

# Dental Claim Form Instructions

Claim Field Identification	Explanations and Instructions
<b>HEADER INFORMATION</b>	
<p>1. Type of Transaction  <input type="checkbox"/> Statement of Actual Services  <input type="checkbox"/> EPSDT/Title XIX  <input type="checkbox"/> Request for Predetermination</p>	<p><b>Optional.</b> If used, check box.</p>
<p>2. Predetermination/ Prior Authorization Code</p>	<p><b>Required, if applicable.</b> If services have been prior Authorized, enter the Prior Authorization Number you received from the Affiliated Computer Services PA Unit (see Field 20 of the Prior Authorization Request and Invoice, shown in Section II).</p>
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>	
<p>3. Company Plan/Name, Address, City, State, ZIP Code</p>	<p><b>Required.</b> Enter Affiliated Computer Services as primary payer here. If patient has other coverage, complete Items # 4-11.</p> <p style="text-align: right;">Affiliated Computer Services, Inc. P.O. Box 240769 Anchorage, AK 99524-0649</p>
<b>OTHER COVERAGE</b>	
<p>4. Other Dental or Medical Coverage?  <input type="checkbox"/> No (Skip Items #5-11)  <input type="checkbox"/> Yes (Complete Items #5-11)</p>	<p><b>Required.</b> A “No” or “Yes” response is required based on information available to the dentist.</p>
<p>5. Name of Policyholder/Subscriber in Item #4 (Last, First, Middle Initial, Suffix)</p>	<p><b>Required, if applicable.</b> If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.</p>
<p>6. Date of Birth MM/DD/CCYY</p>	<p><b>Required, if applicable.</b> Enter the date of birth, in eight-digit format, of the person listed in Item #5.</p>
<p>7. Gender  <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p><b>Required, if applicable.</b> Mark the gender of the person who is listed in Item #5.</p>
<p>8. Policyholder/Subscriber ID (SSN or ID#)</p>	<p><b>Required, if applicable.</b> Enter the Social Security Number or the identifier number of the person who is listed in Item #5. The identifier number is a number assigned by the payer/insurance company to this individual.</p>
<p>9. Plan/Group Number</p>	<p><b>Required, if applicable.</b> Enter the group plan or policy number of the person identified in Item #5.</p>
<p>10. Patient’s Relationship to Person Named in Item #5  <input type="checkbox"/> Self <input type="checkbox"/> Spouse  <input type="checkbox"/> Dependent <input type="checkbox"/> Other</p>	<p><b>Required, if applicable.</b> Mark the patient’s relationship to the other insured named in Item #5.</p>

Claim Field Identification	Explanations and Instructions
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	<b>Required, if applicable.</b> Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.
<b>POLICY HOLDER/SUBSCRIBER INFORMATION</b> (For Insurance Company Named in #3)	
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	<b>Required.</b> Enter the recipient's name, address, and ZIP Code.
13. Date of Birth (MM/DD/CCYY)	<b>Optional.</b> Enter date of birth in MM/DD/CCYY format.
14. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Optional.</b> Enter the patient's gender in appropriate box.
15. Policyholder/Subscriber ID	<b>Required.</b> Enter the recipient's Alaska Medical Assistance ID number.
16. Plan/Group Number	<b>Leave Blank.</b>
17. Employer Name	<b>Optional.</b> If applicable, enter the name of the recipient's employer.
<b>PATIENT INFORMATION</b>	
18. Relationship to Policyholder/Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<b>Optional.</b> If used, mark the box titled "Self" and skip to Item #23.
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS	<b>Optional.</b> Mark "FTS" if patient is a dependent and a part-time student. If neither applies, skip to Item #23.
20. Name, Address, City, State, ZIP Code	<b>Leave Blank.</b>
21. Date of Birth (MM/DD/YY)	<b>Leave Blank.</b>
22. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Leave Blank.</b>
23. Patient ID/Account # (Assigned By Dentist)	<b>Optional.</b> Enter the patient's medical record or account number. This field can accommodate up to 11 characters. Both alpha and numeric characters are acceptable. This information will print following the claim control number (CCN) on your Remittance Advice (RA).

Claim Field Identification	Explanations and Instructions
----------------------------	-------------------------------

RECORD OF SERVICES PROVIDED	
-----------------------------	--

24.	Procedure Date (MM/DD/CCYY)	<b>Required.</b> Enter the date(s) that services were rendered, in MM/DD/CCYY format (e.g., 03/15/2007). Each service or procedure must be entered on a separate line with no more than 10 lines per claim form.
-----	--------------------------------	--

25.	Area of Oral Cavity	<b>Optional.</b> Always report the area of the oral cavity <i>unless</i> one of the following conditions in Item #29 (Procedure Code) exists:
-----	---------------------	---

Code	Area	Code	Area
00	Entire Oral Cavity	20	Upper Left Quadrant
01	Maxillary Arch	30	Lower Left Quadrant
02	Mandibular Arch	40	Lower Right Quadrant
10	Upper Right Quadrant		

26.	Tooth System	<b>Optional.</b>
-----	--------------	------------------

27.	Tooth Number(s) or Letter(s)	<p><b>Required, if applicable.</b> Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth, otherwise leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form.</p>
-----	------------------------------	--

If applicable, use the following codes. When a procedure involves a range of teeth, the range is reported in this field with a hyphen to separate the first and last tooth in the range (e.g., 1-4, 7-10) or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10).

Supernumerary teeth in the **permanent** dentition are identified by the numbers 51-82, beginning with the arch of the upper right third molar, and following around the upper arch to the area of the lower right third molar.

**UPPER ARCH:** Commencing in the upper right quadrant and rotating counterclockwise

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
“Super” #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

**LOWER ARCH:**

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
“Super” #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Supernumerary teeth in the **primary** dentition are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (for example, supernumerary “AS” is adjacent to “A;” supernumerary “TS” is adjacent to “T”).

**UPPER ARCH:** Commencing in the upper right quadrant and rotating counterclockwise

Tooth #	A	B	C	D	E	F	G	H	I	J
“Super” #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Claim Field Identification		Explanations and Instructions																													
<b>LOWER ARCH</b>																															
Tooth #	T	S	R	Q	P	O	N	M	L	K																					
“Super” #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS																					
28.	Tooth Surface	<p><b>Required, if applicable.</b> When the procedure performed involves one or more tooth surfaces, use the following codes. Do not leave any spaces between surface designations in multiple surface restorations.</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td><b>B</b></td> <td><b>Buccal</b></td> <td><b>L</b></td> <td><b>Lingual</b></td> </tr> <tr> <td><b>D</b></td> <td><b>Distal</b></td> <td><b>M</b></td> <td><b>Mesial</b></td> </tr> <tr> <td><b>F</b></td> <td><b>Facial (or labial)</b></td> <td><b>O</b></td> <td><b>Occlusal</b></td> </tr> <tr> <td><b>I</b></td> <td><b>Incisal</b></td> <td></td> <td></td> </tr> </tbody> </table>										Code	Description	Code	Description	<b>B</b>	<b>Buccal</b>	<b>L</b>	<b>Lingual</b>	<b>D</b>	<b>Distal</b>	<b>M</b>	<b>Mesial</b>	<b>F</b>	<b>Facial (or labial)</b>	<b>O</b>	<b>Occlusal</b>	<b>I</b>	<b>Incisal</b>		
Code	Description	Code	Description																												
<b>B</b>	<b>Buccal</b>	<b>L</b>	<b>Lingual</b>																												
<b>D</b>	<b>Distal</b>	<b>M</b>	<b>Mesial</b>																												
<b>F</b>	<b>Facial (or labial)</b>	<b>O</b>	<b>Occlusal</b>																												
<b>I</b>	<b>Incisal</b>																														
29.	Procedure Code	<p><b>Required.</b> Enter the dental procedure code that describes the service provided (refer to the table in your billing manual).</p>																													
30.	Description of Service	<p><b>Required.</b> Enter a brief description of services provided. When billing for general anesthesia or any form of sedation, state justification for service in Item #35.</p>																													
31.	Fee	<p><b>Required.</b> Report the dentist’s full fee for the procedure.</p>																													
32.	Other Fee(s)	<p><b>Optional.</b></p>																													
33.	Total Fee	<p><b>Required.</b> Enter the total charge for all services and fees.</p>																													
<b>MISSING TEETH INFORMATION</b>																															
34.	Place an “X” On Each Missing Tooth	<p><b>Required.</b> Missing teeth should be reported when pertinent to Periodontal, Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim.</p>																													
35.	Remarks	<p><b>Required, if applicable.</b> Use this field to report Third Party Liability amounts, emergency services and medical justification. If more than one situation applies to a claim, first enter the TPL amount paid followed by two spaces (\$###.##) and then any additional information. Use this field when services require justification of medical necessity or other unusual services, such as the name of the recipient’s Primary Care Dentist when care is rendered by a dentist other than the Primary Care Dentist (refer to Appendix E for additional Care Management Program information), a procedure code that requires a report or multiple supernumerary teeth. The remarks must state the reasons for treatment, including the need for anesthesia. Additional documentation may be attached to the claim, if desired.</p>																													

Claim Field Identification		Explanations and Instructions
<b>AUTHORIZATIONS</b>		
36.	Patient/Guardian Consent Signature	<b>Optional.</b> Alaska Medical Assistance recipients do not need to sign.
37.	Insured's Signature	<b>Optional.</b> Alaska Medical Assistance recipients do not need to sign. Claims prepared by the dentist's Practice Management Software may insert "Signature on File."
<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>		
38.	Place of Treatment	<b>Required.</b> There are four possible choices to mark: provider or dentist office, a hospital, an extended care facility or other if none applies.
39.	Number of Enclosures (Radiographs or Oral Images)	<b>Required.</b> This item is completed whether or not radiographs, oral images or study models are submitted with claim: No enclosures, enter "00," or enter number of images in appropriate box using two digits. If less than 10, use "0" in the first position. <i>Please do not submit radiographs with claim or prior authorization requests unless specifically requested to do so.</i>
40.	Is Treatment for Orthodontics?	<b>Required.</b> If "No," skip to Item #43. If "Yes," complete Items #41 and 42.
41.	Date Appliance Placed (MM/DD/CCYY)	<b>Required, if applicable.</b> Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.
42.	Months of Treatment Remaining	<b>Required, if applicable.</b> Enter the estimated number of months required to complete orthodontic treatment.
43.	Replacement or Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete Item #44)	<b>Required, if applicable.</b> This item applies to crowns and all fixed or removable prosthesis. Follow these criteria: a. If claim does not involve a prosthetic restoration, mark "No." b. If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark "No." c. If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is replacement of a crown, mark "Yes."
44.	Date of Prior Placement (MM/DD/CCYY)	<b>Optional.</b> Complete if answer to Item #43 was "Yes."
45.	Treatment Resulting From: <input type="checkbox"/> Occupational Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident	<b>Required.</b> If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box.
46.	Date of Accident (MM/DD/CCYY)	<b>Required, if applicable.</b> Enter the date on which the accident noted in Item #45 occurred.
47.	Auto Accident State	<b>Required, if applicable.</b> Enter the state in which the auto accident noted in Item #45 occurred, otherwise leave blank.

Claim Field Identification		Explanations and Instructions
<b>BILLING DENTIST OR DENTAL ENTITY</b>		
48.	Dentist's Name, Address, City, State, ZIP Code	<b>Required.</b> Enter the dental professional's name (individual or group name). Enter your mailing address (street, city, state, and ZIP Code+4).
49.	Dentist's National Provider Identifier	<b>Required.</b> Enter the NPI number for the billing entity.
50.	Dentist's License Number	<b>Optional. Note:</b> If the billing dentist is an individual, enter the dentist's license number. This is not the dentist's Medicaid Contract ID. Leave blank if a billing entity (e.g. corporation).
51.	Dentist's Social Security Number or TIN (Federal Tax ID)	<b>Optional.</b> Enter the SSN or TIN of the biller/pay to provider.
52.	Dentist's Phone Number	<b>Optional.</b> Enter the telephone number of your office.
52a.	Additional Provider ID	<b>Required.</b> Enter the billing provider's Medicaid Contract ID.
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>		
53.	Dentist Signature	<b>Required.</b> The claim must be signed and dated by the dentist or authorized representative of the dentist. A facsimile signature is acceptable. Claim forms prepared by the dentist's Practice Management Software may insert the treating dentist's printed name in this Item #.
54.	Dentist's National Provider Identifier	<b>Required.</b> Enter the NPI for the rendering /servicing dental provider.
55.	Dentist's License Number	<b>Required.</b> Enter the license number of the Treating Dentist. This may vary from the Billing Dentist. <b>Note:</b> This is not the dentist's Medicaid Contract ID.
56.	Treating Dentist's Address, City, State, ZIP Code	<b>Required.</b> Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box. Enter street, city, state, and ZIP Code+4.
56a.	Dentist's Provider Specialty Code	<b>Required, if applicable.</b> Enter the taxonomy code that indicates the type of dental professional who delivered the treatment. The provider specialty codes (also known as provider taxonomy codes) can be viewed at <a href="http://www.wpc-edi.com/codes/codes.asp">www.wpc-edi.com/codes/codes.asp</a> .
57.	Dentist's Phone Number	<b>Optional.</b> If used, enter the telephone number of your office.
58.	Additional Provider ID	<b>Required.</b> Enter the rendering provider's Medicaid Contract ID.

**Note:** This ADA claim form is a two-part form. Keep the yellow carbon copy and mail the white original to:

Affiliated Computer Services, Inc.  
P.O. Box 240769  
Anchorage, AK 99524-0769