ADA Version 2006

Claim form billing instructions for the Department of Human Services

DHS
Oregon Department of Human Services

Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the ADA Version 2006 billing form correctly the first time. If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~ DHS ~

MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted.

Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

Before you bill

- Read your provider guidelines.
- Verify recipient eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.
- Use the commercially available ADA Version 2006 claim form.

A few tips!

- When submitting handwritten claim forms, you must use blue or black ink.
- Make sure your handwriting is legible.
- If possible, submit no more than ten lines of services per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

Form suppliers

- ADA forms are not supplied by DHS.
- Forms are available by contacting one of the following:
  - Local business forms suppliers
  - American Dental Association (800-947-4746) or on the Web at <www.adacatalog.org>

Services billed on ADA Version 2006

- Dental services provided by a:
  - Dentist
  - Denturist
- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

Introducing ADA Version 2006

A D A 2 0 0 6

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

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

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. 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)

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. 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

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

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

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)

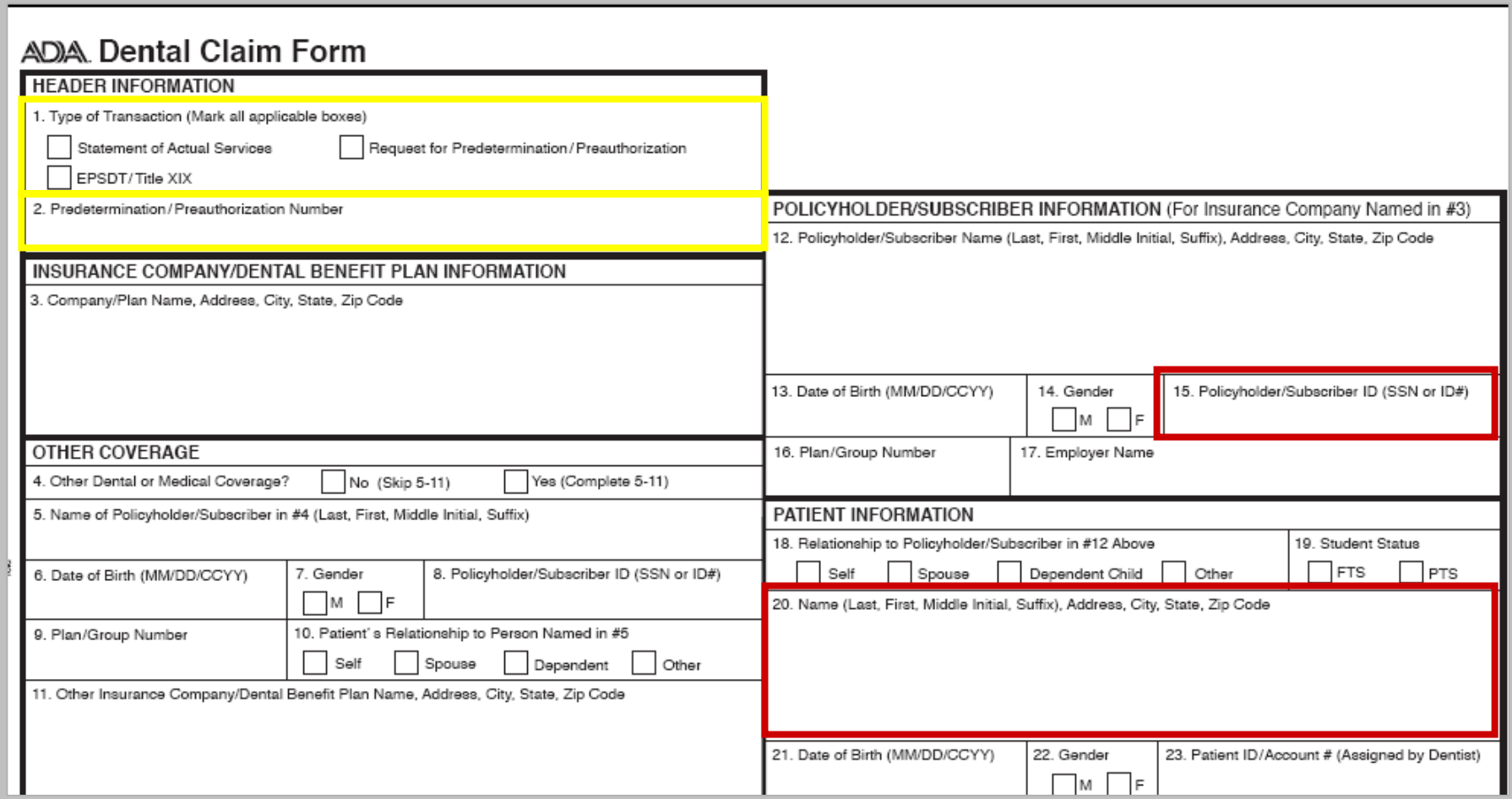
To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

ADA Version 2006

- Not sure if you are using the correct form?

The bottom left corner will look like this.

Top section



ADA Dental Claim Form

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☐ 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

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#)

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16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

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

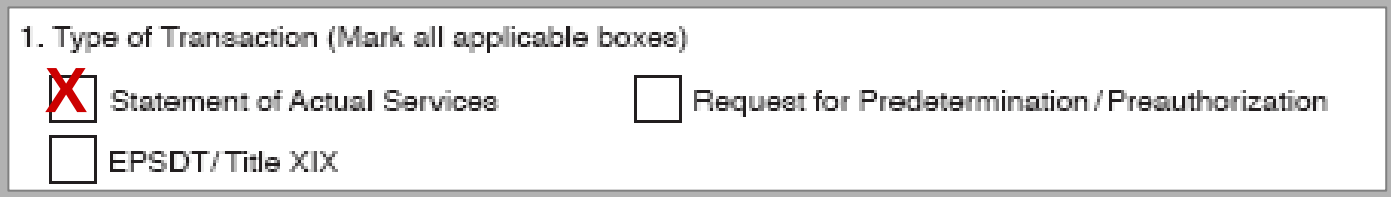
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

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

Red = Required

Yellow = Optional

Box 1 - Optional



Type of Transaction

- Indicate whether the claim is for pre-treatment or for actual services.

Box 2 - Optional

Preauthorization Number

- If the service you provided required prior authorization (PA), enter the nine-digit prior authorization number that was issued for the service.
- Only use one prior authorization number per claim form.

Box 15 - Required

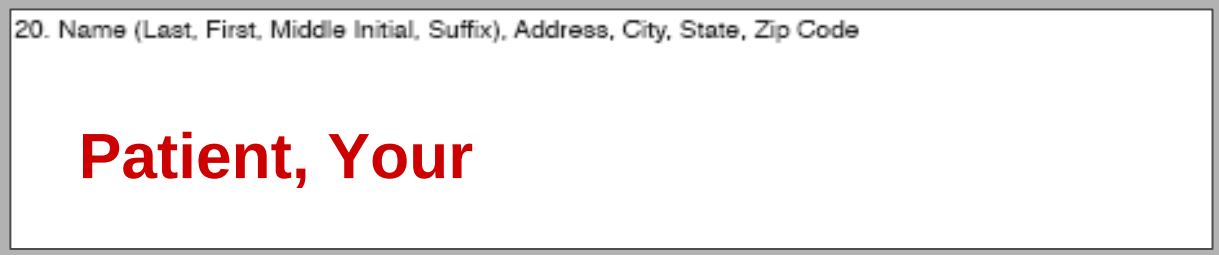
15. Policyholder/Subscriber ID (SSN or ID#)

X X # # # X # X

Recipient ID Number

- Enter the recipient's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.
- Do not use the recipient's Social Security Number.

Box 20 - Required



Recipient Name

- Enter the recipient's name exactly as it is printed on the Medical Care Identification.
- Use your recipient's last name first.
- Do not use nicknames.

Middle section

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

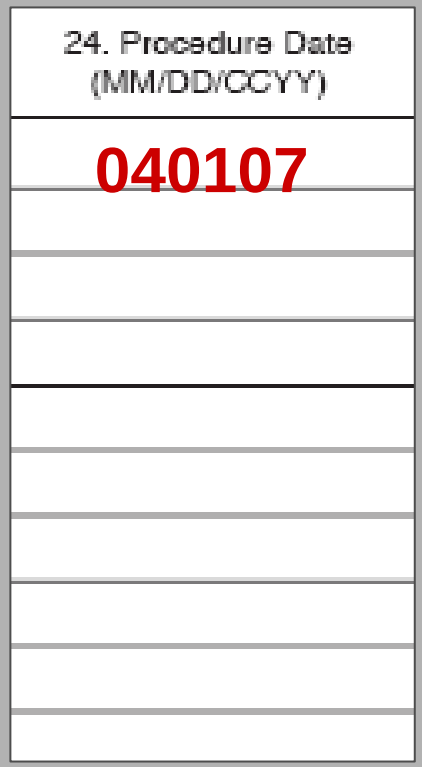
MISSING TEETH INFORMATION	Permanent																Primary										32. Other Fee(s)	
34. (Place an 'X' on each missing tooth)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

Red = Required

Yellow = Optional

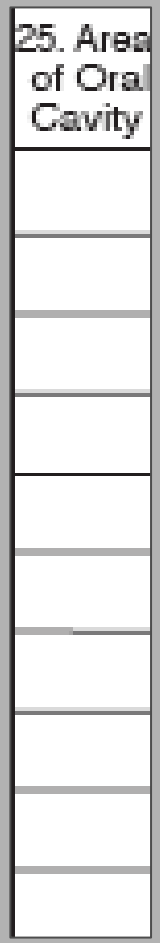
Box 24 - Required



Procedure Date

- This box must list numeric dates of service for each line item.

Box 25 - Optional



Area of Oral Cavity

- If appropriate, use one of the following codes for each line item.

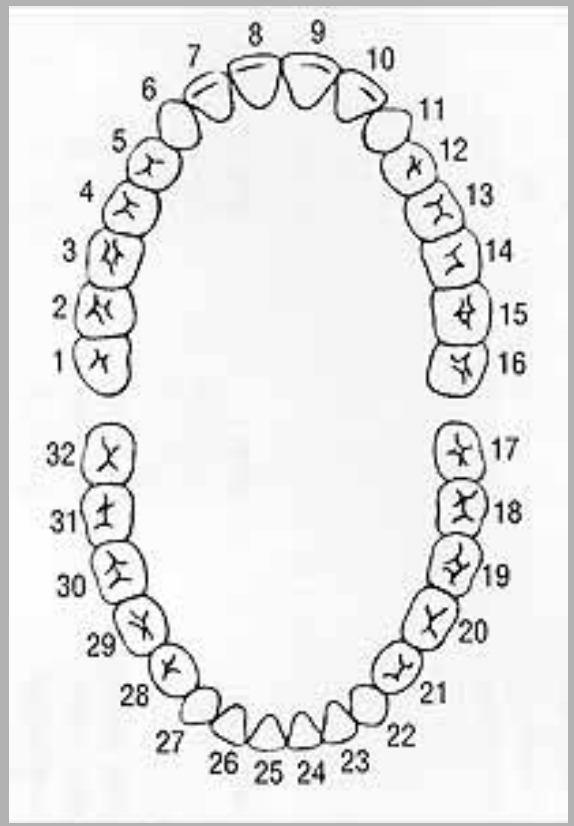
00	Entire Oral Cavity
01	Maxillary Arch
02	Mandibular Arch
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

Box 27 - Optional

Tooth Numbers or Letters

- If appropriate, enter the tooth number or letter.
- Leave blank if the procedure does not directly involve a tooth or range of teeth.
- Refer to tooth chart appearing on the following page.
  - A-T Deciduous teeth
  - 1-32 Permanent teeth
  - 51-82 Supernumerary teeth

Tooth Chart



1. 3rd Molar (wisdom tooth)
2. 2nd Molar (12-year molar)
3. 1st Molar (6-year molar)
4. 2nd Bicuspid (2nd premolar)
5. 1st Bicuspid (1st premolar)
6. Cuspid (canine/eye tooth)
7. Lateral incisor
8. Central incisor
9. Central incisor
10. Lateral incisor
11. Cuspid (canine/eye tooth)
12. 1st Bicuspid (1st premolar)
13. 2nd Bicuspid (2nd premolar)
14. 1st Molar (6-year molar)
15. 2nd Molar (12-year molar)
16. 3rd Molar (wisdom tooth)

17. 3rd Molar (wisdom tooth)
18. 2nd Molar (12-year molar)
19. 1st Molar (6-year molar)
20. 2nd Bicuspid (2nd premolar)
21. 1st Bicuspid (1st premolar)
22. Cuspid (canine/eye tooth)
23. Lateral incisor
24. Central incisor
25. Central incisor
26. Lateral incisor
27. Cuspid (canine/eye tooth)
28. 1st Bicuspid (1st premolar)
29. 2nd Bicuspid (2nd premolar)
30. 1st Molar (6-year molar)
31. 2nd Molar (12-year molar)
32. 3rd Molar (wisdom tooth)

Box 28 - Optional

28. Tooth Surface

Tooth Surface

- If appropriate, list the tooth surface code for each service.

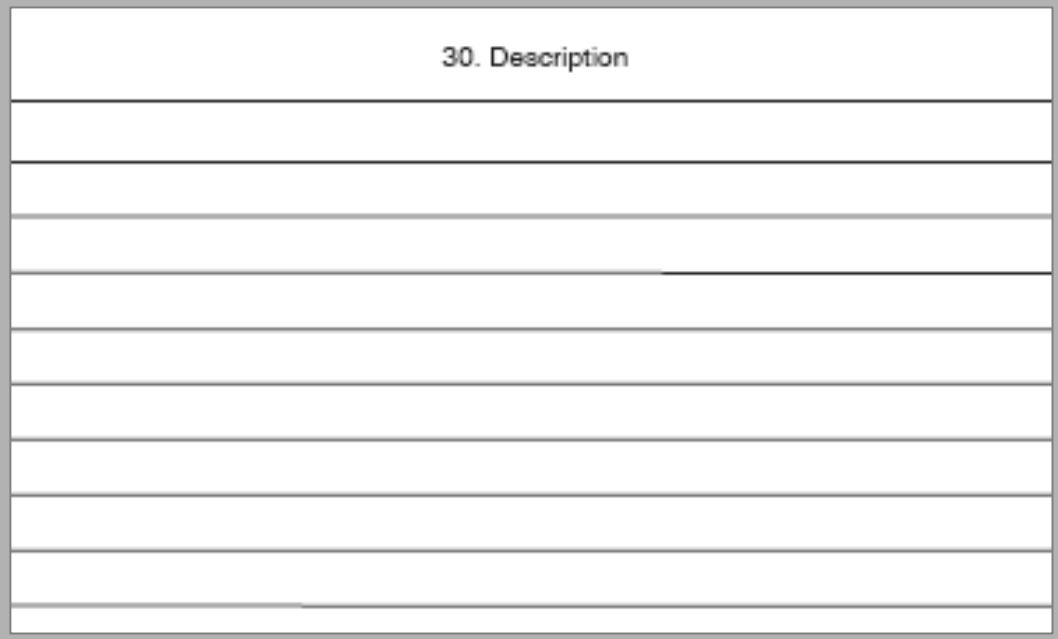
B	Buccal
M	Mesial
D	Distal
O	Occlusal
L	Lingual
I	Incisal
F	Facial

Box 29 - Required

Procedure Code

- For each line, list the five-character ADA procedure code for each individual tooth/service that was provided.
- ADA procedure codes always begin with D.

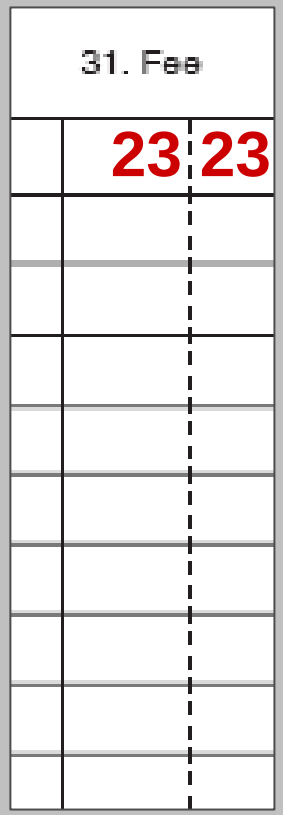
Box 30 - Optional



Description

- List the description of the service performed for each line item.

Box 31 - Required



Fee

- Enter the total usual and customary charge for each line of service.
- Do not list credits.
- Do not use dashes.

Box 33 - Required

33.Total Fee		23	23

Total Fee

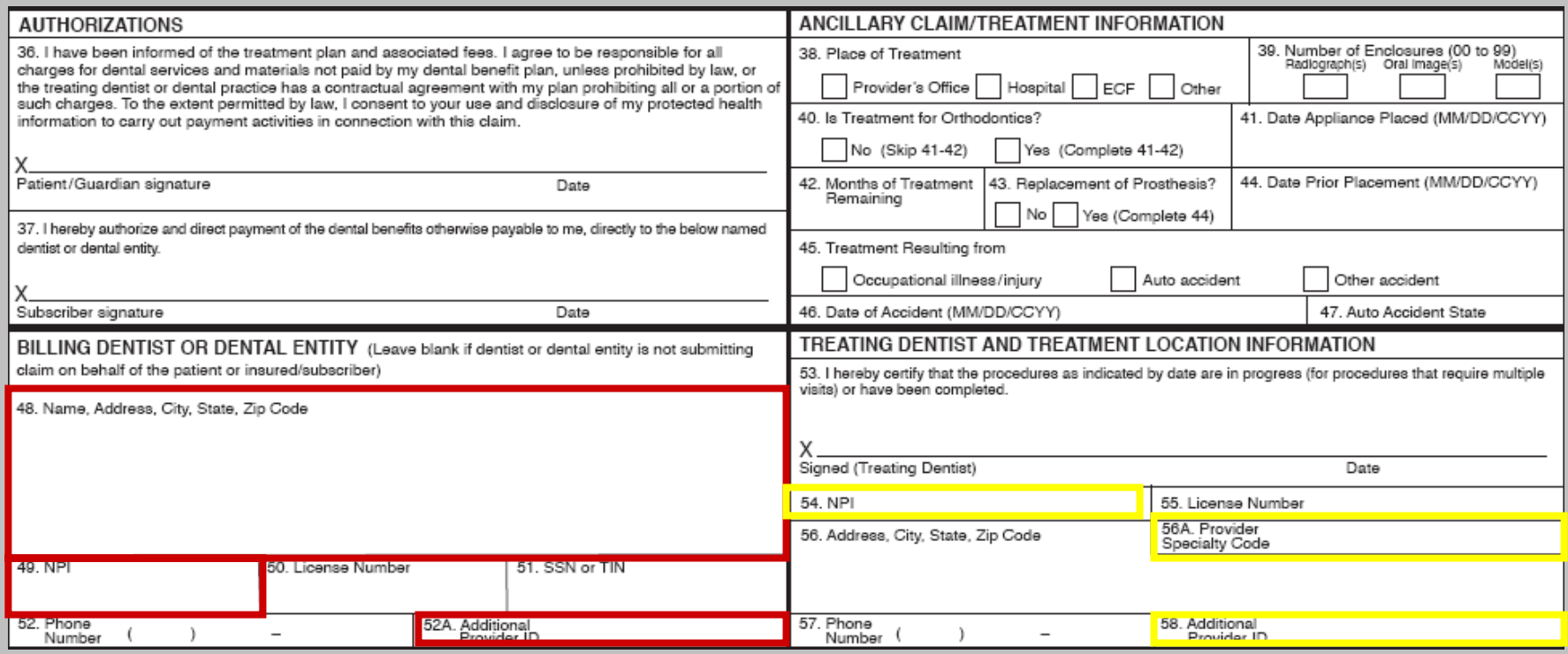
- Enter the total for all fees listed in Box 31.

Box 35 - Optional

Remarks

- If appropriate, enter “Payment by other plan” information, if any; or leave blank and attach a copy of plan’s Remittance Advice (RA).
- You can also use this area for documentation when requesting prior authorization, or for unusual circumstances when filing a claim.

Bottom section



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

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

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

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

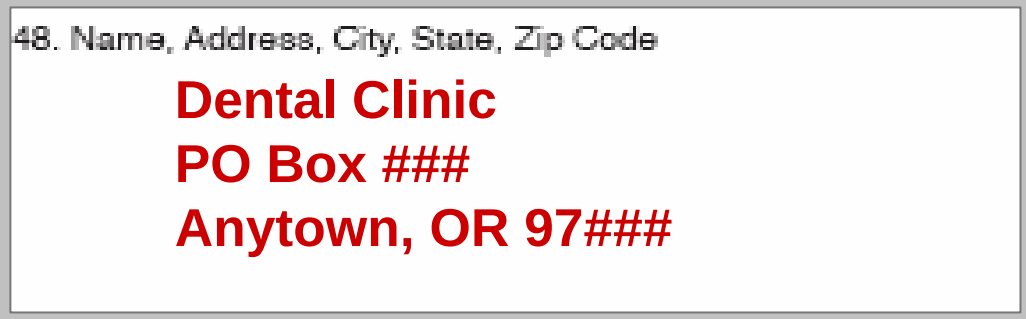
57. Phone Number ( ) –

58. Additional Provider ID

Red = Required

Yellow = Optional

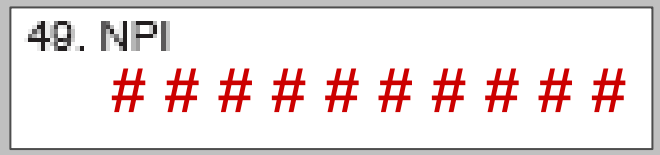
Box 48 - Required



Billing Provider Name

- Enter the name and address of the Billing Provider.

Box 49 - Required



Billing Provider National Provider Identifier (NPI)

- Enter the ten-digit NPI of the billing provider.

Box 52A - Required

Additional Provider ID

- Enter the six-digit (DHS issued) billing provider number.
- Do not enter the billing provider’s license number in this box.

Box 54 - Optional

54. NPI ##########

Treating Provider National Provider Identifier (NPI)

- If the billing provider identified in box 48, 49 and 52A is a billing clinic, enter the ten-digit NPI of the treating dentist.

- Or, if the treating dentist is already identified in box 48, 49, and 52A, leave this box blank.

Box 58 - Optional

Additional Treating Provider ID

- If the billing provider identified in box 48, 49 and 52A is a billing clinic, enter the six-digit (DMAP issued) provider number of the treating dentist.
- Or, if the treating dentist is already identified in box 48, 49 and 52A, leave this box blank.
- Do not use license numbers in this box.

COMPLETED

EXAMPLE

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[X] Statement of Actual Services [ ] Request for Predetermination / Preauthorization [ ] EPSDT / Title XIX

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

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13. Date of Birth (MM/DD/CCYY) | 14. Gender [ ] M [ ] F | 15. Policyholder/Subscriber ID (SSN or ID#) XX###X#X

16. Plan/Group Number | 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

Patient, Your

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	30. Description	31. Fee
1	040107					D0120		23 23
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

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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

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

Dental Clinic
PO Box ###
Anytown, OR 97###

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

52. Phone Number ( ) – | 52A. Additional Provider ID ######

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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X_____
Signed (Treating Dentist) Date

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

57. Phone Number ( ) – | 58. Additional Provider ID ######

Resources

Where to mail your claim

- Mail your ADA 2006 claim form to:

  DMAP
  PO Box 14953
  Salem, OR 97309-4957

Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or questions concerning your ADA 2006 claim form.
- They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: DMAP.providerservices@state.or.us

Thank You!