First Health Services Corporation®
A Coventry Health Care Company
1835 S. Bragaw St., Suite 200
Anchorage, AK 99508-3469
1-800-770-5650
1-907-644-6800
http://alaska.fhsc.com

Alaska

June 27, 2007

CDT Claim Form Instructions

The Alaska Medicaid Management Information System (MMIS) is now equipped to accommodate the new J400 American Dental Association claim form. During a transition period which will end August 31, 2007, Alaska Medicaid will accept either older versions of the American Dental Association claim form or the new version (J400) of the American Dental Association claim form. Older versions of the American Dental Association claim form received on or after September 1, 2007 will be returned to the provider without processing.

Instructions for submitting the new version (J400): All claims must be submitted with the Medicaid Provider ID number. National Provider Identifier (NPI) numbers may also be submitted.* A few of the critical fields and the information on how to complete them are listed below:

ADA 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
First Health Service Corporation
P.O. Box 240769
Anchorage, AK 99524-0649

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

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

13. Date of Birth (MM/DD/CCYY) **03/03/1933** | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number **LEAVE BLANK** | 17. Employer Name

Item #4 Required. If the answer to Item #4 is no, then skip Items #5-11. If the answer to Item #4 is yes, then Items #5-11 must be completed. Items #5-11 apply to the individual that has the other coverage and should be completed with the applicable information.

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

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

* Providers will need to include their Medicaid Provider ID number on all paper claim forms until they have been tested for submission of NPI number only.

ADA Dental Claim Form

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   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

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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

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Recipient Name
Recipient Address
Recipient City, State ZIP Code

13. Date of Birth (MM/DD/CCYY) **03/03/1933** | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number **LEAVE BLANK** | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS
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)

Item #12 Required. Enter the recipient's information.

Item #15 Required. Enter the recipient's Alaska Medical Assistance ID #.

Item #23 Optional. Enter the patient's medical record or account number. The field can accommodate up to 11 characters (alpha/numeric are acceptable). This information will print following the Claim Control Number (CCN) on your Remittance Advice (RA).

16. Plan/Group Number **LEAVE BLANK** | 17. Employer Name **OPTIONAL**

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) **LEAVE BLANK** | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

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.

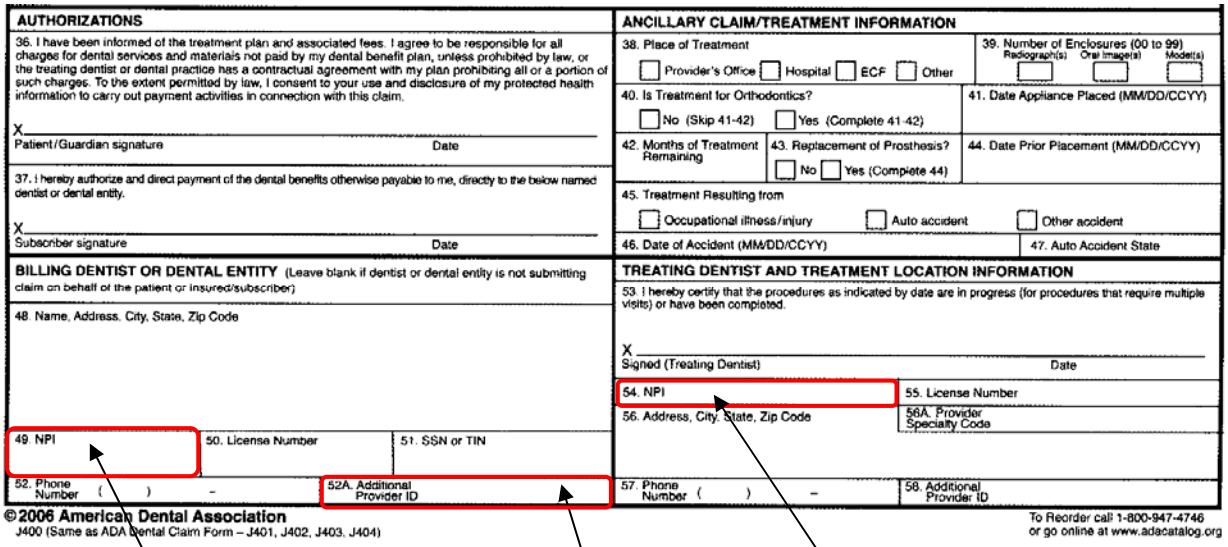
X_____
Subscriber signature Date

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

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

Item #35 Required, if applicable. Use this Item # to report Third Party Liability amounts, emergency services and medical justification. If more than one situation applies to a claim, first enter the TPL amount paid followed by two spaces ($###.##) and then any additional information.



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: Provider's Office, Hospital, ECF, Other

39. Number of Enclosures (00 to 99): Radiograph(s), Oral Image(s), Model(s)

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 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

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

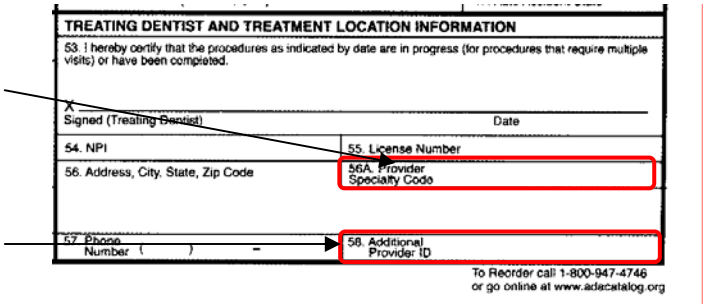
Item #49 Required. Enter the NPI for the billing entity.

Item #54 Required. Enter the NPI for the rendering/servicing entity.

Item #52A Required. Enter the Medicaid Provider ID Number for the billing dentist or dental entity.

Item # 56A Required, if applicable. Enter the taxonomy code that depicts the type of dental professional delivering the treatment.

Item #58 Required. Enter the appropriate Medicaid Provider ID Number for the rendering dentist.



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.

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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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For more information and instructions, please go to http://www.ada.org/prof/resources/topics/topics_claimform.pdf and http://www.wpc-edi.com/codes.

The provider manual is currently being updated with the above information. It will be available on FHSC's website (http://alaska.fhsc.com) upon completion. Watch the provider newsletter and Remittance Advice for more information.