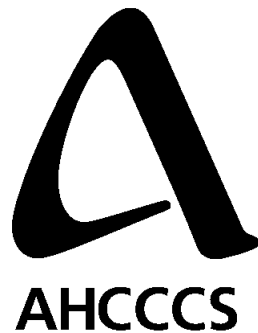




## **Chapter 7**

# **Fee-for-Service Billing on the ADA Claim Form**





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## **INTRODUCTION**

Prior to January 1, 2007, the Health Insurance Portability and Accountability Act (HIPAA) required that dentist's bill for services on the ADA 2006 claim form. Dental claims for dates of service on and after January 1, 2004 must be billed on the ADA 2006 form. Claims billed on a CMS 1500 claim form for dates of service on and after January 1, 2007 will be denied.

**NOTE:** This chapter applies to paper ADA 2006 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at [www.azahcccs.gov](http://www.azahcccs.gov). The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

## **COMPLETING THE ADA CLAIM FORM**

The following instructions explain how to complete the ADA Claim Form and whether a field is "Required," "Required if applicable," or "Not required."

- 1. Type of Transaction** **Not required**
- 2. Predetermination/Preauthorization Number** **Required if applicable**

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

2. Predetermination/Preauthorization Number

030010004321

- 3. Insurance Company Plan Name** **Required if applicable**



**4. Other Dental or Medical Coverage** **Required**

Check appropriate box to indicate whether recipient has third party coverage.

4. Other Dental or Medical Coverage?	<input checked="" type="checkbox"/> No (Skip 5-11)	<input type="checkbox"/> Yes (Complete 5-11)
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**5. Subscriber Name** **Required if applicable**

**6. Date of Birth** **Required if applicable**

**7. Gender** **Required if applicable**

**8. Subscriber Identifier** **Required if applicable**

**9. Plan/Group Number** **Required if applicable**

**10. Relationship to Primary Subscriber** **Required if applicable**

**11. Other Carrier Name, Address** **Required if applicable**

**12. Primary Subscriber Name and Address** **Required**

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.  
Enter the recipient's address

12. NAME (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
<b>Earp, Wyatt H.</b>
<b>123 E. OK Corral Drive</b>
<b>Tombstone, AZ 85638</b>



**13. Date of Birth**

**Required**

Enter the recipient's date of birth.

13. Date of Birth <b>08/14/1851</b>
--

**14. Gender**

**Required**

Check the appropriate box to indicate the patient's gender.

14. Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/>
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**15. Subscriber Identifier**

**Required**

Enter the recipient's *AHCCCS ID number*. Contact the AHCCCS Verification Unit if there are questions about eligibility or the AHCCCS ID number. (See Chapter 2, Recipient Eligibility and Enrollment).

15. Subscriber Identifier (SSN or ID#) <b>A12345678</b>
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**16. Plan/Group Number**

**Not required**

**17. Employer Name**

**Not required**

**18. Relationship to Primary Subscriber**

**Not required**

**19. Student Status**

**Not required**

**20. Name**

**Not required**

**21. Date of Birth**

**Not required**

**22. Gender**

**Not required**



**23. Patient ID/Account Number**

**Required**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.

23. Patient ID/Account # (Assigned by Dentist)
<b>WEARP5678</b>

**24. Procedure Date**

**Required**

Enter the procedure date in MM/DD/YYYY format.

24. Procedure Date (MM/DD/CCYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1			
2			
3			

**25. Area of Oral Cavity**

**Required**

Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 *Designation System for Teeth and Areas of the Oral Cavity* for codes.

24. Procedure Date (MM/DD/CCYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1			
2			
3			



**26. Tooth System**

**Required**

Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation system. Enter "JO" when using ANSI/ADA/ISO Specification No. 3950.

24. Procedure Date (MM/DD/CCYY)		25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

**27. Tooth Number(s) or Letter(s)**

**Required**

Enter the tooth number when the procedure directly involves a tooth. Use commas to separate individual tooth numbers. If a range of teeth is involved, use a hyphen to separate the first and last tooth in the range.

24. Procedure Date (MM/DD/CCYY)		25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

**28. Tooth Surface**

**Required**

Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	



**29. Procedure Code**

**Required**

Enter the appropriate procedure code from the *CDT-4 Manual*.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	

**30. Description**

**Required**

Enter the description of the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	

**31. Fee**

**Required**

Enter the fee for the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	

**32. Other Fees**

**Not required**



**33. Total Fee Required**

Enter the total of all fees in Field 31.

32. Other Fee(s)			
33. Total Fee			

**34. Missing Teeth Required**

Mark all missing teeth.

MISSING TEETH INFORMATION	Permanent															
	1	2	X	4	5	6	7	8	9	10	11	12	13	14	15	16
34. (Place an 'X' on each missing tooth)	32	31	30	29	28	22	26	25	24	23	22	21	20	19	18	17

**35. Remarks Not required**

**36. Parent/Guardian Signature and Date Not required**

**37. Subscriber Signature and Date Not required**

**38. Place of Treatment Required**

Check the appropriate box.

38. Place of Treatment (Check applicable box)			
<input checked="" type="checkbox"/> Provider's Office	<input type="checkbox"/> Hospital	<input type="checkbox"/> ECF	<input type="checkbox"/> Other

**39. Number of Enclosures Required if applicable**

**40. Is Treatment for Orthodontics? Required if applicable**

**41. Date Appliance Placed Required if applicable**

**42. Months of Treatment Remaining Required if applicable**



**43. Replacement of Prosthesis** **Required**

Check the appropriate box. If “Yes” is checked, complete Field 44.

43. Replacement of Prosthesis? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)
---

**44. Date of Prior Placement** **Required if applicable**

If “Yes” is checked in Field 43, enter the date of prior placement in MM/DD/YYYY format.

**45. Treatment Resulting From** **Required if applicable**

Check the appropriate box, as applicable.

**46. Date of Accident** **Required if applicable**

Enter the date in MM/DD/YYYY format.

**47. Auto Accident State** **Required if applicable**

Enter the name of the state where the accident occurred.

**48. Billing Dentist/Dental Entity Name and Address** **Required**

Enter the name and address of the billing dentist or dental entity.

48. Name, Address, City, State, Zip Code <b>Holliday, John H.</b> <b>123 E. Main Street</b> <b>Scottsdale, AZ 85252</b>
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**49. NPI** **Required**

Enter the appropriate NPI of the billing dentist or dental entity.

49. Provider ID <b>654321</b>
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**50. License Number**

**Required**

Enter the license number of the billing dentist or dental entity.

50. License Number

**987-654321**

**51. SSN or TIN**

**Required**

Enter the Social Security Number or tax ID number of the billing dentist or dental entity.

51. SSN or TIN

**123-45-6789**

**52. Phone Number**

**Not required**

**52a. Additional Provider ID**

**Required if Applicable**

**53. Signature of Treating Dentist**

**Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

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

Signed (Treating Dentist)

Date

**54. NPI**

**Required**

Enter the NPI of the treating dentist.

49. Provider ID

**654321**



**55. License Number**

**Required**

Enter the license number of the treating dentist.

50. License Number <b>987-654321</b>
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**56. Address (Treating Dentist)**

**Not required**

**56a. Specialty Code**

**Not Required**

**57. Phone Number (Treating Dentist)**

**Not required**

**58. Additional Provider ID**

**Required if Applicable**



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