COMPLETION OF THE CMS 1500 (08/05) CLAIM FORM
MEDICAID DENTAL PROGRAM
ORAL AND MAXILLOFACIAL SURGEONS ONLY

Listed below are the required and optional boxes for completing the CMS 1500 (08/05) for Oral and Maxillofacial Surgeons (OMS) only. Effective September 1, 2004, OMS dental claims submitted on paper and in electronic format are required to be filed on the claim form that applies to the procedure codes submitted as follows: Current Dental Terminology (CDT) procedure codes are to be filed on the ADA 2006 claim form and Current Procedure Terminology (CPT) procedure codes are to be filed on the CMS 1500 (08/05) Claim Form.

*Beginning January 1, 2000 dental providers were no longer required to file with a patient's private dental insurance prior to filing with Medicaid. DHHS provides boxes on this claim form (9a, 9c, 9d, 10d, 11, 11b and 11c and Amount Paid) for you to report a private carrier or Medicare payment, if applicable. If you are reporting to Medicaid that you have billed another insurance or Medicare, complete the boxes indicated to show the primary payment or denial. If you have **NOT** billed another 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. An EOB from 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,which indicates multiple insurance policies/not all filed – call TPL. Contact your Dental Program Coordinator if you receive this edit. A primary insurance payer should only be listed once on the CMS 1500 claim form.*

Required Boxes

Box 1a
Insured's ID Number

Enter the beneficiary's ten-digit Medicaid ID number exactly as it appears on the Medicaid identification card.

Box 9a
Other Insured's Policy
Or Group Number

This box is designated for private insurance or Medicare information. If you have billed a private insurance or Medicare, then enter the policy number of the insured in this box. Do not use a hyphen or space as a separation within the policy number. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

Box 9c
Employer's Name
Or School Name

This box is designated for private insurance or Medicare information. Enter the amount paid by the private insurance or Medicare policy. If the private insurance or Medicare denies payment, put $0.00 in this box and a "1" in Box 10d. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

Box 9d

Insurance Plan Name Or Program Name

This box is designated for private insurance or Medicare information. Enter the carrier code number for the private insurance policy or Medicare in this box. Carrier codes are located in your Medicaid Dental Provider Manual or you can visit the DHHS website at www.scdhhs.gov for the most recent carrier code listing. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

Box 10d Reserved for Local Use

This box is designated for private insurance or Medicare information. Enter "1" for a private insurance or Medicare denial or "6" if this person is a crime victim. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

Box 11 Insured's Policy Group or FECA Number

This box is designated for private insurance or Medicare information. Report the private insurance or Medicare policy number in this box. Do not use a hyphen or space as a separation within the policy number. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial***.

Box 11b Employer's Name Or School Name

This box is designated for private insurance or Medicare information. Enter the amount the private insurance company or Medicare has paid to you. If the primary insurance company denies payment, put $0.00 in this box and a "1" in Box 10d. ***Leave this box blank if not reporting a private insurance or Medicare payment or denial.***

Box 11c Insurance Plan Name or Program Name

This box is designated for private insurance or Medicare information. Enter the carrier code number of the private insurance or Medicare in this box. Carrier codes are located in your Medicaid Dental Provider Manual or you can visit the DHHS website at www.scdhhs.gov for the most recent carrier code listing. ***Leave this box blank if not reporting a private insurance or a Medicare payment or denial.***

Box 12

Patient's or Authorized Person's Signature

Enter "Signature on file", "SOF" or patient's legal signature. 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**

Box 24a
Date(s) of Service
(Unshaded Section)

Enter the month, day and year in the UNSHADED section of the line for each procedure. Information has to appear in the "To" section.

Box 24b
Place of Service
(Unshaded Section)

Enter the appropriate two-digit place of service code in the UNSHADED section of the line. 11-Office, 12- Home, 21-Inpatient Hospital, 22-Outpatient Hospital, 23 – Emergency Room – Hospital, 24- Ambulatory Surgical Center, 31 – Skilled Nursing Facility, 32 – Nursing Facility, 33 – Custodial Care Facility, 71 – State or Local Public Health Clinic, 72 – Rural Health Clinic, 99 – Other Unlisted Facility

Box 24c
EMG (Emergency)
(Unshaded Section)

Entering a "Y", if applicable, in the UNSHADED section of this line or the corresponding field on the electronic claim record indicates an **emergency.** Emergency patients are exempt from a co-payment. If not an emergency, leave blank.

Box 24d
Procedures, Services or Supplies
CPT/HCPCS
(Unshaded Section)

Enter the appropriate CPT procedure code in the unshaded section of the line. Oral surgeons must file *only* CPT procedure codes on the CMS 1500 (08/05) Claim Form. CDT procedure codes must be filed on the ADA Claim Form (this includes procedure code D9999). Filing procedures on the wrong claim form will result in a rejected claim.

Box 24f
Charges
(Unshaded Section)

You must enter your usual and customary charge in the UNSHADED section in this box for each procedure code listed.

Box 24i
ID Qualifier
(Shaded Section)

From **January 1, 2007 to May 22, 2007** enter in the SHADED section of the line **"1D"** for Medicaid provider in this box. On **May 23, 2007** and afterwards use qualifier **"ZZ"** for the taxonomy code.

See the chart below for dental taxonomy codes that may be used.

Category/Description Code	Code
Dentists: 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
Dental Specialty (see following list)	Various
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Box 24j
Rendering Provider
(Shaded Section)

From **January 1, 2007 to May 22, 2007** enter in the SHADED section of the line the Medicaid *individual* provider ID number who rendered the service. Effective on and after **May 23, 2007** enter the 10-character taxonomy number of the *individual* provider who rendered the service.

Box 24j
Rendering Provider
(Unshaded Section)

Enter in the UNSHADED section of the line the NPI number of the rendering individual provider. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI number may be entered. The NPI number may be reported as early as **January 1, 2007**, but must be reported on and after **May 23, 2007**.

Box 28
Total Charge

Enter the total amount from all the charges in Box 24f in this box.

Box 29
Amount Paid

This box is designated for private insurance or Medicare information. ***Leave this box blank if you are billing Medicaid as the primary payer.*** Enter the total amount from other insurance sources if you have filed with a private insurance or

Medicare as primary payers. If the private insurance or Medicare denies payment, put $0.00. ***Required, if reporting a private insurance or Medicare payment or denial.***

Box 30
Balance Due

Enter the balance due in this box.

Box 32
Service Facility
Location Information

IF APPLICABLE, enter the name, address, and ZIP+4 code of the location where the services were rendered if the address is different from the address in Field 33.

Box 32a
National Provider Identification
(NPI)

IF APPLICABLE, enter the NPI number of the *service facility location* in Field 32. The NPI may be reported as early as **January 1, 2007**, but must be reported on and after **May 23, 2007**.

Box 32b
(Shaded Section)

IF APPLICABLE, on and before **May 22, 2007,** enter the two-byte qualifier "1D" followed by the Medicaid Provider ID number of the *service facility location in Field 32.* There should be no spaces or separation between them. On or after **May 23, 2007,** enter the two-byte qualifier "ZZ" followed by the taxonomy code of the *service facility* (no spaces).

Box 33
Billing Provider Information
& Phone Number

Enter the provider of service/supplier's billing name, address, ZIP+4 code, and telephone number. Do not use commas, periods, or other punctuation in the address. When entering a 9-digit zip code (ZIP+4), include the hyphen. Do not use a hyphen or space as a separator within the telephone number. Claims will be paid to the provider number submitted in this box. This **pay-to provider** number is indicated on the Remittance Advice and check.

Box 33a
National Provider Identifier
(NPI)

Effective May 23, 2007, you MUST enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI **group/organization** number must be entered.

If not billing as a member of a group, then enter the 10-character **individual** NPI number. The NPI may be reported as early as January 1, 2007.

Box 33b
(Other Identification Numbers) (Shaded Section)

Prior to May 23, 2007 enter the two-byte qualifier **"1D"** followed by the Medicaid *group* provider number (no spaces) if you are billing for a **group or organization.** Example: 1DZAXXXX.

If billing for an **individual** provider, enter the two-byte qualifier **"1D"** followed by the Medicaid *individual* provider ID number. Example: 1DZX0000.

On or after May 23, 2007, enter the two-byte qualifier **"ZZ"** followed by the taxonomy code (no spaces). Example: ZZ1223S0112X.

Optional Boxes

Box 1
Medicare, Medicaid, Tricare Champus, Champ VA, Group Health Plan, Feca BLK Lung, Other

Check Medicaid.

Box 4
Insured's Name

Enter the insured's name (Last Name, First Name Middle Initial).

Box 21
Diagnosis or Nature of Illness or Injury

This box is not required, but you may enter a diagnosis code and your claim will not reject. Enter the diagnosis of the patient indicated by the current edition of the International Classification of Diseases, Ninth Edition, Clinic Modification (ICD-9-CM) code number.

Box 24d
Procedures, Services or Supplies
Modifier Section
(Unshaded Section)

Modifiers are not required.

Box 26
Patient's Account Number

Put the beneficiary's chart number or account number in this box. The first nine characters will be keyed. The account number is helpful in tracking the claim if the beneficiary's Medicaid ID number is invalid or incorrect. The patient account number

	will be listed as the “Own Reference Number” on the remittance advice.
Box 27 **Accept Assignment**	Complete this box to indicate that the provider accepts assignment of Medicaid benefits. Submitting a claim to SC Medicaid automatically indicates the provider accepts assignment.
Box 31 **Signature of Physician or Supplier Including Degrees and Credentials**	Not required.