



## **Medical Assistance Administration**



# **ABCD**

## **Access to Baby and Child Dentistry**

### **Supplemental Billing Instructions**

**[WAC 388-535-1245]**

**October 2003**

## **About this publication**

**These are supplemental billing instructions.**

**Please refer to MAA's Dental Program Billing Instructions for a complete listing of dental services for which ABCD children qualify.**

**This publication supersedes all previous MAA ABCD Dental Billing Instructions.**

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# Important Contacts

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## Where do I call for information on

**Becoming a DSHS provider;  
Submitting a provider change of  
address or ownership; or  
Questions about the status of a  
provider application?**

Provider Enrollment  
Toll-Free (866) 545-0544

## Where do I send my dental bills?

Division of Program Support  
PO Box 9253  
Olympia WA 98507-9253

## Who do I call to request free in-office provider training?

Field Services Unit  
(360) 725-1024  
(360) 725-1027  
(360) 725-1022  
(360) 725-1023

## Where do I call if I have questions on

**Payments, denials, general questions  
regarding claims processing, Healthy  
Options?**

Medical Assistance Customer  
Service Center  
(800) 562-6188

**Private insurance or third party  
liability, other than Healthy Options?**

Coordination of Benefits Section  
(800) 562-6136

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## Where can I view and download MAA's Billing Instructions or Numbered Memorandum?

**Go to:**

<http://maa.dshs.wa.gov>

Click on "Provider Publications/  
Fee Schedules."

# Definitions

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**This section defines terms, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance Program.**

**Access to Baby and Child Dentistry (ABCD)** – A program to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers up through the age of five. [WAC 388-535-1050]

**American Dental Association (ADA)** – The ADA is a national organization for dental professionals/dental societies.

**Anterior** – Teeth and tissue in the front of the mouth. Specifically only these permanent teeth:

- (1) Mandibular anterior teeth – incisors and canines: Permanent teeth 22, 23, 24, 25, 26, and 27; Primary teeth M, N, O, P, Q and R; and
- (2) Maxillary anterior teeth – incisors and canines: Permanent teeth 6, 7, 8, 9, 10, and 11; Primary teeth C, D, E, F, G and H.

**By Report (BR)** – A method of reimbursement in which MAA determines the amount it will pay for a service when the rate for that service is not included in MAA’s published fee schedules. Upon request, the provider must submit a “report” which describes the nature, extent, time, effort, and/or equipment necessary to deliver that service. [WAC 388-535-1050]

**Client** - An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

**Code of Federal Regulations (CFR)** - Rules adopted by the federal government. [WAC 388-500-0005]

**Community Services Office (CSO)** - An office of the department's economic services administration that administers social and health services at the community level. [WAC 388-500-0005]

**Core Provider Agreement** – The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

**Current Dental Terminology** – A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA). [WAC 388-535-1050]

**Department** - The state Department of Social and Health Services.

**Division of Developmental Disabilities (DDD)** - The organization within DSHS that supports individuals enrolled in DDD per [RCW 71A.10.020](#) (3) and (4), and [WAC 388-825-030](#). [WAC 388-500-0005]

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Maximum Allowable** – The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

**Medicaid** – The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs. Also known as Title XIX.

**Medical Assistance Administration (MAA)** – The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities. [WAC 388-500-0005]

**Medical Identification (ID) card** – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards. [WAC 388-500-0005]

**Medically Necessary** - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no

other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. [WAC 388-500-0005]

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

- a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated);
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
- c) First five letters of the last name (and spaces if the name is fewer than five letters); and
- d) Alpha or numeric character (tiebreaker).

**Posterior** – Teeth and tissue towards the back of the mouth.

- (1) **Mandibular posterior teeth** – molars and premolars: **Permanent teeth** 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32 and **Primary teeth** K, L, S, N, and T; and
- (2) **Maxillary posterior teeth** – molars and premolars: **Permanent teeth** 1, 2, 3, 4, 5, 12, 13, 14, 15 and 16, and **Primary teeth** A, B, I, and J.

**Provider or Provider of Service** - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical [dental] care, goods and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

**Revised Code of Washington (RCW) -**  
Washington State laws.

**Usual and Customary** – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA. [WAC 388-535-1050]

**Washington Administrative Code (WAC) -** Codified rules of the State of Washington.

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# Access to Baby and Child Dentistry (ABCD) Program

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## What is the ABCD Program?

The Access to Baby and Child Dentistry (ABCD) program is an initiative to increase access to dental services for Medicaid eligible infants, toddlers, and preschoolers. The program's goal is to ensure that positive dental experiences in early childhood will lead to lifelong practices of good oral health. This is done in part by identifying and removing obstacles to early preventive treatment, such as the lack of transportation to a dental office, language interpretation issues, etc. For further information, see *How does the ABCD Program work?*

The ABCD program is a partnership between the public and private sectors, including:

- ✓ The Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA);
- ✓ The University of Washington School of Dentistry;
- ✓ The Washington State Dental Association;
- ✓ The Washington Dental Service Foundation;
- ✓ Local dental societies;
- ✓ Local health jurisdictions; and
- ✓ Other funding sources.

The mission is to identify Medicaid-eligible infants and toddlers who have not yet reached their fifth birthday and to match each child to an ABCD-certified dentist. Children will remain in the ABCD program until their sixth birthday.

The ABCD program encourages the use of proven and effective preventive techniques (e.g., oral health instructions, glass ionomers), while disallowing the use of less effective interventions (e.g., prophylaxis for children 0-5 years of age).

**Please note:** ABCD children are entitled to the full scope of care as described in the MAA [Dental Billing Instructions](#). These [ABCD Billing Instructions](#) identify those specific services that are eligible for higher reimbursement.

## What are the goals of the ABCD Program?

### The ABCD program will:

- Positively affect the oral health status of the participating children by ensuring early preventive treatments, thus avoiding more traumatic and costly care in the future.
- Examine the cost effectiveness of preventive treatment over restorative care.
- Involve the children, parent(s)/guardians(s), advocates, and dental providers to create a high level of community satisfaction.
- Evaluate the effect of an enhanced access/prevention program on low-income children's utilization of dental services using four variables (structure, history, cognition, and expectations).
- Examine the effects of improved access and enhanced preventive dentistry on the parent's/guardian's beliefs and expectations about children's oral health, satisfaction, and fear. By encouraging positive parental attitudes towards dental care, we can ensure that children receive timely intervention.
- Provide critical information regarding early interventions and cost containment to support statewide implementation of the ABCD Program.

## How does the ABCD program work?

The following chart lists the people/agencies involved in the ABCD Program and shows how they interact to ensure eligible children receive preventive dental services.

<b>Who...</b>	<b>Responsibility...</b>
Healthcare providers and community service programs including Local Health Jurisdictions	Identify eligible MAA clients and refer them for orientation.
Local community ABCD enrollment units (function may not be available in all counties)	<p>Provide an orientation to the client and/or parent(s)/guardian(s) and prepares the family and child for the dental visit.</p> <p>Enroll the client and family into the ABCD program and provide limited oral health information and training in correct office behavior.</p> <p>Provide the client with an ABCD program identification (ID) card. The client's parent(s)/guardian(s) must show this ID card to the dentist to prove the client is eligible for the program.</p> <p>Assure that obstacles to care, such as lack of transportation and limited English proficiency, are addressed.</p> <p>Coordinate with local agencies in providing outreach and linkages services to eligible clients.</p>
ABCD Program-Certified Dentists	<p>Provide preventative and restorative treatment for an eligible client.</p> <p>Bill MAA for provided services according to these <u>ABCD Program Billing Instructions</u>.</p> <p>Perform follow-up with the client's parent(s)/ guardian(s). (See <i>Family Oral Health Instruction</i> section.)</p>

<b>Who...</b>	<b>Responsibility...</b>
Local Dental Societies	Oversee provider activities and perform peer review.
Medical Assistance Administration (MAA)	Reimburses program-certified dentists for services covered under this program.
University of Washington School of Dentistry	Provides technical and procedural consultation on the enhanced treatments and conducts continued provider training and certification.
Washington Dental Service Foundation and other funding sources	Provides funding and technical assistance to support client outreach and linkage, and provider recruitment.

# Client Eligibility

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## Who is eligible?

In addition to an ABCD identification card, eligible clients will have a DSHS Medical Identification card containing DSHS eligibility information. Before you provide any service to a Medical Assistance client, be sure to check the client's current monthly DSHS Medical ID card.

Clients whose Medical ID cards have one of the following identifiers are eligible for dental services under the ABCD Program:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program - Children’s Health Insurance Program
LCP-MNP	Limited Casualty Program/ Medically Needy Program

## Are clients enrolled in an MAA managed care plan eligible?

Clients, **5 years old and younger**, who are enrolled in an MAA managed health care plan should have an identifier in the *HMO* column on their DSHS Medical ID card. These clients **are eligible for all Medicaid-covered dental services and the ABCD Program under the fee-for-service program.**

See MAA’s Dental Program Billing Instructions for eligibility information regarding services other than those outlined in this manual.

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# Family Oral Health Education

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- A Family Oral Health Education visit is allowed twice per year, **per family**.
- This Family Oral Health Education visit should be at least 20-30 minutes in duration.
- Document the duration of the visit in the written record.
- Bill MAA under the Patient Identification Code (PIC) of the first child seen in the family. Do not use the parent's PIC.
- Family Oral Health Education **must be billed using ADA code D9999 with Expedited Prior Authorization number 870000997**. See page E.2.

You must provide **all** of the following services during a Family Oral Health Education visit in order to be reimbursed for D9999 with EPA# 870000997.

1. **Risk Assessment:** Assess the risk of dental disease for the child. Obtain a history of previous dental disease activity for this child and any siblings from the parent(s)/guardian(s). Also note the dental health of the parent(s)/guardian(s).
2. **"Lift the Lip" Training:** Show the "Lift the Lip" videotape or flip chart provided to you at the certification workshop. Have the parent(s)/guardian(s) practice examining the child using the lap position. Ask if the parent(s)/guardian(s) feels comfortable doing this once per month.
3. **Teeth Cleaning Training:** Demonstrate how to position the child to clean the teeth. Have the parent(s)/guardian(s) actually practice cleaning the teeth. Encourage teeth cleaning as a treatment for teething. Record the parent's/guardian's response.
4. **Dietary Counseling:** Talk with the parent(s)/guardian(s) about the need to use a cup, rather than a bottle, when giving the child anything sweet to drink. Note any other dietary recommendations you make.
5. **Fluoride Supplements:** Discuss fluoride supplements with the parent(s)/guardian(s). The dentist must write a fluoride prescription for the child, if appropriate. Let the parent/guardian know fluoride supplements are covered under MAA's Prescription Drug Program. Fluoride prescriptions written by the dentist may be filled at any Medicaid-participating pharmacy. Ensure that the child is not already receiving fluoride supplements through a prescription written by the child's physician.
6. **Follow-up:** Within three months after a family oral health education visit, contact the parent(s)/guardian(s) to remind them about lifting the lip, cleaning the child's teeth, and using fluoride supplements.

**All training and follow-up contacts must be documented in the client's chart.**

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# Billing

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## What has changed?

- The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. In order to comply with HIPAA requirements, MAA is **discontinuing all state-unique procedure codes, including the “Add-On” codes** previously listed in the ABCD fee schedule. MAA now requires the use of applicable ADA procedure codes.
- MAA has adjusted the rates for those ADA procedure codes that used to have a state-unique “Add-On” code assigned. This higher reimbursement rate only applies to ABCD providers who are serving eligible clients 5 years of age and younger.
- In addition to the services in these supplemental billing instructions, children **are also eligible** for the full scope of dental care listed in MAA’s Dental Program Billing Instructions.
- Services in the MAA Dental program not identified in these supplemental billing instructions are not eligible for the higher ABCD reimbursement, but may be given to the child as necessary and billed to MAA.

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# Fee Schedule

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HCPCS Code	Brief Description	Maximum Allowable Fee
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## Initial Comprehensive Oral Evaluation:

D0150	<p><b>Comprehensive oral evaluation</b>                      For MAA purposes, this is to be considered an initial exam. One initial evaluation allowed per client, per provider or clinic.</p> <p>Normally used by a general dentist and/or a specialist when evaluating a patient comprehensively.</p> <p><i>Six months must elapse before a periodic evaluation will be reimbursed.</i></p>	\$37.37
D0120	<p><b>Periodic oral evaluation</b>                      One periodic evaluation is allowed every six months.</p>	27.27

## Fluoride Varnish Application:

D1203	<p><b>Topical application [gel or varnish]</b>                      Allowed up to three times in a 12-month period.</p> <p>Document in the client's file which material (e.g., topical gel or fluoride varnish is used).</p>	\$21.60
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**Oral Health Education:**

ADA Code	EPA #	Description	ABCD Maximum Allowable
<p><b>This procedure code requires expedited prior authorization. See instructions below.</b></p>			
D9999	870000997	<p><b>Family Oral Health Education</b> Allowed twice per calendar year, per family.</p> <p><b>EPA Criteria</b></p> <p>When billing for this code (D9999) and placing the assigned EPA number 870000997 onto the ADA claim form, a provider is verifying that all of the following occurred:</p> <ul style="list-style-type: none"> <li>• The provider is an MAA-approved ABCD provider;</li> <li>• The child is 5 years of age or younger; and</li> <li>• All of the following services were provided during the Family Oral Health Education:                             <ul style="list-style-type: none"> <li>✓ Risk Assessment;</li> <li>✓ “Lift the Lip” Training;</li> <li>✓ Teeth Cleaning Training;</li> <li>✓ Dietary Counseling;</li> <li>✓ Fluoride Supplements Discussion/Prescription; and</li> <li>✓ Follow-up.</li> </ul> </li> </ul> <p><b>Refer to page C.1 for further information.</b></p>	\$25.25

**Amalgams:** Allowance includes polishing.

D2140	<b>Amalgam - one surface, primary.</b> Tooth and surface designations required.	\$51.01
D2150	<b>Amalgam - two surfaces, primary.</b> Tooth and surface designations required.	70.32
D2160	<b>Amalgam - three or more surfaces, primary.</b> Tooth and surface designations required.	86.56

**Resin Restorations (Composite/Glass Ionomer):**

Allowed only on anterior teeth C through H and M through R.

D2330	<b>Resin-based composite - 1 surface, anterior</b> Tooth and surface designations required.	\$76.76
D2331	<b>Resin-based composite – 2 surfaces, anterior</b> Tooth and surface designations required.	89.54
D2332	<b>Resin-based composite – 3 surfaces, anterior</b> Tooth and surface designations required.	103.73
D2335	<b>Resin-based composite - 4 or more surfaces or involving incisal angle (anterior).</b> Tooth and surface designations required.	103.73

**Other Restorative Procedures:**

D2930	<b>Prefabricated stainless steel crown - primary tooth.</b> Tooth designation required.	146.45
D2390	<b>Resin-based composite crown, anterior – primary tooth</b> Tooth designation required.	151.50
D2933	<b>Prefabricated stainless steel crown with resin window – primary upper anterior teeth (C-H)</b> (This is a complete procedure; no add-on for this procedure.)	106.05
D3220	<b>Therapeutic pulpotomy, covered only as complete procedure, once per tooth.</b> Tooth designation required.	76.19

**Anesthesia:**

D9230	<p><b>Analgesia, anxiolysis, inhalation of nitrous oxide</b>                  MAA does not cover analgesia or anxiolysis under either the ABCD program or the Dental Program. Use this code when billing for inhalation of nitrous oxide.</p>	\$6.24
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**Drugs:**

D9630	<p><b>Other drugs and/or medicaments</b>                  Use this code when billing for pharmaceuticals. Payable only when billed with either D9220, D9241, or D9248. MAA limits this procedure code to parenteral and multiple oral agents for conscious sedation and general anesthesia agents only.</p>	<b>By Report</b>
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**Miscellaneous Services:**

D9920	<p><b>Behavior management</b>                  Involves a patient whose documented behavior requires the assistance of <b>one additional dental professional staff</b> to protect the patient from self-injury while treatment is rendered.</p>	\$27.27
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# How to Complete the ADA Claim Form

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These instructions are based on the ADA Dental Claim Form, 2002.

MAA encourages the use of the 2002 version of the ADA form to expedited claims processing. However, if using older versions of the ADA claim form, enter the required quadrant and arch designations in the “Tooth Surface” field (field 28).

See sample claim form, page F.5.

## General Information

- Include any required expedited prior authorization number.
- Send only one claim form for payment. If the number of services exceeds one claim form, a second form can be submitted. Please make sure that all necessary claim information (provider number, patient identification code, etc.) is repeated on the second form. Each claim form should show the total charges for the services listed.
- Use either blue or black ink only. **Do not use red ink pens, highlighters, “post-it notes,” stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers on claim form.
- These instructions only address those fields that are required for billing MAA.

### Send your claims for payment to:

Division of Program Support  
 PO Box 9253  
 Olympia WA 98507-9253

### Field   Description

**HEADER INFORMATION**

2. **Predetermination/Preauthorization Number** – Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.

**PRIMARY PAYER INFORMATION**

3. **Name, Address, City, State, Zip Code**: Enter the address for DSHS that is listed in the shaded box above.

**OTHER COVERAGE**

4. **Other Dental or Medical Coverage** – Check the appropriate response.
5. **Subscriber Name (Last, First, Middle Initial, Suffix)** – If different from the patient, enter the name of the subscriber.
6. **Date of Birth (MM/DD/CCYY)** – Enter the subscriber’s date of birth.
8. **Subscriber Identifier (SSN or ID#)** – Enter the subscriber’s SSN or other identifier assigned by the payer.
9. **Plan/Group Number** – If the client has third party coverage, enter the dental plan # of the subscriber.
10. **Relationship to Primary Subscriber** – Check the applicable box.
11. **Other Carrier Name, Address, City, State, Zip Code** – Enter any other applicable third party insurance.

**PRIMARY SUBSCRIBER INFORMATION**

12. **Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code** – If different from patient’s

(field 20), enter the legal name and address of the subscriber here.

13. **Date of birth (MM/DD/CCYY)** – If different from patient’s, enter the subscriber’s date of birth.
15. **Subscriber Identifier (SSN or ID#)** – Enter the SSN or other identifier assigned by the payer.
16. **Plan/Group Number** – Enter the subscriber’s group’s Plan or Policy Number.
17. **Employer Name** – Enter the name of the subscriber’s employer.

**PATIENT INFORMATION**

18. **Relationship to Primary Subscriber** – Check the appropriate box.
20. **Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code** – Enter the client’s legal name, address, and **Patient Identification Code (PIC)**. MAA identifies clients by this code, not by their name. This alphanumeric code is assigned to each MAA client and consists of:
- First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated).
  - Six-digit birthdate, consisting of numerals only (MMDDYY).
  - First five letters of the last name (or fewer if the name is less than five letters).
  - Alpha or numeric character (tiebreaker).

21. **Date of Birth (MM/DD/CCYY)** – Enter the client’s date of birth.
23. **Patient ID/Account #:** If you wish to use a medical record number, enter that number here.

**RECORD OF SERVICES PROVIDED**

Each service performed must be listed as a separate, complete one-line entry. Each extraction or restoration must be listed as a separate line entry.

If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.

24. **Procedure Date (MM/DD/CCYY)**  
Enter the six-digit date of service, indicating month, day, and year (e.g., October 1, 2003 = 100103).

25. **Area of Oral Cavity** – If the procedure code requires an arch or a quadrant designation, enter one of the following:

- 01 Maxillary area
- 02 Mandibular area
- 10 Upper right quadrant
- 20 Upper left quadrant
- 30 Lower left quadrant
- 40 Lower right quadrant

If you are using a claim form that does not include this column, enter one of the above codes in the tooth surface column (field 28).

27. **Tooth Number(s) or Letter(s)** – Enter the appropriate tooth number, letter(s):
- 01 through 32 for permanent teeth
  - A through T for primary teeth
  - SN for supernumerary teeth

28. **Tooth Surface** – Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to five codes may be listed in this column:

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

29. **Procedure Code:** Enter the procedure code from this fee schedule that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment.

30. **Description of Services** - Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending time. If billing for anesthesia, enter *only* the total # of minutes on the claim. To indicate a payment by another plan, write “insurance payment” in the description area and the amount in field 31. Attached the insurance EOB to the claim.

31. **Fee** - Enter your usual and customary fee (not MAA's maximum allowable rate) for each service rendered.

33. **Total Fee** – Total of all charges.

**MISSING TEETH INFORMATION**

34. Place an “X” on the appropriate missing teeth.

**REMARKS**

35. **Remarks** - This field may be used for justification for the services rendered, the name of any referring provider or facility, or the name of any provider who administered anesthesia.

**Example of Remark:** “Jane Doe, CRNA administered anesthesia.”

**ANCILLARY CLAIM/  
TREATMENT INFORMATION**

38. **Place of Treatment** – Check the applicable box and enter one of the following codes to show the place of service at which the service was performed:

- Office** 11 dental office
- Hosp** 21 inpatient hospital
- 22 outpatient hospital
- 23 hospital emergency room
- ECF** 32 nursing facility
- 31 skilled nursing facility
- 54 intermediate care facility/mentally retarded
- Other** 12 client’s residence
- 24 professional services in an ambulatory surgery center
- 03 school-based services
- 50 federally qualified health center
- 71 state or public health clinic (department)

39. **Number of Enclosures (00-99)** – Check the appropriate box. If you check *yes*, indicate how many X-rays are enclosed.

**Note:**

- Do not send X-rays when billing for services.
- X-rays are necessary only when prior authorization is being requested.
- Please write "X-rays enclosed" on the mailing envelope and mail to the Program Management and Authorization Section (see “Authorization” in either Section D or Section E for address.)

40. **Is Treatment for Orthodontics?** – Check appropriate box.

41. **Date Appliance Placed (MM/DD/CCYY)** – This field **must be completed** for orthodontic treatment.

43. **Replacement of Prosthesis?** – Check appropriate box. If “yes,” enter reason for replacement in field 35 (Remarks).

44. **Date Prior Placement (MM/DD/CCYY)** – Enter appropriate date if “yes” is check for field 43.

45. **Treatment Resulting from:** Check appropriate box.

46. **Date of Accident (MM/DD/CCYY)** – Enter date of accident.

**BILLING DENTIST OR DENTAL ENTITY**

48. **Name, Address, City, State, Zip Code** – Enter the dentist’s name and address as recorded with MAA.

49. **Provider ID** – Enter the provider number assigned by MAA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the MAA Remittance and Status Report in the *Provider Number* area at the top of the page. It is this code by which providers are identified, not by provider name. **Without this number, we may be unable to determine the provider and pay the claim.**
52. **Phone Number** – Enter the billing dentist’s phone number.

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

54. **Provider ID** – Enter the performing provider number if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique identification number and/or name.
56. **Address, City, State, Zip Code** – If different than field 48, enter the treating dentist’s information here.
57. **Phone Number** – If different from field 52, enter the treating dentist’s phone number here.

# ADA Dental Claim Form

# SAMPLE

**HEADER INFORMATION**

1. Type of Transaction (Check all applicable boxes):  
 Statement of Actual Services - OR -  Request for Predetermination/Prefabrication  
 EFSOT/Title XIX

2. Predetermination/Prefabrication Number:  
 870000997-Line 3

**PRIMARY PAYER INFORMATION**

3. Name, Address, City, State, Zip Code  
 Division of Program Support  
 PO Box 9253  
 Olympia, WA 98507-9253

**OTHER COVERAGE**

4. Other Dental or Medical Coverage?  No (Skip 5-11)  Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/YYYY) 7. Gender  M  F 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number 10. Relationship to Primary Subscriber (Check applicable box)  
 Self  Spouse  Dependent  Other

11. Other Carrier Name, Address, City, State, Zip Code

**PRIMARY SUBSCRIBER INFORMATION**

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

13. Date of Birth (MM/DD/YYYY) 14. Gender  M  F 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Primary Subscriber (Check applicable box)  
 Self  Spouse  Dependent Child  Other 19. Student Status  
 FTS  PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
 KI121099DAVISA  
 DAVIS, KAREN L.

21. Date of Birth (MM/DD/YYYY) 22. Gender  M  F 23. Patient ID/Account # (Assigned by Dentist)  
 121099

**RECORD OF SERVICES PROVIDED**

1	24. Procedure Date (MM/DD/YYYY)	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	101503					D0150	Comprehensive Oral Evaluation	50.00
2	101503					D1203	Application Fluoride Varnish	30.00
3	101503					D9999	Family Oral Health Instruction	25.00
4	101503			B	LO	D2150	Amalgam 2 Surface	75.00
5								
6								
7								
8								
9								
10								

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	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		
																	T	S	R	Q	P	O	N	M	L	K		175.00

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 obligations 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

**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  
 Any Street  
 Any Town, WA 99201

49. Provider ID: 5310000  
 50. License Number  
 51. SSN or TIN  
 52. Phone Number ( )

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment (Check applicable box)  
 Provider's Office  Hospital  DCF  Other

39. Number of Enclosures (00 to 99) (X-ray, Radiograph, Orth Image(s), Models)

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)  Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/YYYY)

42. Months of Treatment Remaining 43. Replacement of Prosthesis?  
 No  Yes (Complete 44) 44. Date Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from (Check applicable box)  
 Occupational illness/injury  Auto accident  Other accident

46. Date of Accident (MM/DD/YYYY) 47. Auto Accident State

**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 these procedures.

X \_\_\_\_\_  
 Signed (Treating Dentist) Date

54. Provider ID 55. License Number

56. Address, City, State, Zip Code  
 57. Phone Number ( )  
 58. Treating Provider Specialty