



## **Health and Recovery Services Administration**



# **ABCD**

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

### **Supplemental Billing Instructions**

**WAC 388-535-1245**

## Copyright Disclosure

*Current Procedural Terminology (CPT) is copyright 2006 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein.*

*Current Dental Terminology (CDT™) five digit alphanumeric codes and descriptions are copyright 2006 American Dental Association (ADA). All Rights Reserved. ADA assumes no liability for data contained or not contained herein.*

## About this publication

These are *supplemental* billing instructions.

Please refer to HRSA's *Dental Program for Clients Through Age 20 Billing Instructions* for a complete listing of dental services for which ABCD children qualify.

This publication supersedes all previous HRSA ABCD Dental Billing Instructions and is published by the Washington State Department of Social and Health Services, Health and Recovery Services Administration

**Note:** The effective date and publication date for any particular page of this document may be found at the bottom of the page.

## Fee Schedule

You may access HRSA's Dental Fee Schedule at: <http://maa.dshs.wa.gov/RBRVS/Index.html>.

## HRSA's Billing Instructions and Numbered Memoranda

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at <http://maa.dshs.wa.gov/download/index.htm>.

To request a free paper copy from the Department of Printing:

- **Go to:** <http://www.prt.wa.gov> (On-line orders filled daily.) Click *General Store*. Follow prompts to *Store Lobby* → *Shop by Agency* → *Department of Social and Health Services* → *Health and Recovery Services Administration* → desired issuance; **or**
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Telephoned and faxed orders may take up to 2 weeks to fill.)

# Table of Contents

---

<b>Important Contacts</b> .....	ii
<b>Definitions &amp; Acronyms</b> .....	1
<b>Section A: Access to Baby and Child Dentistry (ABCD) Program</b>	
What is the ABCD program?.....	A.1
Who may provide ABCD Dentistry?.....	A.2
How does the ABCD program work?.....	A.2
<b>Section B: Client Eligibility</b>	
Who is eligible? .....	B.1
Are clients enrolled in an HRSA managed care organization eligible? .....	B.1
<b>Section C: Coverage</b>	
What is covered?.....	C.1
<b>Coverage Table</b> .....	C.5
Fee Schedule .....	C.8
<b>Section D: Completing the ADA Claim Form</b>	
General Information.....	D.1
1994 ADA Claim Form Instructions.....	D.2
Sample 1994 ADA Claim Form .....	D.6
1999 ADA Claim Form Instructions.....	D.7
Sample 1999 ADA Claim Form .....	D.11
2002/2004 ADA Claim Form Instructions .....	D.12
Sample 2002/2004 ADA Claim Form .....	D.17
2006 ADA Claim Form Instructions.....	D.18
Sample 2006 ADA Claim Form .....	D.23

# Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)]

## How can I use the Internet to...

### Find information on becoming a DSHS provider?

Visit Provider Enrollment at:  
<http://maa.dshs.wa.gov/provrel>

Click *Sign up to be a DSHS WA state Medicaid provider* and follow the on-screen instructions.

### Ask questions about the status of my provider application?

Visit Provider Enrollment at:  
<http://maa.dshs.wa.gov/provrel>

- Click *Sign up to be a DSHS WA state Medicaid provider*
- Click *I want to sign up as a DSHS Washington State Medical provider*
- Click *What happens once I return my application?*

### Submit a change of address or ownership?

Visit Provider Enrollment at:  
<http://maa.dshs.wa.gov/provrel>

- Click *I'm already a current Provider*
- Click *I want to make a change to my provider information*

### Payments, denials, claims processing, or HRSA managed care organizations?

Visit the Customer Service Center for Providers at:  
<http://maa.dshs.wa.gov/provrel>

- Click *I'm already a current Provider*
- Click *Frequently Asked Questions*

or call/fax:  
 800.562.3022, Option 2 (toll free)  
 360.725.2144 (fax)

or write to:  
 HRSA Customer Service Center  
 PO Box 45562  
 Olympia, WA 98504-5562

## If I don't have access to the Internet, how do I find information on...

### Becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:  
 800.562.3022 (toll free)

or write to:  
 HRSA Provider Enrollment  
 PO Box 45562  
 Olympia, WA 98504-5562

**If I don't have access to the Internet, how do I find information on... (cont.)**

**Private insurance or third-party liability, other than HRSA managed care?**

Office of Coordination of Benefits  
PO Box 45565  
Olympia, WA 98504-5565  
800.562.6136 (toll free)

**How do I find out about Internet billing (electronic claims submission)?**

Call the HRSA/HIPAA E-Help Desk at: 800.562.3022 (toll free) and choose option #2, then option #4

or e-mail to:  
hipaae-help@dshs.wa.gov

- or -

visit:  
WinASAP and WAMedWeb:  
<http://www.acs-gcro.com>

Click *Medicaid* then *Washington State*.

All other HIPAA transactions:  
<https://wamedweb.acs-inc.com>

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:  
<http://www.acs-gcro.com>

Click *Medicaid*, then *Washington State*, then *Enrollment*.

or call ACS EDI Gateway, Inc. at:  
800.833.2051 (toll free)

After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 800.833.2051.

**How can I access the HRSA Dental web site?**

Visit:  
<http://maa.dshs.wa.gov/ProvRel/Dental/Dental.html>

**Where can I view and download HRSA fee schedules?**

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

**How do I check on a client's eligibility status?**

Call ACS at:  
800.833.2051 (toll free)

or call HRSA at:  
800.562.3022 (toll free) and choose option #2

You may also access the WAMedWeb Online Tutorial at:  
<http://maa.dshs.wa.gov/wamedwebtutor>

**Where do I write to get prior authorization?**

Program Management &  
Authorization Section-Dental Program  
PO Box 45506  
Olympia WA 98504-5506

For procedures that do not require  
Radiographs - Fax: 360.586.5299

**How do I obtain copies of billing instructions or numbered memoranda?**

To view an electronic copy, visit:  
<http://maa.dshs.wa.gov>

Click *Billing Instructions/Numbered Memoranda*

- or -

To request a hard copy, visit the  
Department of Printing's web site at:  
<http://www.prt.wa.gov>

Click *General Store*

# Definitions & Acronyms

This section defines terms, abbreviations, and acronyms used in these billing instructions that relate to the ABCD Program. The definitions in HRSA's current *Dental Program for Clients Through Age 20 Billing Instructions* apply unless modified by these definitions for the purposes of the ABCD Program.

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

**(ABCD)** – A program to increase access to dental services for Medicaid-eligible clients age five and younger.

**Anterior** – The maxillary and mandibular incisors and canines and tissue in the front of the mouth.

- Permanent maxillary anterior teeth include teeth 6, 7, 8, 9, 10, and 11.
- Permanent mandibular anterior teeth include teeth 22, 23, 24, 25, 26, and 27.
- Primary maxillary anterior teeth include teeth C, D, E, F, G, and H.
- Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

**Current Dental Terminology (CDT)** - 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).

**Dental Home** – The ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referrals to specialists when appropriate.

## **Health and Recovery Services**

**Administration (HRSA)** - 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.

**Medicaid** - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

**Medical Identification (ID) Card** – The form the Department of Social and Health Services uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

**Medically necessary** - See WAC 388-500-0005.

**Posterior** – The maxillary and mandibular incisors and canines and tissue in the front of the mouth.

- Permanent maxillary posterior teeth include teeth 1, 2, 3, 4, 5, 12, 13, 14, 15, and 16.
- Permanent mandibular posterior teeth include teeth 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32.
- Primary maxillary posterior teeth include teeth A, B, I, and J.
- Primary mandibular posterior teeth include teeth K, L, S, and T.

**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).

**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 HRSA.

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

# Access to Baby and Child Dentistry (ABCD) Program

---

## What is the ABCD program? [Refer to WAC 388-535-1245]

The Access to Baby and Child Dentistry (ABCD) program is a program established to increase access to dental services for Medicaid-eligible clients through age five. 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), Health and Recovery Services Administration (HRSA);
- The University of Washington School of Dentistry;
- The Washington Dental Service Foundation;
- The Washington State Dental Association;
- Local dental societies;
- Local health jurisdictions; and
- Other funding sources.

The **mission** is to identify eligible infants and toddlers (see "*Who is eligible?*") before age one and to match each child to an ABCD-certified dentist. Children will remain in the ABCD program until their sixth birthday. [Refer to WAC 388-535-1245 (1)(a)]

Health care providers and community service programs identify and refer eligible clients to the ABCD program. If enrolled, the client and an adult family member may receive:

- Oral health education;
- Anticipatory guidance;
- Assistance with transportation, interpreter services, and other issues related to dental services; and
- Dental services. [Refer to WAC 388-535-1245 (2)]

**Note:** ABCD children are entitled to the full scope of care as described in HRSA's *Dental Program for Clients Through Age 20 Billing Instructions*. These *ABCD Program Billing Instructions* identify those specific services that are eligible for higher reimbursement.

## Who may provide ABCD Dentistry? [WAC 388-535-1245 (3)]

*Dentists* who are certified through the continuing education program at the University of Washington School of Pediatric Dentistry are eligible for ABCD program enhanced reimbursement rates.

## 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>
Community service programs including Local Health Jurisdictions	Identify Medicaid-eligible clients and refer them to the program.
Local community ABCD enrollment units (function may not be available in all counties)	Provide an orientation to the client and/or parent(s)/guardian(s) and prepares the family and child for the dental visit.
	Enroll the client and family into the ABCD program and encourage timely and appropriate dental visits.
	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.
	Address obstacles to care, such as lack of transportation and limited English proficiency.
	Coordinate with local agencies in providing outreach and linkages services to eligible clients.
ABCD Program-Certified Dentists	Provide preventative and restorative treatment for an eligible client.
	Bill HRSA for provided services according to these <i>ABCD Program Billing Instructions</i> .

## How does the ABCD program work? (cont.)

Who...	Responsibility...
Local Dental Societies	Encourage and support participation from members.
Health and Recovery Services Administration (HRSA)	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	Provides management services, funding, and technical assistance to support client outreach, linkage, and provider recruitment.

**This page intentionally left blank.**

# Client Eligibility

---

## Who is eligible? [Refer to WAC 388-535-1245 (1)(a)(b)]

Clients 5 years old and younger are eligible. In addition to an ABCD identification card, eligible clients will have a DSHS Medical Identification (ID) Card containing DSHS eligibility information. **Before** you provide any service to an HRSA 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	Children's Health Program
CNP CHIP	State Children's Health Insurance Program
LCP-MNP	Limited Casualty Program/ Medically Needy Program

## Are clients enrolled in an HRSA managed care organization eligible? [Refer to WAC 388-535-1245 (1)(c)]

Clients, **5 years old and younger**, who are enrolled in a managed care organization (MCO) 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.

**Note:** See HRSA's *Dental Services for Clients Through Age 20 Billing Instructions* for eligibility information regarding services other than those outlined in this manual.

**This page intentionally left blank.**

# Coverage

---

## What is covered? [Refer to WAC 388-535-1245 (4)]

HRSA pays enhanced fees to ABCD-certified participating providers for furnishing ABCD program services. ABCD program services include all of the following, when appropriate:

- Family oral health education. An oral health education visit:
  - ✓ Is limited to one visit per day, per family, up to two visits per child in a 12-month period; and
  - ✓ Must include all of the following:
    - **"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) feel comfortable doing this once per month.
    - **Oral hygiene training:** Demonstrate how to position the child to clean the teeth. Have the parent(s)/guardian(s) actually practice cleaning the teeth. Record the parent's/guardian's response.
    - **Risk assessment for early childhood caries:** 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).
    - **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.
    - **Application of gel or varnish.**

- **Discussion of 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 HRSA'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.
- **Documentation** in the client's file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided and duration of the oral education visit.

**Note:** Bill HRSA 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 (EPA) number 870000997.** See page C.6.

- Periodic oral evaluations, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
- Comprehensive oral evaluations, once per client, per provider or dental clinic, as an initial examination.
- Amalgam and resin restorations on primary teeth, as specified in current HRSA-published documents.

**Note:** HRSA covers amalgam and resin restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar.

**Note:** HRSA covers resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth.

- Fabricated resin crowns for primary anterior teeth once every three years without PA if the tooth requires a four or more surface restoration.
- Therapeutic pulpotomy.
- Prefabricated stainless steel crowns on primary teeth, as specified in current HRSA-published documents.

## ABCD Program

- Resin-based composite crowns on anterior primary teeth.
- Glass ionomers used for Immediate Restorative Treatment (IRT). This is allowed for children through age 5 when provided in the dental office or dental clinic.
- Other dental-related services, as specified in current HRSA-published documents.

**Note:** The client's file must show documentation of the ABCD program services provided. [WAC 388-535-1245 (5)]

**This page intentionally left blank.**

# Coverage Table

ADA Code	Description	PA	Limitations	Maximum Allowable Fee
D0120	Periodic oral evaluation	No	One periodic evaluation is allowed every six months.	<a href="#">On-line Fee Schedules</a>
D0150	Comprehensive oral evaluation	No	<p>For HRSA purposes, this is to be considered an initial exam. One initial evaluation allowed per client, per provider or dental 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>	
D1203	Topical fluoride application [gel or varnish]	No	<p>Allowed up to three times in a 12-month period per client, per provider or clinic.</p> <p>Document in the client's file which material (e.g., topical gel or fluoride varnish is used).</p>	
D2140	Amalgam - one surface, primary or permanent.	No	<p>Tooth and surface designations required. Allowance includes polishing.</p>	

ADA Code	Description	PA	Limitations	Maximum Allowable Fee
D2150	Amalgam - two surfaces, primary or permanent.	No	Tooth and surface designations required. Allowance includes polishing.	<a href="#">On-line Fee Schedules</a>
D2160	Amalgam - three surfaces, primary or permanent.	No	Tooth and surface designations required. <b>Not allowed on primary first molars.</b>	
D2330	Resin-based composite - 1 surface, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.	
D2331	Resin-based composite – 2 surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.	
D2332	Resin-based composite – 3 surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.	
D2390	Resin-based composite crown, anterior – primary tooth	No	Tooth designation required.	
D2391	Resin-based composite – one surface, posterior	No	Tooth and surface designations required.  <b>Note:</b> Use this code when billing for a <b>glass ionomer</b> used for Immediate Restorative Treatment (IRT). This is allowed for children through age 5 when provided in the dental office or dental clinic.	
D2392	Resin-based composite – two surfaces, posterior	No	Tooth and surface designations required.	

ADA Code	Description	PA	Limitations	Maximum Allowable Fee
D2393	Resin-based composite – three surfaces, posterior	No	Tooth designation required. <b>Not allowed on primary first molars.</b>	<a href="#">On-line Fee Schedules</a>
D2930	Prefabricated stainless steel crown - primary	No	Tooth designation required.	
D3220	Therapeutic pulpotomy	No	Covered only as complete procedure, once per tooth. Tooth designation required.	
D9920	Behavior management	No	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.	
D9999	Family Oral Health Education	Use EPA # 870000997.	<b>EPA Criteria:</b>  Limited to one visit per day, per family, up to two visits <b>per child</b> , per 12-month period.	

## Fee Schedule

You may view HRSA's Dental Schedule on-line at:

<http://maa.dshs.wa.gov/RBRVS/Index.html>

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at <http://maa.dshs.wa.gov> (click *Billing Instructions/Numbered Memoranda*).

To request a free paper copy from the Department of Printing:

- **Go to:** <http://www.prt.wa.gov> (On-line orders filled daily.) Click *General Store*. Follow prompts to *Store Lobby* → *Shop by Agency* → *Department of Social and Health Services* → *Health and Recovery Services Administration* → desired issuance; **or**
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Telephoned and faxed orders may take up to 2 weeks to fill.)

# Completing the ADA Claim Form

HRSA accepts **ONLY** the following American Dental Association (ADA) dental claim forms:

- 1994;
- 1999;
- 2002/2004; and
- 2006 (HRSA-preferred).

Any other dental claim forms will not be processed and will be returned to the provider.

**Remember:** If you submit your claims electronically, HRSA will be able to process them faster.

## 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, 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 HRSA.

### Send your claims for payment to:

**Claims Processing**  
**PO Box 9253**  
**Olympia WA 98507-9253**

## 1994 ADA Claim Form Instructions

Field No.	Name	Entry
<b>HEADER INFORMATION</b>		
1.	Provider ID#	Enter your National Provider Identifier (NPI).
2.	Prior Authorization #	Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.
3.	Carrier Name and Address	Enter the address for DSHS that is listed in the shaded box on page D.1.
<b>PATIENT COVERAGE INFORMATION</b>		
4.	Patient Name	<p>Enter the client's legal name, address, and <b>Patient Identification Code (PIC)</b>. HRSA identifies clients by this code, not by their name. This alphanumeric code is assigned to each HRSA client and consists of:</p> <ul style="list-style-type: none"> <li>• First and middle initials (<i>or</i> a dash (-) must be entered if the middle initial is not indicated).</li> <li>• Six-digit birthdate, consisting of numerals only (MMDDYY).</li> <li>• First five letters of the last name (or fewer if the name is less than five letters).</li> <li>• Alpha or numeric character (tiebreaker).</li> </ul>
5.	Relationship to Employee	Check the applicable box.
7.	Patient Birthdate	Enter the client's date of birth.
9.	Employee/Subscriber Name and Address	If different from patient's (field 20), enter the legal name and address of the subscriber here.
10.	Employee/Subscriber Dental Plan ID Number	Enter the subscriber's SSN or other identifier assigned by the payer.
11.	Employee/Subscriber Birthday	Enter the subscriber's date of birth.
12.	Employer (Company) Name and Address	Enter the name and address of the subscriber's employer.
13.	Group Number	Enter the subscriber's group Plan or Policy Number.
14	Is Patient Covered by Another Dental Plan? Or is Patient Covered by a Medical Plan?	Indicate whether or not there is multiple coverage.
15a.	Name and Address of Carrier(s)	Enter any other applicable third party insurance.
15b.	Group Number	If the client has third party coverage, enter the dental plan # of the subscriber.

Field No.	Name	Entry
-----------	------	-------

**PATIENT COVERAGE INFORMATION (cont.)**

17a.	Employee/Subscriber Name (if Different from Patient's)	If different from the patient, enter the name of the subscriber.
17b.	Employee/Subscriber Dental Plan ID Number	If different from patient's, enter the subscriber's date of birth.
17c.	Employee/Subscriber Birthdate	Enter the subscriber's date of birth.
18.	Relationship to Patient	Check the applicable box.

**BILLING DENTIST**

21.	Name of Billing Dentist, or Dental Entity	Enter the dentist's or dental entity's name.
22.	Address Where Payment should be Remitted	Enter the dentist's or dental entity's address.
23.	City, State, Zip	Enter the dentist's or dental entity's city, state, and zip code.
26.	Dentist's Phone Number	Enter the dentist's or dental entity's phone number.
28.	Place of Treatment	<p>Check the applicable box and enter one of the following codes to show the place of service at which the service was performed:</p> <p><b><u>Office</u></b>    <b>11</b> dental office</p> <p><b><u>Hosp</u></b>      <b>22</b> outpatient hospital</p> <p>                  <b>24</b> professional services in an ambulatory surgery center</p> <p><b><u>Other</u></b>    <b>05</b> indian health service facility</p> <p>                  <b>06</b> indian health service facility</p> <p>                  <b>07</b> tribal 638 facility</p> <p>                  <b>08</b> tribal 638 facility</p> <p>                  <b>50</b> federally qualified health center</p>

Field No.	Name	Entry
-----------	------	-------

**BILLING DENTIST (cont.)**

29.	Radiographs or Models Enclosed?	Do not send X-rays when billing for services.
30.	Is Treatment Result of Occupational Illness or Injury?	Check the appropriate box. If you check <i>yes</i> , enter brief description and dates.
31.	Is Treatment Result of an Auto Accident?	Check the appropriate box. If you check <i>yes</i> , enter brief description and dates.
32.	Other Accident?	Check the appropriate box. If you check <i>yes</i> , enter brief description and dates.
33.	If Prosthesis, is this Initial Placement?	Check the appropriate box. If you check <i>no</i> , enter reason for replacement.
34.	Date of Prior Placement?	Enter appropriate date if “yes” is check for field 33.
35.	Is Treatment for Orthodontics?	Check the appropriate box. If service already commenced, enter the date appliances placed and the months of treatment remaining.
36.	Identify Missing Teeth with an “x”.	Place an “X” on the appropriate missing teeth.
<b>Each service performed</b> must be listed as a separate, complete one-line entry. <b>Each extraction or restoration</b> must be listed as a separate line entry. If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.		
37.	<b>Examination and Treatment Plan</b>	Follow instructions below:
	Tooth # or letter	Enter the appropriate tooth number or letter(s) 01 through 32 for permanent teeth A through T for primary teeth 51 through 82 or AS through TS for supernumerary teeth
	Surface	Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to <b>five codes</b> may be listed in this column:  B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal
Description of service	Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending times.	

Field No.	Name	Entry
-----------	------	-------

**BILLING DENTIST (cont.)**

37.	Examination and Treatment Plan (cont.)	Follow instructions below:
	Date service performed	Enter the six-digit date of service, indicating month, day, and year (e.g., April 1, 2007 = 040107).
	Procedure number	Enter the procedure code from this fee schedule that represents the procedure or service performed. <b>The use of any other procedure code(s) will result in denial of payment.</b>
	Fee	Enter <b>your usual and customary fee</b> (not HRSA's maximum allowable rate) for each service rendered.
38.	Remarks for Unusual Services	Enter the provider number assigned by HRSA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the HRSA Remittance and Status Report in the <b>Provider Number</b> area at the top of the page. It is this code by which providers are identified, not by provider name. <b>Without this number your claim will be denied.</b> If the claim type requires a rendering provider to be identified, enter the rendering provider's NPI and Medicaid provider number here.
41.	Total fee Charged	Total of all charges.
42.	Payment by other plan	Enter payment from other plan. Attach the insurance EOB to the claim.



P.O. Box 9695  
Boston, MA 02114

Delta Claim Form

See reverse for instructions

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services Provider ID#		2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization # Patient ID#		3. Carrier name and address									
PATIENT COVERAGE INFORMATION	4. Patient name first m.l. last		5. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other		6. Sex m f		7. Patient birthdate MM DD YY		8. If full time student school city				
	9. Employee/subscriber name and mailing address			10. Employee/subscriber dental plan I.D. number		11. Employee/subscriber birthdate MM DD YY		12. Employer (company) name and address		13. Group number			
	14. Is patient covered by another dental plan yes no If yes, complete 15-a. Is patient covered by a medical plan? yes no		15-a. Name and address of carrier(s)			15-b. Group no.(s)		16. Name and address of other employer(s)					
17-a. Employee/subscriber name (if different from patient's)				17-b. Employee/subscriber dental plan I.D. number		17-c. Employee/subscriber birthdate MM DD YY		18. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other					
19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim.  Signed (Patient* - see reverse) _____ Date _____						20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.  Signed (Employee/subscriber) _____ Date _____							
BILLING DENTIST	21. Name of Billing Dentist or Dental Entity				30. Is treatment result of occupational illness or injury? No Yes		If yes, enter brief description and dates						
	22. Address where payment should be remitted				31. Is treatment result of auto accident?								
	23. City, State, Zip				32. Other accident?								
	24. Dentist Soc. Sec. or T.I.N. (see reverse*)		25. Dentist license no.		26. Dentist phone no.		33. If prosthesis, is this initial placement?		(if no, reason for replacement)		34. Date of prior placement		
	27. First visit date current series		28. Place of treatment Office Hosp. ECF Other		29. Radiographs or models enclosed? No Yes How many?		35. Is treatment for orthodontics?		If service already commenced enter: Date appliances placed		Mos. treatment remaining		
36. Identify missing teeth with "x"		37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.											
		Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)				Date service performed Mo. Day Year		Procedure number	Fee	For administrative use only	
38. Remarks for unusual services													
39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.  Signed (Treating Dentist) _____ License Number _____ Date _____								41. Total Fee Charged					
40. Address where treatment was performed  City _____ State _____ Zip _____								42. Payment by other plan					
								Max. Allowable					
								Deductible					
								Carrier %					
								Carrier pays					
								Patient pays					

©American Dental Association, 1994  
J510 (Same as ADA Dental Claim Form - J504, J511, J512)  
DDCF3.1197

FAX ORDERS TO 1-888-299-2212  
OR CALL DENTAL FORMS DEPARTMENT  
1-800-368-1368

## 1999 ADA Claim Form Instructions

Field No.	Name	Entry
<b>HEADER INFORMATION</b>		
2.	Prior Authorization #	Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.
3.-7.	Carrier Name, Address, City, State, and Zip	Enter the address for DSHS that is listed in the shaded box on page D.1.
<b>PATIENT</b>		
8.-11. 16	Patient Name (Last, First, Middle), Address, City, State, Zip Code	<p>Enter the client's legal name, address, and <b>Patient Identification Code (PIC)</b>. HRSA identifies clients by this code, not by their name. This alphanumeric code is assigned to each HRSA client and consists of:</p> <ul style="list-style-type: none"> <li>• First and middle initials (<i>or</i> a dash (-) must be entered if the middle initial is not indicated).</li> <li>• Six-digit birthdate, consisting of numerals only (MMDDYY).</li> <li>• First five letters of the last name (or fewer if the name is less than five letters).</li> <li>• Alpha or numeric character (tiebreaker).</li> </ul>
12.	Date of Birth (MM/DD/YYYY)	Enter the client's date of birth.
13.	Patient ID#	If you wish to use a medical record number, enter that number here.
17.	Relationship to Subscriber/Employee	Check the appropriate box.
<b>SUBSCRIBER/EMPLOYEE</b>		
19.	Subs./Emp. ID#/SSN#	Enter the SSN or other identifier assigned by the payer.
20.	Employer Name	Enter the name of the subscriber's employer.
21.	Group #	Enter the subscriber's group Plan or Policy Number.
22.-23. 25.-27.	Subscriber/Employee Name (Last, First, Middle), Address, City, State, Zip Code	If different from patient's (field 20), enter the legal name and address of the subscriber here.
28.	Date of Birth (MM/DD/YYYY)	If different from patient's, enter the subscriber's date of birth.

Field No.	Name	Entry
-----------	------	-------

**OTHER POLICIES**

31.	Is Patient Covered by Another Plan	Check the appropriate response.
32.	Policy #	If the client has third party coverage, enter the dental plan # of the subscriber.
33.	Other Subscriber's Name	If different from the patient, enter the name of the subscriber.
34.	Date of Birth (MM/DD/CCYY)	Enter the subscriber's date of birth.
36.	Plan/Program Name	Enter any other applicable third party insurance.

**BILLING DENTIST**

42.	Name of Billing Dentist, or Dental Entity	Enter the dentist's or dental entity's name.
43.	Phone Number	Enter the dentist's or dental entity's phone number.
44.	Provider ID #	Enter your NPI here.
46.	Address Where Payment should be Remitted	Enter the dentist's or dental entity's address.
49.	Place of Treatment	<p>Check the applicable box and enter one of the following codes to show the place of service at which the service was performed:</p> <p><b><u>Office</u></b>    <b>11</b> dental office  <b><u>Hosp</u></b>      <b>22</b> outpatient hospital                    <b>24</b> professional services in an ambulatory surgery center  <b><u>Other</u></b>    <b>05</b> indian health service facility                    <b>06</b> indian health service facility                    <b>07</b> tribal 638 facility                    <b>08</b> tribal 638 facility                    <b>50</b> federally qualified health center</p>
50.-52.	City, State, Zip	Enter the dentist's or dental entity's city, state, and zip code.

Field No.	Name	Entry
-----------	------	-------

**BILLING DENTIST (cont.)**

53.	Radiographs or Models Enclosed?	Do not send X-rays when billing for services.
54.	Is Treatment for Orthodontics?	Check the appropriate box. If service already commenced, enter the date appliances placed and the months of treatment remaining.
55.	If Prosthesis (Crown, Bridge, Dentures), is this Initial Placement?	Check the appropriate box. If you check <i>no</i> , enter reason for replacement and date of prior placement.
56.	Is Treatment Result of Occupational Illness or Injury?	Check the appropriate box. If you check <i>yes</i> , enter brief description and dates.
57.	Is Treatment Result of:	Check the appropriate box and enter a brief description and dates, when appropriate.

**RECORD OF SERVICES PROVIDED**

<p><b>Each service performed</b> must be listed as a separate, complete one-line entry. <b>Each extraction or restoration</b> must be listed as a separate line entry. If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.</p>		
59.	Examination and Treatment Plans	Follow instructions below:
	Date	Enter the six-digit date of service, indicating month, day, and year (e.g., April 1, 2007 = 040107).
	Tooth	Enter the appropriate tooth number, letter(s): <ul style="list-style-type: none"> <li>• 01 through 32 for permanent teeth</li> <li>• A through T for primary teeth</li> <li>• 51 through 82 or AS through TS for supernumerary teeth</li> </ul>
	Surface	Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to <b>five codes</b> may be listed in this column: <p>B = Buccal  D = Distal  F = Facial  I = Incisal  L = Lingual  M = Mesial  O = Occlusal</p>
	Diagnosis index #	Leave this field blank.

Field No.	Name	Entry
-----------	------	-------

**RECORD OF SERVICES PROVIDED (cont.)**

59.	Examination and Treatment Plan (cont.)	Follow instructions below:
	Procedure code	Enter the procedure code from this fee schedule that represents the procedure or service performed. <b>The use of any other procedure code(s) will result in denial of payment.</b>
	Qty	Indicate units of service.
	Description	Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending time.
	Fee	Enter <b>your usual and customary fee</b> (not HRSA's maximum allowable rate) for each service rendered.
60.	Missing Teeth Information	Place an "X" on the appropriate missing teeth.
	Payment by other plan	Enter payment from other plan. Attach the insurance EOB to the claim.
61.	Remarks	Enter the provider number assigned by HRSA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the HRSA Remittance and Status Report in the <b>Provider Number</b> area at the top of the page. It is this code by which providers are identified, not by provider name. <b>Without this number your claim will be denied.</b> If the claim type requires a rendering provider to be identified, enter the rendering provider's NPI and Medicaid provider number here.

**Dental Claim Form**

©American Dental Association, 1999 version 2000

1. <input type="checkbox"/> Dentist's pre-treatment estimate Specialty (see backside)		3. Carrier Name																								
2. <input type="checkbox"/> Medicaid Claim Prior Authorization # <input type="checkbox"/> EPSDT		4. Carrier Address																								
		5. City	7. Zip																							
6. Patient Name (Last, First, Middle)		9. Address																								
		10. City	11. State																							
PATIENT	12. Date of Birth (MM/DD/YYYY) / /	13. Patient ID #	14. Sex <input type="checkbox"/> M <input type="checkbox"/> F																							
	15. Phone Number ( )		16. Zip Code																							
17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		18. Employer/School Name _____ Address _____																								
SUBSCRIBER/EMPLOYEE	19. Subs./Emp. ID#/SSN#	20. Employer Name	21. Group #																							
	22. Subscriber/Employee Name (Last, First, Middle)																									
	23. Address		24. Phone Number ( )																							
	25. City	26. State	27. Zip Code																							
	28. Date of Birth (MM/DD/YYYY) / /	29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	30. Sex <input type="checkbox"/> M <input type="checkbox"/> F																							
	31. 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 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 under applicable law, I authorize release of any information relating to this claim.  X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)																									
31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical		32. Policy #																								
33. Other Subscriber's Name		34. Date of Birth (MM/DD/YYYY) / /																								
		35. Sex <input type="checkbox"/> M <input type="checkbox"/> F	36. Plan/Program Name																							
37. Employer/School Name _____ Address _____		38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student																								
40. Employer/School Name _____ Address _____		41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.  X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)																								
BILLING DENTIST	42. Name of Billing Dentist or Dental Entity		43. Phone Number ( )																							
	46. Address		44. Provider ID #																							
	50. City		45. Dentist Soc. Sec. or T.I.N.																							
	51. State	52. Zip Code	47. Dentist License #																							
	53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		48. First visit date of current series:																							
	54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____		49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other																							
55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No if no, reason for replacement: _____ Date of prior placement: _____		56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____																								
57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____																										
58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____																										
59. Examination and treatment plans - List teeth in order																										
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #																							
			Procedure Code																							
			Qty																							
			Description																							
			Fee																							
			Admin. Use Only																							
60. Identify all missing teeth with "X"																										
Permanent								Primary								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	Payment by other plan
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable
61. Remarks for unusual services																								Deductible		
																								Carrier %		
																								Carrier pays		
																								Patient pays		
62. 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 procedures.  X _____ Signed (Treating Dentist) License # _____ Date (MM/DD/YYYY)												63. Address where treatment was performed														
												64. City				65. State				66. Zip Code						

©American Dental Association, 1999

## 2002/2004 ADA Claim Form Instructions

Field No.	Name	Entry
<b>HEADER INFORMATION</b>		
2.	Predetermination/Preauthorization Number	Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.
<b>PRIMARY PAYER INFORMATION</b>		
3.	Name, Address, City, State, Zip Code	Enter the address for DSHS that is listed in the shaded box on page D.1.
<b>OTHER COVERAGE</b>		
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.
<b>PRIMARY SUBSCRIBER INFORMATION</b>		
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 Plan or Policy Number.
17.	Employer Name	Enter the name of the subscriber's employer.
<b>PATIENT INFORMATION</b>		
18.	Relationship to Primary Subscriber	Check the appropriate box.

Field No.	Name	Entry
-----------	------	-------

**PATIENT INFORMATION (cont.)**

20.	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	<p>Enter the client's legal name, address, and <b>Patient Identification Code (PIC)</b>. HRSA identifies clients by this code, not by their name. This alphanumeric code is assigned to each HRSA client and consists of:</p> <ul style="list-style-type: none"> <li>• First and middle initials (<i>or</i> a dash (-) must be entered if the middle initial is not indicated).</li> <li>• Six-digit birthdate, consisting of numerals only (MMDDYY).</li> <li>• First five letters of the last name (or fewer if the name is less than five letters).</li> <li>• Alpha or numeric character (tiebreaker).</li> </ul>
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**

<p><b>Each service performed</b> must be listed as a separate, complete one-line entry. <b>Each extraction or restoration</b> must be listed as a separate line entry. If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.</p>		
24.	Procedure Date (MM/DD/CCYY)	Enter the six-digit date of service, indicating month, day, and year (e.g., April 1, 2007 = 040107).
25.	Area of Oral Cavity	<p>If the procedure code requires an arch or a quadrant designation, enter one of the following:</p> <p>01 Maxillary area            02 Mandibular area            10 Upper right quadrant            20 Upper left quadrant            30 Lower left quadrant            40 Lower right quadrant</p>
27.	Tooth Number(s) or Letter(s)	<p>Enter the appropriate tooth number, letter(s):</p> <ul style="list-style-type: none"> <li>• 01 through 32 for permanent teeth</li> <li>• A through T for primary teeth</li> <li>• 51 through 82 or AS through TS for supernumerary teeth</li> </ul>

Field No.	Name	Entry
-----------	------	-------

**RECORD OF SERVICES PROVIDED (cont.)**

28.	Tooth Surface	<p>Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to <b>five codes</b> may be listed in this column:</p> <p>B = Buccal            D = Distal            F = Facial            I = Incisal            L = Lingual            M = Mesial            O = Occlusal</p>
29.	Procedure Code	<p>Enter the procedure code from this fee schedule that represents the procedure or service performed. <b>The use of any other procedure code(s) will result in denial of payment.</b></p>
30.	Description of Services	<p>Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending time.</p>
31.	Fee	<p>Enter <b>your usual and customary fee</b> (not HRSA's maximum allowable rate) for each service rendered.</p>
33.	Total Fee	<p>Total of all charges.</p>
34.	Missing Teeth Information	<p>Place an "X" on the appropriate missing teeth.</p>
35.	Remarks	<p>Enter the provider number assigned by HRSA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the HRSA Remittance and Status Report in the <b>Provider Number</b> area at the top of the page. If performing provider is different than that listed in field 49, enter the rendering provider's Medicaid provider number here.</p> <p>To indicate a payment by another plan, enter "insurance payment" and the amount. Attached the insurance EOB to the claim.</p>

Field No.	Name	Entry
-----------	------	-------

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38.	Place of Treatment	<p>Check the applicable box and enter one of the following codes to show the place of service at which the service was performed:</p> <p><b>Office</b> 11 dental office  <b>Hosp</b> 22 outpatient hospital  24 professional services in an ambulatory surgery center  <b>Other</b> 05 indian health service facility  06 indian health service facility  07 tribal 638 facility  08 tribal 638 facility  50 federally qualified health center</p>
39.	Number of Enclosures (00-99)	<p>Check the appropriate box.</p> <p><b>Note:</b> Do not send X-rays when billing for services.</p>
40.	Is Treatment for Orthodontics?	Check appropriate box.
41.	Date Appliance Placed (MM/DD/CCYY)	This field <b>must be completed</b> 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 HRSA.
49.	Provider ID	Enter your National Provider Identifier (NPI). It is this code by which providers are identified, not by provider name. <b>Without this number your claim will be denied.</b>
52.	Phone Number	Enter the billing dentist’s phone number.

Field No.	Name	Entry
-----------	------	-------

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

54.	Provider ID	Enter the performing provider's NPI if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique NPI 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

Insured and/or Administered by Connecticut General Life Insurance Company CIGNA Dental



HEADER INFORMATION
1. Type of Transaction (Check all applicable boxes)
Statement of Actual Services
Request for Predetermination/Preauthorization
EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION
3. Name, Address, City, State, Zip Code
CIGNA Dental - Sherman
P.O. Box 188037
Chattanooga, TN 37422-8037
1.800.244.6224

OTHER COVERAGE
4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)
5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number 10. Patient's Relationship to Other Insured (Check applicable box)
Self Spouse Dependent Other

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

PRIMARY INSURED INFORMATION

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

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

16. Plan/Group Number 17. Employer Name
3205336 Hanford Employee Welfare Trust

PATIENT INFORMATION

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

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

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

RECORD OF SERVICES PROVIDED

Table with columns: 24. Procedure Date (MM/DD/CCYY), 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. Rows 1-10.

MISSING TEETH INFORMATION

Table for missing teeth with columns for Permanent (1-16) and Primary (A-J) teeth, and 32. Other (Fee(s)).

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 activities 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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
Provider's Office Hospital ECF Other
39. Number of Enclosures (00 to 99) Radiograph(s) Other Image(s) Model(s)

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

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

45. Treatment Resulting from (Check applicable box)
Occupational Illness/Injury Auto accident Other accident

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

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

49. Provider ID 50. License Number 51. SSN or TIN

52. Phone Number ( ) -

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 procedures.

X Signed (Treating Dentist) Date

54. Provider ID 55. License Number

56. Address, City, State, Zip Code

58. Treating Provider Specialty

## 2006 ADA Claim Form Instructions

Field No.	Name	Entry
<b>HEADER INFORMATION</b>		
2.	Predetermination/Preauthorization Number	Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>		
3.	Company/Plan Name, Address, City, State, Zip Code	Enter the address for DSHS that is listed in the shaded box on page D.1.
<b>OTHER COVERAGE</b>		
4.	Other Dental or Medical Coverage	Check the appropriate response.
5.	Name of Policyholder/Subscriber (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.	Policyholder/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 Policyholder/Subscriber	Check the applicable box.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter any other applicable third party insurance.
<b>POLICYHOLDER/SUBSCRIBER INFORMATION</b>		
12.	Policyholder/Subscriber 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.	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the SSN or other identifier assigned by the payer.
16.	Plan/Group Number	Enter the subscriber's group Plan or Policy Number.
17.	Employer Name	Enter the name of the subscriber's employer.
<b>PATIENT INFORMATION</b>		
18.	Relationship to Policyholder/Subscriber	Check the appropriate box.

Field No.	Name	Entry
-----------	------	-------

**PATIENT INFORMATION (cont.)**

20.	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	<p>Enter the client's legal name, address, and <b>Patient Identification Code (PIC)</b>. HRSA identifies clients by this code, not by their name. This alphanumeric code is assigned to each HRSA client and consists of:</p> <ul style="list-style-type: none"> <li>• First and middle initials (<i>or</i> a dash (-) must be entered if the middle initial is not indicated).</li> <li>• Six-digit birthdate, consisting of numerals only (MMDDYY).</li> <li>• First five letters of the last name (or fewer if the name is less than five letters).</li> <li>• Alpha or numeric character (tiebreaker).</li> </ul>
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**

<p><b>Each service performed</b> must be listed as a separate, complete one-line entry. <b>Each extraction or restoration</b> must be listed as a separate line entry. If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.</p>		
24.	Procedure Date (MM/DD/CCYY)	Enter the six-digit date of service, indicating month, day, and year (e.g., April 1, 2007 = 040107).
25.	Area of Oral Cavity	<p>If the procedure code requires an arch or a quadrant designation, enter one of the following:</p> <p>01 Maxillary area            02 Mandibular area            10 Upper right quadrant            20 Upper left quadrant            30 Lower left quadrant            40 Lower right quadrant</p>
27.	Tooth Number(s) or Letter(s)	<p>Enter the appropriate tooth number, letter(s):</p> <ul style="list-style-type: none"> <li>• 01 through 32 for permanent teeth</li> <li>• A through T for primary teeth</li> <li>• 51 through 82 or AS through TS for supernumerary teeth</li> </ul>

Field No.	Name	Entry
-----------	------	-------

**RECORD OF SERVICES PROVIDED (cont.)**

28.	Tooth Surface	<p>Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to <b>five codes</b> may be listed in this column:</p> <p>B = Buccal            D = Distal            F = Facial            I = Incisal            L = Lingual            M = Mesial            O = Occlusal</p>
29.	Procedure Code	<p>Enter the procedure code from this fee schedule that represents the procedure or service performed. <b>The use of any other procedure code(s) will result in denial of payment.</b></p>
30.	Description	<p>Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending time.</p>
31.	Fee	<p>Enter <b>your usual and customary fee</b> (not HRSA's maximum allowable rate) for each service rendered.</p>
33.	Total Fee	<p>Total of all charges.</p>
34.	Missing Teeth Information	<p>Place an "X" on the appropriate missing teeth.</p>
35.	Remarks	<p>Enter the provider number assigned by HRSA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the HRSA Remittance and Status Report in the <b>Provider Number</b> area at the top of the page. If performing provider is different than that listed in field 49, enter the rendering provider's Medicaid provider number here.</p> <p>To indicate a payment by another plan, enter "insurance payment" and the amount. Attach the insurance EOB to the claim.</p>

Field No.	Name	Entry
-----------	------	-------

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38.	Place of Treatment	<p>Check the applicable box and enter one of the following codes to show the place of service at which the service was performed:</p> <p><b>Office</b> 11 dental office  <b>Hosp</b> 22 outpatient hospital                24 professional services in an ambulatory surgery center  <b>Other</b> 05 indian health service facility                06 indian health service facility                07 tribal 638 facility                08 tribal 638 facility                50 federally qualified health center</p>
39.	Number of Enclosures (00 to 99)	<p>Check the appropriate box.</p> <p><b>Note:</b> Do not send X-rays when billing for services.</p>
40.	Is Treatment for Orthodontics?	Check appropriate box.
41.	Date Appliance Placed (MM/DD/CCYY)	This field <b>must be completed</b> 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 HRSA.
49.	NPI	Enter your National Provider Identifier (NPI). It is this code by which providers are identified, not by provider name. <b>Without this number your claim will be denied.</b>
52.	Phone Number	Enter the billing dentist’s phone number.

Field No.	Name	Entry
-----------	------	-------

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

54.	NPI	Enter the performing provider's NPI if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique NPI 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

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
 Statement of Actual Services     Request for Predetermination/Preauthorization  
 EPSDT/Title XIX

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

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

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

**OTHER COVERAGE**

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

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

**PATIENT INFORMATION**

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

9. Plan/Group Number    10. Patient's Relationship to Person Named in #5  
 Self     Spouse     Dependent     Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

16. Plan/Group Number    17. Employer Name

18. Relationship to Policyholder/Subscriber in #12 Above  
 Self     Spouse     Dependent Child     Other    19. Student Status  
 FTS     PTS

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

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

**RECORD OF SERVICES PROVIDED**

	24. Procedure Date (MM/DD/CCYY)	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	2	3	4	5	6	7	8	9	10	11	12				
1																			
2																			
3																			
4																			
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
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

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 activities 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

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment  
 Provider's Office     Hospital     ECF     Other

39. Number of Enclosures (00 to 99)  
Radiograph(s)    Oral Image(s)    Model(s)

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)     Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining    43. Replacement of Prosthesis?  
 No     Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  
 Occupational Illness/Injury     Auto accident     Other accident

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

**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

49. NPI    50. License Number    51. SSN or TIN

52. Phone Number ( ) -    52A. Additional Provider ID

**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.

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

54. NPI    55. License Number

56. Address, City, State, Zip Code    56A. Provider Specialty Code

57. Phone Number ( ) -    58. Additional Provider ID

**This page intentionally left blank.**