



# First Health Services Corporation®

A Coventry Health Care Company

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June 27, 2007

## CDT Claim Form Instructions

The Alaska Medicaid Management Information System (MMIS) is now equipped to accommodate the new J400 American Dental Association claim form. During a transition period which will end August 31, 2007, Alaska Medicaid will accept either older versions of the American Dental Association claim form or the new version (J400) of the American Dental Association claim form. Older versions of the American Dental Association claim form received on or after September 1, 2007 will be returned to the provider without processing.

Instructions for submitting the new version (J400): All claims must be submitted with the Medicaid Provider ID number. National Provider Identifier (NPI) numbers may also be submitted.\* A few of the critical fields and the information on how to complete them are listed below:

### ADA Dental Claim Form

<b>HEADER INFORMATION</b> 1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prauthorization <input type="checkbox"/> EPSDT/Title XIX		<b>POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)</b> 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <b>Recipient Name</b> <b>Recipient Address</b> <b>Recipient City, State ZIP Code</b>	
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b> 3. Company/Plan Name, Address, City, State, Zip Code <b>First Health Service Corporation</b> <b>P.O. Box 240769</b> <b>Anchorage, AK 99524-0649</b>		13. Date of Birth (MM/DD/CCYY) <b>03/03/1933</b>	14. Gender <input type="checkbox"/> M <input type="checkbox"/> F
<b>OTHER COVERAGE</b> 4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		15. Policyholder/Subscriber ID (SSN or ID#)	16. Plan/Group Number <b>LEAVE BLANK</b>
		17. Employer Name	

**Item #4 Required.** If the answer to Item #4 is no, then skip Items #5-11. If the answer to Item #4 is yes, then Items #5-11 must be completed. Items #5-11 apply to the individual that has the other coverage and should be completed with the applicable information.

<b>OTHER COVERAGE</b>		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		

\* Providers will need to include their Medicaid Provider ID number on all paper claim forms until they have been tested for submission of NPI number only.

# ADA Dental Claim Form

<b>HEADER INFORMATION</b>			<b>POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)</b>		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prior Authorization <input type="checkbox"/> EPSDT/Title XIX			12. Policyholder/Subscrber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <b>Recipient Name</b> <b>Recipient Address</b> <b>Recipient City, State ZIP Code</b>		
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>			13. Date of Birth (MM/DD/CCYY)    14. Gender    15. Policyholder/Subscrber ID (SSN or ID#)		
3. Company/Plan Name, Address, City, State, Zip Code <b>First Health Service Corporation</b> <b>P.O. Box 240769</b> <b>Anchorage, AK 99524-0649</b>			03/03/1933 <input type="checkbox"/> M <input type="checkbox"/> F    LEAVE BLANK		
<b>OTHER COVERAGE</b>			<b>PATIENT INFORMATION</b>		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)			16. Plan/Group Number    17. Employer Name <b>LEAVE BLANK</b>		
5. Name of Policyholder/Subscrber in #4 (Last, First, Middle Initial, Suffix)			18. Relationship to Policyholder/Subscrber in #12 Above    19. Student Status		
8. Date of Birth (MM/DD/CCYY)    7. Gender    8. Policyholder/Subscrber ID (SSN or ID#)			<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other <input type="checkbox"/> FTS <input type="checkbox"/> PTS		
9. Plan/Group Number    10. Patient's Relationship to Person Named in #5			20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			21. Date of Birth (MM/DD/CCYY)    22. Gender    23. Patient ID/Account # (Assigned by Dentist)		
			<input type="checkbox"/> M <input type="checkbox"/> F    LEAVE BLANK		

**Item #12 Required.** Enter the recipient's information.

**Item #15 Required.** Enter the recipient's Alaska Medical Assistance ID #.

**Item #23 Optional.** Enter the patient's medical record or account number. The field can accommodate up to 11 characters (alpha/numeric are acceptable). This information will print following the Claim Control Number (CCN) on your Remittance Advice (RA).

16. Plan/Group Number <b>LEAVE BLANK</b>	17. Employer Name <b>OPTIONAL</b>
<b>PATIENT INFORMATION</b>	
18. Relationship to Policyholder/Subscrber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other	
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
21. Date of Birth (MM/DD/CCYY) <b>LEAVE BLANK</b>	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F
23. Patient ID/Account # (Assigned by Dentist)	

35. Remarks		
<b>AUTHORIZATIONS</b>		
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
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscrber)		
48. Name, Address, City, State, Zip Code		
49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52A. Additional Provider ID	

**Item #35 Required, if applicable.** Use this Item # 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.

<b>AUTHORIZATIONS</b> 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			<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b> 38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other 39. Number of Enclosures (00 to 99) Radiograph(s) _____ One Image(s) _____ Model(s) _____ 40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY) _____ 42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY) _____ 45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident 46. Date of Accident (MM/DD/CCYY) _____ 47. Auto Accident State _____		
<b>BILLING DENTIST OR DENTAL ENTITY</b> (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 _____			<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b> 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)

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 or go online at www.adacatalog.org

**Item #49 Required.** Enter the NPI for the billing entity.

**Item #54 Required.** Enter the NPI for the rendering/servicing entity.

**Item #52A Required.** Enter the Medicaid Provider ID Number for the billing dentist or dental entity.

**Item # 56A Required, if applicable.** Enter the taxonomy code that depicts the type of dental professional delivering the treatment.

**Item #58 Required.** Enter the appropriate Medicaid Provider ID Number for the rendering dentist.

<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b> 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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 or go online at www.adacatalog.org

For more information and instructions, please go to [http://www.ada.org/prof/resources/topics/topics\\_claimform.pdf](http://www.ada.org/prof/resources/topics/topics_claimform.pdf) and <http://www.wpc-edi.com/codes>.

The provider manual is currently being updated with the above information. It will be available on FHSC's website (<http://alaska.fhsc.com>) upon completion. Watch the provider newsletter and Remittance Advice for more information.