, **B**, **C**, or **D**) here.
29b.	Qty.	M	
30.	Description	M	Enter brief description of service provided (not justification).
31.	Fee	M	Report full fee for each procedure.
31a.	Other Fee(s)	C	Enter any applicable additional fees, otherwise leave blank.
32.	Total Fee	M	Enter total of all fees (field 31 and 31a).
33.	Missing Teeth Information	M	Missing teeth should be reported when pertinent to Periodontal, Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim.
34.	Diagnosis Code List Qualifier	C	If a diagnosis code is entered in field 34a, enter an ICD-10 (**AB**) qualifier
34a.	Diagnosis Code(s)	O	Diagnosis codes are not required. If a diagnosis code is used: • Enter the primary diagnosis code on line **A**; if multiple diagnosis codes apply, enter secondary ones on lines **B** – **D**. • Only ICD-10 diagnosis codes may be used.
35.	Remarks	C	Enter applicable third party liability amounts. Additional documentation must be **attached** to claim as needed for medical justification.
Authorizations			
36.	Patient/Guardian Signature	O	The patient is not required to give their signature, but the provider must have consent to perform procedure. May enter **Signature on File**.

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
37.	Subscriber Signature	O	
Ancillary Claim/Treatment Information			
38.	Place of Treatment	M	Enter appropriate 2-digit "Place of Service" code; full list available at www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf. Frequently used "Place of Service" codes are: **11** = Office **22** = Out. Hospital **21** = In. Hospital **24** = ASC
39.	Enclosures (Y or N)	M	
40.	Is Treatment for Orthodontics	M	If **No**, skip to field 43; if **Yes**, complete fields 41-42.
41.	Date Appliance Placed (MM/DD/CCYY)	C	
42.	Months of Treatment Remaining	C	
43.	Replacement of Prosthesis	M	If **No**, skip to field 45; if **Yes**, complete field 44.
44.	Date of Prior Placement (MM/DD/CCYY)	C	
45.	Treatment Resulting from	C	Check all that apply; complete fields 46-47 as applicable.
46.	Date of Accident (MM/DD/CCYY)	C	
47.	Auto Accident State	C	
Billing Dentist or Dental Entity			
48.	Name, Address, City, State, Zip Code	M	Provider billing information must match the information on service authorization or claim will deny.
49.	NPI	M	
50.	License Number	O	
51.	SSN or TIN	O	
52.	Phone Number	O	
52a.	Additional Provider ID	C	Use to report Group Enterprise ID if group has more than one location. **Only** the Group Enterprise ID will be accepted; any other entry may cause claim to deny.

Claim Field Identification		M: Mandatory C: Mandatory-Conditional O: Optional B: Leave Blank	Alaska Medicaid-Specific Instructions
Treating Dentist and Treatment Location Information			
53.	Treating Dentist's Signature	M	
54.	NPI	M	
55.	License Number	O	
56.	Address, City, State, Zip Code	M	
56a.	Provider Specialty Code	C	If applicable, enter the appropriate provider specialty (**taxonomy**) of the treating provider; this must match Alaska Medicaid provider enrollment records.
57.	Phone Number	O	
58.	Additional Provider ID	B	