

**COMPLETION OF THE 2006 AMERICAN DENTAL ASSOCIATION (ADA)  
CLAIM FORM FOR MEDICAID REIMBURSEMENT**

*Listed below are the required and optional boxes for completing the ADA 2006 claim form for Medicaid reimbursement. Effective January 1, 2000 dental providers were no longer required to file with a patient's private insurance prior to filing Medicaid. DHHS designates specific boxes on this claim form (8,9,11,12,15,16 and 35) for you to report a private insurance or Medicare payment or denial, if applicable. If you have **NOT** billed another private insurance or Medicare, leave these boxes blank. If you put information in the TPL boxes, your claim is subject to TPL validity and consistency edits and may reject with insurance edit codes.*

*If you are reporting to Medicaid that you have billed another private insurance or Medicare, complete the boxes as indicated. An EOB for the private insurance or Medicare is not required except for claims with a Medicare covered procedure that Medicare has denied or claims that have received Edit Code 151. Contact your program coordinator if you receive this edit. A primary insurance should only be listed once on the ADA claim form.*

**Box    Description**

- 2. Predetermination/Preauthorization Number:** Enter the assigned seven-digit prior authorization number. If you have had a service prior approved, use miscellaneous procedure code D9999 in Box 29 in the place of the requested procedure(s). If D9999 is not used in the place of the prior approved procedure(s), your claim will reject. **REQUIRED, IF APPLICABLE.**

The word "emergency" must be present in this box if you are filing an emergency service(s) for a dental patient between the ages of 19 and 21. This prohibits an automatic deduction of the \$3.00 dental co-payment. For the 837 Dental electronic claim, the word "emergency" must be present in the first 9 positions of the 2300 loop, used for claim level notes, in the NTE02 segment. **For more information on the dental co-payment, see the Medicaid Dental Bulletin dated 03-03-04. REQUIRED, IF APPLICABLE.**

- 3. Company/Plan Name, Address, City, State, Zip Code:** Enter Medicaid Claims Receipt, PO Box 2136, Columbia, SC 29202 **OPTIONAL.**
- 8. Policyholder/Subscriber (SSN or ID#):** This is a designated box for private insurance or Medicare information. Enter the private insurance or Medicare policy number IF you have billed either one. **Leave blank if not reporting a private insurance or Medicare information. REQUIRED, if reporting a private insurance or Medicare payment or denial.**
- 9. Plan/Group Number:** This is a designated box for private insurance or Medicare information. If you are filing a private insurance or Medicare payment or denial, then enter the three-digit insurance carrier code number in this box. Carrier codes for most insurance companies are listed in the current dental manual. The most recent carrier code listing can be found on the DHHS web site at [www.scdhhs.gov](http://www.scdhhs.gov). **Leave this box blank if not reporting a private insurance or Medicare information. REQUIRED, if reporting a private insurance or Medicare payment or denial.**
- 11. Other Insurance Company/Dental Benefit Plan Name, Address, City State, Zip Code:** This is a designated box for private insurance or Medicare information. If a private insurance company or Medicare denial is listed on the claim in conjunction with a

zero payment, write \$0.00 and put the number “1” in this box. **IF** you have received a payment from the private insurance or Medicare, put the amount paid to you in this box. **Leave blank if not reporting a private insurance or Medicare information.** **REQUIRED**, if reporting a private insurance or Medicare payment or denial.

12. **Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** This is a designated box for private insurance or Medicare information. If a private insurance company or Medicare denial is listed on the claim in conjunction with a zero payment, put \$0.00 and the number “1” in this box. **IF** you have received a payment from the private insurance or Medicare, put the amount paid to you in this box. **Leave this box blank if not reporting private insurance or Medicare information.** **REQUIRED**, if reporting a private insurance or Medicare payment or denial.
15. **Policyholder/Subscriber ID (SSN or ID#):** This box is designated for private insurance or Medicare information. Enter the private insurance or Medicare policy number if you have billed either one. **Leave this box blank if not reporting private insurance or Medicare information.** **REQUIRED**, if reporting a private insurance or Medicare payment or denial.
16. **Plan/Group Number:** This box is designated for private insurance or Medicare information. If you have billed a private insurance company or Medicare, then enter the three-digit insurance carrier code number in this box. Carrier code numbers for most insurance companies are listed in the current dental manual. The most recent carrier code listing can be found on the DHHS web site at [www.scdhhs.gov](http://www.scdhhs.gov). **Leave this box blank if not reporting private insurance or Medicare information.** **REQUIRED**, if reporting a private insurance or Medicare payment or denial.
20. **Name (Last, First, Middle initial, Suffix) Address, City, State, Zip Code:** Enter the patient’s name, address, city, state and zip code. This box is not required, but recommended. **OPTIONAL.**
23. **Patient ID/Account # (Assigned by Dentist):** Enter the beneficiary’s ten-digit Medicaid identification number exactly as it appears on the Medicaid identification card. **REQUIRED.**
24. **Procedure Date (MM/DD/CCYY):** Enter date of service. All dates must include the four-digit year. **REQUIRED.**
27. **Tooth Number(s) or Letter(s):** Valid tooth numbers (1-32 for permanent teeth or letters A-T for primary teeth) must be indicated for any procedure performed on an individual tooth. Do not put a zero in front of a single digit tooth number or your claim will reject. Valid quadrant codes (UR, UL, LR, LL) for procedures that may require quadrants can be placed in this column. When billing for the removal of a **supernumerary** tooth, see the attached chart on page 3 of this bulletin for the corresponding tooth numbers. **REQUIRED, if applicable.**
28. **Tooth Surface:** Restoration services that include tooth surface(s) M-mesial, D-distal, O-occlusal/incisal, B-buccal/facial or L-lingual must indicated in the appropriate combinations. *Duplicate restorations on a single surface are not covered.* DHHS will reimburse multiple restorations performed on the same tooth on the same date of service at a combined surface rate. The tooth numbers, letters and surfaces must be the same as documented in the patient’s medical record. **REQUIRED, if applicable.**

Compliance with HIPAA-required code sets has changed the way Dentists and Oral and Maxillofacial Surgeons bill supernumerary teeth. The chart below indicates how you must complete the ADA claim form when billing for services performed on these teeth:

Permanent Tooth #	Tooth # To Use for Permanent Supernumerary Teeth (Put in Tooth # Column)	Deciduous Tooth #	Tooth # To Use for Deciduous Supernumerary Teeth (Put in Tooth # Column)
1	51	A	AS
2	52	B	BS
3	53	C	CS
4	54	D	DS
5	55	E	ES
6	56	F	FS
7	57	G	GS
8	58	H	HS
9	59	I	IS
10	60	J	JS
11	61	K	KS
12	62	L	LS
13	63	M	MS
14	64	N	NS
15	65	O	OS
16	66	P	PS
17	67	Q	QS
18	68	R	RS
19	69	S	SS
20	70	T	TS
21	71		
22	72		
23	73		
24	74		
25	75		
26	76		
27	77		
28	78		
29	79		
30	80		
31	81		
32	82		

**29. Procedure Code:** Enter the appropriate CDT procedure code **REQUIRED.**

**30. Description:** Enter the description of service rendered. Recommended, but not required. **OPTIONAL.**

**31. Fee:** *Enter your usual and customary charge for each listed service.* If you are handwriting the claim, do not put a dash in the cents box or your claim will be paid in pennies, not dollars. Example: (\$25.00). **REQUIRED.**

**32. Other Fee(s):** **LEAVE BLANK.** The Medicaid computer does not read this box.

**33. Total Fee:** Enter the total amount billed for all line items from Box 31. **REQUIRED.**

**35. Remarks:** This is a box designated for private insurance or Medicare information. Leave this box BLANK if you are billing Medicaid as the primary payer. Enter total amount received from other insurance sources (from Boxes 11 & 12) if you have filed with a private insurance or Medicare as primary payers. **REQUIRED, if reporting a private insurance or Medicare payment.**

**36. Authorizations:** Enter "Signature on file", "SOF" or the patient's legal signature and the date. The patient's or authorized person's signature indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim. **REQUIRED.**

**38. Place of Treatment:** Place an "X" on Provider's Office for treatment occurring in the office. Place an "X" on the Hospital box for treatment occurring in the hospital. ECF Box: Enter an "X" for nursing home. Other Box: Enter an "X" for other places of service (i.e., school). **REQUIRED.**

**45. Treatment Resulting From:** Check applicable box. **REQUIRED, if applicable.**

**46. Date of Accident (MM/DD/CCYY):** **REQUIRED, if applicable.**

**47. Auto Accident State:** **REQUIRED, if applicable.**

**48. Name, Address, City, State, Zip Code:** **REQUIRED.** Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.). Include the zip code + 4.

**49. NPI: (National Provider Identifier):** *Effective March 1, 2007*, you may enter your **GROUP NPI** number, if applicable. *The group NPI will be required in this box effective on and after May 23, 2007, if applicable.* Reporting your group NPI in this box will report your Medicaid earned income to the IRS under your Federal Tax Identification number. If you put your group NPI in this box, then you **must** report an individual NPI provider number (a member of your group) in Box 54 or your claim will reject. **REQUIRED, if applicable.**

The NPI is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities and will be required on electronic and hard copy claims filed to SC Medicaid effective May 23, 2007. An NPI is unique to an individual dentist or dental entity and has no intrinsic meaning. Additional information on the NPI and enumeration can be obtained from the ADA's Internet Web site [www.ada.org/goto/npi](http://www.ada.org/goto/npi).

**52A. Additional Provider ID:** *Effective March 1, 2007 and required through May 22, 2007*, you may enter your **GROUP Medicaid provider ID number**, if applicable. Entering your Medicaid group provider ID will report your earned Medicaid income to the IRS under your federal tax identification number. If you put your Medicaid group provider ID number in this box, then you **must** report an individual Medicaid provider ID number (a member of your group) in Box 58 or your claim will reject. **REQUIRED, if applicable, through May 22, 2007.**

**54. NPI (National Provider Identifier):** *Effective March 1, 2007*, you may enter the **INDIVIDUAL NPI** number in this box. *Effective on and after May 23, 2007, the individual NPI number is required in this box.* Reporting your individual NPI in this

box (with no ID numbers present in Boxes 49 and 52A) will report your Medicaid earned income either to your federal tax identification number (if you are a individual/sole source proprietor and have no other members in your group) or your social security number. **REQUIRED, effective May 23, 2007.**

**56. Address, City, State, Zip Code:** Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box. At minimum, enter the Zip Code + 4. **REQUIRED.**

**56A.Provider Specialty Code:** *Effective March 1, 2007 and required on and after May 23, 2007*, you may enter the taxonomy code that indicates the type of dental professional who delivered the treatment. **IMPORTANT:** *The taxonomy code used on the claim must agree with the taxonomy the provider registered with SCDHHS.* **REQUIRED, effective May 23, 2007.** See the table below:

Category/Description Code	Code
Dentist: A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see the following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

**58. Additional Provider ID:** *Effective March 1, 2007 and through May 22, 2007* you may enter your **INDIVIDUAL Medicaid provider ID number.** Entering your individual Medicaid provider number in this box (with no ID numbers present in Boxes 49 and 52A) will report your Medicaid earned income either to your federal tax identification number (if you are a individual/sole source proprietor and have no other members in your group) or your social security number. **REQUIRED, through May 22, 2007.**