Chapter 10: Billing on the ADA Claim Form

Introduction

Health Choice Insurance Co. (HCE) requires the use of the most current ADA claim form. Claim forms must be filed for all services provided.

Any updates to the ADA Dental Claim Form completion instructions will be posted on the ADA's web site at: www.ada.org/goto/dentalcode

National Provider Identifier (NPI)

49 and 54

NPI (National Provider Identifier): This is an identifier assigned by the Federal government to all providers considered HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation.

An NPI is unique to an individual dentist or dental entity, and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA Internet Web site: www.ada.org/goto/npi

Additional Provider Identifier

52A and 58

Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

Data Element Specific Instructions

Form completion instructions are provided for each data item, which is identified by a number. Please note that data items are in groups of related information. These instructions explain the reasons for such groupings, and the relationships (if any) between groups.

Completing the ADA Claim Form

Header Information

The 'header' provides information about the type of submission being made. This information applies to the entire transaction.

HEADER INFORMATION
1. Type of Transaction (Check all applicable boxes) Statement of Actual Services ☐ Request for Predetermination/Preauthorization
2. Predetermination/Preauthorization Number **103336669724**

1. **Type of Transaction -Not required**
   There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box marked "Request for Predetermination/Preauthorization". If the claim is through the **E**arly and **P**eriodic **S**creening, **Diagnostic** and **T**reatment Program, check the box marked "EPSDT/Title XIX".

2. **Predetermination/Preauthorization Number -Required if applicable**
   If you are submitting a claim for a procedure that has been pre-authorized by a third party payer, enter the preauthorization or predetermination number provided by the insurance company.

Insurance Company/Dental Benefit Plan Information

Insurance Company/Dental Benefit Plan Information
3. Name, Address, City, State, Zip Code **Health Choice Insurance Co.** **410 N. 44th St. Ste 500** **Phoenix, AZ 85008**

3. **Company/Plan Name, Address, City, State, Zip Code -Required if applicable**

   Enter the information for the insurance company or dental benefit plan that is the third party payer receiving the claim.

Policy/Subscriber Information (For Insurance Company Named in Item #3)

This section documents information about the insured person who may or may not be the patient.

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
4. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip **Claus, Santa J.** **1234 N. Pole Place** **Phoenix, AZ 85001**		
5. Date of Birth (MM/DD/CCYY) **10/05/1999**	6. Gender M ☐ F	7. Policyholder/Subscriber Identifier
8. Plan/Group Number	9. Employer Name	

4. **Policy Holder/Subscriber Name and Address -Required**
   Enter the complete name, address and zip code of the policy holder/subscriber with coverage from the company/plan named in #

5. **(MM/DD/CCYY)-Date of Birth required**

   A total of eight digits are required in this field; two for the month, two for the day of the month and four for the year.

6. **Gender- required**
   This applies to the primary insured, who may or may not be the patient. Check "M" for male or "F" for female.

7. **Policy holder/Subscriber Identifier (ID)-Required**
   Enter the social security number of the person in Item #4, or the unique identifying number that has been assigned to the primary insured by the payer or insurance company.

8. **Plan/Group Number -Not required**
   Enter the policy holder/subscriber's group plan/policy number.

9. **Employer Name-Not required**
   If applicable, enter the name of the policy holder/subscriber's employer.

Patient Information

The information in this section of the claim form pertains to the patient.

PATIENT INFORMATION		
10. Relationship to Policyholder/Subscriber in #12 above Self ☐ Spouse Dependent		11. Student Status FTS ☐ PTS
12. Name (Last, First, Middle, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender M ☐ F	15. Patient ID/Account# (Assigned by Dentist)

10. **Relationship to Policy holder/Subscriber in #4 above-Not required**
    Mark the relationship c the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. If the patient is also the primary insured, mark the box titled "Self" and skip to item #15.

11. **Student Status -Not required**
    Mark "FTS" if patient is a dependent and a full-time student. Mark "PTS" if patient is a dependent and a part-time student. If neither applies, skip to Item #20.

12. **Name** (Last, First, Middle, Suffix), **Address, City, State, Zip Code -Not required**
    Enter the complete name, address and zip code of the patient.

13. **Date of Birth (MM/DD/CCYY)-Not required**
    A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.

14. **Gender -Not required**
    This applies to the patient. Mark "M" for male or "F" for female.

15. **Patient ID/Account # (Assigned by Dentist)-Required**
    Enter if the dentist's office has assigned a number to identify the patient.

Record of Services Provided

The "Record of Services Provided" contains information regarding the treatment performed (actual services), or proposed treatment (predetermination/preauthorization).

RECORD OF SERVICES PROVIDED								
	16. Proced ure	17. Area of Oral	18. To oth	19. Tooth Numbe	20. Tooth Surfac	21. Procedure Code	22. Description	23. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
MISSING TEETH			Pe				Pr	24.
26. Place an "X" on each			1 2 3 4 5		9 10 11 12		A B C F G H	Other
			32 31 30 29 28		24 23 22 21		T S R O N M	25.
27. Remarks								

NOTE: Items 16 through 22 following apply to each of the 10 available lines on the claim form for reporting dental procedures provided to the patient. **The remaining four Items in this section of the form (32-35) do not repeat.**

16. **Procedure Date (MM/DD/CCYY)-Required**
    Enter procedure date for actual services performed or leave blank if the claim is for preauthorization/predetermination. The date, if included, must have two digits for the month, two for the day, and four for the year.
    The presence or absence of a Procedure Date should be consistent with the type of transaction(s) marked in Item #1. (e.g., actual services; predetermination/preauthorization.

17. **Area of Oral Cavity-Required**
    Use of this field is conditional. Always report the area of the oral cavity **unless** one of the following conditions in Item #20 (Procedure Code) exists:
    a. The procedure identified in #20 requires the identification of a tooth or a range of teeth.
    b. The procedure identified in #20 incorporates a specific area of the oral cavity in its nomenclature (for example, 05110 complete denture-maxillary).
    c. The procedure identified in #20 does not relate to any portion of the oral cavity (for example, 05914 auricular prosthesis, or 09220 deep sedation/general anesthesia-first 30 minutes).

Area of the oral cavity is designated by a two-digit code, selected from the following code list:

CODE	AREA
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

18. **Tooth System-Required**
    Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation System (1-32 for **permanent** dentition and A – T for **primary** detention). Enter "JO" when using the International Standards Organization System.

19. **Tooth Number(s) or Letter(s)-Required**
    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 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).

Health CHOICE INSURANCE CO.

Supernumerary teeth in the **permanent** dentition are identified in the ADA's Universal/National Tooth Designation System ("JP") by the numbers 51 through 82, beginning in the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32.) This enumeration is illustrated in the following chart:

Tooth#	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super"	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Arch

Tooth#	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
"Super"	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Supernumerary teeth in the **primary** dentition are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is adjacent to "A", supernumerary "TS" is adjacent to "T"). This enumeration is illustrated in the following chart:

Upper Arch (commencing in the upper right quadrant and rotating counter-clockwise)

Tooth#	A	B	C	D	E	F	G	H	I	J
"Super"	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Arch

Tooth#	T	S	R	Q	P	O	N	M	L	K
"Super"	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

20. Tooth Surface-Required

This item is necessary when the procedure performed by tooth involves one or more tooth surfaces. The following single letter codes are used to identify surfaces:

SURFACE	CODE
Buccal	B
Distal	D
Facial (or labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

Do not leave any spaces between surface designations in multiple surface restorations.

21. **Procedure Code -Required**
    Enter the appropriate procedure code found in the version of the *Code on Dental Procedures and Nomenclature* in effect on the “Procedure Date” (Item #16).

22. **Description -Required**
    Provide a brief description of the service provided (e.g., abbreviation of the procedure code’s nomenclature).

23. **Fee-Required**
    Report the dentist’s full fee for the procedure.
    (Note: Item 22 above is the last of the repeating “service line” items)

24. **Other Fee(s)-Not required**
    When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.

25. **Total Fee -Required**
    The sum of all fees from lines in Item #22, plus and fee(s) entered in Item #23.

26. **Missing Teeth Information-Required**
    Missing teeth should be reported when pertinent to Periodontal, Prosthodontics (fixed and removable), or Implant Services procedures on a particular claim.

27. **Remarks -Not required**
    This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim (e.g., for a secondary claim, the amount the primary carrier paid).

    Remarks should be concise and pertinent to the claim submission. Claimants should note that an entry in “remarks” may prompt review by a person as part of claim adjudication, which may affect overall time to process the claim.

Authorizations

This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.

AUTHORIZATIONS
27. 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
28. 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

28. Patient Consent-Not required

The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient's parent, caretaker, guardian or other individual as appropriate under state law and the circumstances of the case.

By signing (or signature on file notice) in this location of the claim form, the patient or patient's representative 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.

Claim forms prepared by the dentist's practice management software may insert "signature on file" when applicable in this item.

29. Insured's Signature -Not required

The signature and date (or "signature on file" notice) are required when the insured wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company.

Claim forms prepared by the dentist's practice management software may insert "signature on file" when applicable in this item.

Ancillary Claim/Treatment Information

This section of the claim form provides additional information to the third party payer regarding the claim.

ANCILLARY CLAIM/TREATMENT INFORMATION				
Place of Treatment (Check applicable box) Provider's Office ☐ Hospital ☐ ECF ☐ Other ☐			Number of Enclosures (00-99) Radiograph(s) Image(s) Model(s) Oral ☐ ☐ ☐	
Is treatment for Orthodontics?			Date Appliance Placed (MM/DD/CCYY)	
No (Skip 31 – 32) (Complete 31 – 32)	Yes			
Months of Treatment Remaining	Replacement of Prosthesis?		Date Prior Placement (MM/DD/CCYY)	
	No ☐ Yes ☐			

Treatment resulting from (Check applicable box)

Occupational illness/injury ☐ Auto accident ☐ Other accident

30. **Place of Treatment (Check applicable box)-Required**
    There are four possible choices to mark – the provider or dentist's office; a hospital; an extended care facility (ECF e.g., nursing home): or "Other" if none of the prior options apply.

31. **Number of Enclosed (00 to 99)-Required if applicable**
    This item is completed whether or not radiographs, oral images or study models are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore no possible attachments are missing.

    When supplementary material is sent with the claim, the number of each type is entered in the appropriate box, using two digits. If less than 10, use 0 in the first position. "Oral Images" include digital radiographic images and photographs and are reported by the number of images.

32. **Treatment for Orthodontics-Required if applicable**
    If no, skip to Item #34. If yes, answer Items 32 & 33.

33. **Date Appliance Placed (MM/DD/CCYY)-Required if applicable**
    Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.

34. **Months of Treatment Remaining-Required if applicable**
    This item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures). Please review the following three situations in order to determine how to complete this item.
    A. If the claim does not involve a prosthetic restoration mark "NO" and proceed to Item #35.
    B. If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Item 35.
    C. If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete section 44.

35. **Date of Prior Placement (MM/DD/CCYY)-Required if applicable**
    Complete if the answer to Item #33 was yes.

36. **Treatment Resulting From (Check applicable box)-Required if applicable**
    If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box in this item, and proceed to Items #36 and #37. **If the services you are providing are not the result of an accident, this item does not apply; skit to Item #48.**

37. **Date of Accident (MM/DD/CCYY)-Required if applicable**
    Enter the date on which the accident noted in Item #35 occurred. Otherwise, leave blank.

38. **Auto Accident State-Required if applicable**
    Enter the state in which the auto accident noted in Item #35 occurred. Otherwise, leave blank.

Billing Dentist or Dental Entity

The "Billing Dentist" or "Dental Entity" section provides information on the individual dentist's name or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist. If the patient is submitting the claim directly, do not complete items 38-42.

<table>
<tr><td colspan="3">BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)</td></tr>
<tr><td colspan="3">38. Name, Address, City, State, Zip Code
Another Dentist Office
9876 N. Scottsdale Rd.
Scottsdale, AZ 22554</td></tr>
<tr><td>39. NPI 3453211234</td><td>40. License Number
4647</td><td>41. SSN or TIN 10-1021111</td></tr>
<tr><td colspan="2">42. Phone Number (480) 355-2222</td><td>42A. Additional
Provider ID 132456</td></tr>
</table>

39. Name, Address, City, State, Zip Code-Required
Enter the name and complete address of a dentist or the dental entity (corporation, group, ect.).

40. NPI (National Provider Identifier)-Required
Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioner's Type 1 NPI.

NOTE: The NPI is an identifier assigned by the Federal government to all providers considered to be HIPPA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation. An NPI is unique to an individual dentist or dental entity, and has no intrinsic meaning. There are two types of NPI available to dentists and dental practices.

Type 1 – Individual Provider: All individual dentists are eligible to apply for Type 1 NPI's regardless of whether they are covered by HIPPA.

Type 2 – Organization Provider: A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.

On paper, there is no way to distinguish a type 1 from a type 2 in the absence of any associated data; they are identical in format. Additional information on NPI and enumeration can be obtained from the ADA's Internet website: www.ada.org/goto/npi

41. License Number -Required
If the billing dentist is an individual, enter the dentist's license number. If a billing entity (e.g., corporation) is submitting the claim, leave blank.

42. SSN or TIN-Required
Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.

43. Phone Number -Not required
Enter the business phone number of the billing dentist or dental entity.

42A. Additional Provider ID -Not required

This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third party payer, Federal government.) Some Legacy IDs have an intrinsic meaning.

Treating Dentist and Treatment Location Information

This section must be completed for all claims. Information that is specific to the dentist who has provided treatment is entered in this section.

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 and that the fees submitted are the actual fees I have charged and intend to collect for those services. X		
44. NPI **3453211234**		45. License Number **4647**
46. Address, City, State, Zip Code **Another Dentist Office**	46A Provider Specialty Code	
9876 N. Scottsdale Rd. **Scottsdale, AZ 22554**		
47. Phone Number (480) 123 - 4567	48. Additional Provider ID **132467**	

44. Certification -Required

Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form. Dentists should be aware that they have an ethical and legal obligation to refund fees for services that are paid in advance but are not completed.

45. NPI (National Provider Identifier)-Required

Enter the treating dentist's Type 1 – Individual Provider NPI in Item #44.

46. License Number-Required

Enter the license number of the treating dentist. This may vary from the billing dentist.

47. Address, City, State, Zip Code -Not required

Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.

46A. Provider Specialty Code -Not required

Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists follow. The general code listed as “Dentist” may be used instead of any other dental practitioner codes.

Provider specialty codes (also known as “provider taxonomy codes”) come from the “Dental Service Providers” section of the Health Choice Providers Taxonomy code list, which is used in HIPPA transactions. Provider taxonomy codes listed above are subset of the full code set under dental providers, which includes codes in categories for dental assistants, dental hygienists, denturists and dental lab technicians. The current full list is posted at: www.wpc-edi.com/codes/codes.asp.

48. Phone Number -Not required

Enter the treating dentist’s telephone number.

49. Additional Provider ID-Not required

This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider’s NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third party payer, Federal government). Some Legacy IDs have an intrinsic meaning.