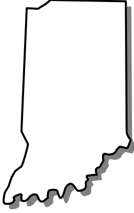

PROVIDER BULLETIN

BT200705 FEBRUARY 13, 2007

To: **All Dental Providers**

Subject: **Updated ADA 2006 Claim Form Requirements**

Overview

The Indiana Health Coverage Program (IHCP) will discontinue acceptance of the current American Dental Association (ADA) 1999, Version 2000 Dental Claim Form (referred to as the ADA 2000 dental claim form) effective May 23, 2007. Beginning May 23, 2007, only the ADA 2006 claim form will be accepted. Paper claims received on the old form will not be processed after May 22, 2007, and will be returned to the provider.

Note: The information in this bulletin supersedes information that has been previously communicated through bulletins, banner pages, or workshop training materials.

Table 1 – Timeline Revised Paper Claim Forms

Current Form	New Form	Transition Period (Old and New Forms Accepted)		Only New Forms Accepted (Cutover Date)
		Start Date	End Date	
ADA 2000	ADA 2006	April 15, 2007	May 22, 2007	May 23, 2007

ADA 2006 Paper Claim Form Changes and Requirements

This section provides a brief overview of the requirements for completion of the ADA 2006 claim form. The ADA 2006 form is a new form that will replace the ADA 1999, Version 2000 claim form which will be discontinued as of May 23, 2007. EDS does not supply dental claim forms and they will not be available on the IHCP Web site. Dental claim forms can be obtained from several sources, including the American Dental Association, by calling 1-800-947-4746.

The instructions outlined in this bulletin are effective for the new ADA 2006 paper claim submissions starting April 15, 2007. Paper claims received beginning May 23, 2007, must meet the new ADA 2006 claim form requirements. Beginning May 23, 2007, non-compliant paper claims submitted for processing will be returned to the provider. During the transition period, the IHCP will accept both the old and the new claim forms. During the transition, providers who have obtained and reported their National Provider Identifier (NPI) number to the IHCP should include both their NPI and their IHCP provider number (legacy provider identifier (LPI)) on the paper claim form. After the transition period, only the NPI will be used to process claims.

Reporting the NPI Using the NPI Reporting Tool

All providers must first report the NPI and taxonomy code(s) via the NPI Reporting Tool available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/NPITool/npi_logon.aspx or by using the *NPI Reporting Form* available on the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. Providers must use the taxonomy codes reported to the IHCP when submitting claims. The NPI page, located at http://www.indianamedicaid.com/ihcp/ProviderServices/npi.asp, contains information about the IHCP NPI Implementation Plan and instructions for obtaining an NPI.

Definitions

Legacy Provider Identifier (LPI) — The provider number issued by the IHCP.

National Provider Identifier (NPI) — New identifier issued through the NPPES developed by CMS. NPI will replace all IHCP provider numbers (LPI) currently used for billing purposes.

taxonomy number — National code identifying a provider type and specialty.

ADA 2006 Claim Form Fields

This section explains completion of the ADA 2006 claim form. Some information is required to complete the claim form, while other information is optional.

The ADA 2006 Claim Form Locator Descriptions table uses bold type to indicate if a field is **Required** or **Required, if applicable**. *Optional* and *Not applicable* information is displayed in normal type. Specific instructions applicable to a particular provider type are noted as well. The instructions describe each form locator by referring to the number found in the left corner of each box on the ADA 2006 claim form. These boxes contain the data elements.

An example of the new claim form is included in this bulletin.

ADA 2006 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
1	Type of Transaction (mark all applicable boxes): Mark the box stating, Dentist's statement of actual services and/or EPSDT. Optional.
2	Predetermination/Preauthorization Number – Prior Authorization #: Optional.
3	**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION** – Company Plan Name, Address, City, State, ZIP Code – Enter primary insurance information with name and address, ZIP Code + 4. **Required, if applicable**. Optional.
4	OTHER DENTAL OR MEDICAL COVERAGE? – Mark yes or no. Optional
5	OTHER SUBSCRIBER NAME: If another insurance is available and the policyholder is other than the member indicated in field 20, provide the policyholder's name. Optional.
6	DATE OF BIRTH: MM/DD/CCYY – If another insurance is available and the policyholder is other than the member indicated in field 20, provide the policyholder's birth date in MMDDCCYY format. Optional.
7	GENDER - M, F – Mark the appropriate box. Optional.

ADA 2006 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
8	POLICYHOLDER/SUBSCRIBER ID (SSN OR ID#) – Required, if applicable.
9	PLAN/GROUP NUMBER – Required, if applicable.
10	PATIENT'S RELATIONSHIP TO PERSON NAMED IN #5 – Required, if applicable.
11	OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE – Required, if applicable.
12	POLICYHOLDER/SUBSCRIBER INFORMATION (FOR INSURANCE COMPANY NAMED IN #3) – Required, if applicable.
13	DATE OF BIRTH (MM/DD/CCYY) – Optional.
14	GENDER – Optional.
15	POLICYHOLDER/SUBSCRIBER ID (SSN OR ID#) – Required, if applicable.
16	PLAN/GROUP NUMBER – Required, if applicable.
17	EMPLOYER NAME – Required, if applicable.
PATIENT INFORMATION	
18	RELATIONSHIP TO POLICYHOLDER/SUBSCRIBER IN #12 ABOVE – Enter an X in the appropriate box. Optional.
19	STUDENT STATUS – Optional.
20	**NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX), ADDRESS, CITY, STATE, ZIP CODE** – Enter the members last name, first name and middle initial as found on the member's IHCP identification card. **Required**.
21	DATE OF BIRTH – Optional.
22	GENDER – Optional.
23	**PATIENT ID/ACCOUNT # (ASSIGNED BY DENTIST)** – Enter the IHCP member's identification (RID) number. This field accommodates the 12 numeric characters. **Required**.
24	**PROCEDURE DATE** – Enter the date the service was rendered in MM/DD/CCYY format. **Required**.
25	AREA OF ORAL CAVITY – Optional.
26	TOOTH SYSTEM – Optional.
27	TOOTH NUMBER(S) OR LETTER(S) – Enter the tooth number or letter for the service rendered. **Required for any procedure performed on an individual tooth. Required, if applicable.**
28	**TOOTH SURFACE** – Enter the tooth surface for the service rendered. **Required, if applicable**.
29	**PROCEDURE CODE** – Enter the appropriate ADA Current Dental Terminology (CDT®) procedure code. **Required**.
30	DESCRIPTION – Optional.

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ADA 2006 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
31	**FEE** – Enter the amount charged for the procedure code. Eight digits are allowed, including two decimal places. **Required**.
32	OTHER – Not used.
33	**TOTAL FEE** - Enter the total of all the individual service line charges. Eight digits are allowed, including two decimal places. **Required**.
34	MISSING TEETH INFORMATION – (PLACE AN 'X' ON EACH MISSING TOOTH) - Mark the diagram as directed. Optional.
35	**REMARKS** – Enter **only** the amount paid by prior payer. All commercial payments are required in this field. **Required if applicable.**
36	AUTHORIZATIONS – PATIENT/GUARDIAN SIGNATURE AND DATE – Optional.
37	AUTHORIZATIONS – SUBSCRIBER SIGNATURE AND DATE – Optional.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38	**PLACE OF TREATMENT** – Indicate the type of facility where treatment was rendered by marking an **X** in the appropriate box. **Required**.
39	NUMBER OF ENCLOSURES (00 TO 99) – Not applicable.
40	IS TREATMENT FOR ORTHODONTICS? – If Yes is marked, provide the additional information requested. Optional.
41	DATE APPLIANCE PLACED (MM/DD/CCYY) – Enter date. Optional.
42	MONTHS OF TREATMENT REMAINING – Optional.
43	REPLACEMENT OF PROSTHESIS? – If Yes is marked, provide the additional information requested. Optional.
44	DATE PRIOR PLACEMENT (MM/DD/CCYY) – Enter date. Optional.
45	**TREATMENT RESULTING FROM** – Mark the appropriate box. **Required, if applicable**.
46	**DATE OF ACCIDENT (MM/DD/CCYY)** – Enter date. **Required, if applicable**.
47	**AUTO ACCIDENT STATE** – Enter state of accident. **Required, if applicable**.
BILLING DENTIST OR DENTAL ENTITY	
48	**NAME, ADDRESS, CITY, STATE, ZIP CODE** – Enter the billing provider service location Name, Address, City, State, and nine-digit ZIP Code. **Required**.
49	**NPI** – Enter the billing or group provider NPI. **Required on or after May 23, 2007**.
50	LICENSE NUMBER – Enter the billing provider LPI. Not used after May 22, 2007.
51	SSN OR TIN – Optional.
52	PHONE NUMBER – Optional.
52A	**ADDITIONAL PROVIDER ID** – Enter the taxonomy code for the billing provider NPI. **Required on or after May 23, 2007**.

ADA 2006 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53	**TREATING DENTIST AND TREATMENT LOCATION INFORMATION – SIGNED (TREATING DENTIST)** – An authorized person, someone designated by the provider, or the dentist must sign and date the claim. A signature stamp is acceptable; however, a typed signature is not acceptable. **Required, unless the *Signature on File* form has been completed and is included in the provider enrollment file**. **DATE** – Provide the date the claim was submitted in a MMDDYYYY format. **Required**. *If two or more physicians perform services on the same patient on the same date of service, these services must be filed on separate claims.*
54	**NPI** - Enter the rendering provider NPI. **Required on or after May 23, 2007**.
55	LICENSE NUMBER – Optional.
56	ADDRESS, CITY, STATE, ZIP CODE – Enter rendering provider address. Optional.
56A	**PROVIDER SPECIALTY CODE** – Enter the rendering provider taxonomy code for the NPI. **Required on or after May 23, 2007.**
57	PHONE NUMBER – Optional.
58	ADDITIONAL PROVIDER ID – Enter the LPI for the rendering provider. Not used after May 22, 2007.

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ADA 2006 Dental Claim Form

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

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)

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

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#)

16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

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								

MISSING TEETH INFORMATION

34. (Place an "X" on each missing tooth)

Permanent																Primary									
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
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

32. Other Fee(s)
33. Total Fee

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

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J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Sample