DWC FORM-70
INSTRUCTIONS FOR COMPLETING THE ADA J515 DENTAL CLAIM FORM FOR TEXAS WORKERS' COMPENSATION CLAIMS

The ADA Dental Billing form is designed so that the Insurance Carrier's name and address (Item 3-Primary Payer Information) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the left and right margins.

The upper-right blank space is provided for insertion of the payer's claim or control number.

(a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow. **R=Required, C=Conditional, O=Optional**

(b) When a name and address field is required, the full entity or individual name, address, and zip code must be entered (i.e., Items 3, 12, 20, and 48).

(c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 41, 44, and 53).

(d) If the number of procedures being reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the insurance carrier.

(e) "Request for Reconsideration" must be indicated on the top of the form when applicable.

Data Element Specific Instructions

1. Leave blank.
2. Preauthorization or voluntary certification number. (C)
3. Workers' compensation insurance carrier name and address. (R)

4 - 11. Leave blank.

12. Local insured employer's current business address, city, state, zip code, (R) and phone number, if known (C).

13-14. Leave blank.

15. Workers' Compensation insurance carrier claim number, if known. (C)

16-19. Leave blank.

20. Injured worker's name address, city, state, zip code, and phone number, if known. (R)
21. Injured worker's date of birth. (R)
22. Injured worker's gender. (R)
23. Injured worker's ID (if SSN not available, use driver's license # & jurisdiction, green card # plus "ZY", visa # plus "TA", or passport # plus "ZZ") NOTE: Do not use dental record or account number.
24. Date of service. (R)
25. Designate the tooth number or letter when a procedure code directly involves a tooth. Use "Area of Oral Cavity" code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'. (C)
26. Enter the applicable ANSI ASC X12 code list qualifier: Use "**JP**" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "**JO**" when using the ANSI/ADA/ISO Specification No. 3950. (C)
27. Designate the tooth number when the procedure code reported directly involves a tooth. If a range of teeth are being reported, use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported. (C)
28. Designate tooth surface(s) when the procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: **B** = Buccal; **D** = Distal; **F** = Facial; **L** = Lingual; **M** = Mesial; and **O** = Occlusal. (C)
29. Use the appropriate dental procedure code from the current version of the *Code on Dental Procedures and Nomenclature*. (R)
30. Description of the service provided. (R)
31. Dentist's full charge for the dental procedure reported. (R)
32. Leave blank.
33. Total of all charges listed on the claim form. (R)
34. Report missing teeth on each claim submission. (C)

35. Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth. (C)
36-37. Leave blank.
38. Indicate the place of service. (ECF is the acronym for **E**xtended **C**are **F**acility (e.g., nursing home). (R)
39. Indicate the number of enclosures to the claim form. (C)
40. Check “No” and skip to block 45.
45. Check “Occupational illness/injury.” (R)
46. Date of injury or occupational illness. (R)
47. Leave blank.
48. Name, address, city, state, and zip code of the individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information where the health (dental) care was rendered or services were provided. This information should appear on any payments or correspondence that will be remitted to the billing dentist. (R)
49-50. Leave blank.
51. Federal tax I.D., Social Security number or country’s unique ID# of the entity listed in box 48. (R)
52. Phone number of the entity listed in box 48. (R)
53. The treating, or rendering, dentist's signature and date the claim form was signed. (R)
54. Once adopted by CMS, DWC will require the use of a National Provider Identification Number in lieu of the license information. (C)
55. Professional license type code, license number, and jurisdiction (no spaces or hyphens e.g., DS12345TX) of the individual dentist who rendered the health care. (R)
56. Full address, including city, state, and zip code, where the treatment was performed by the treating (rendering) dentist. (R)
57. Phone number, if different than the entity listed in box 52. (C)
58. Leave blank.