CHAPTER 10:

Billing on the ADA Claim Form

Reviewed/Revised: 10/1/18, 8/5/19, 9/23/19, 1/1/20, 7/5/20, 1/1/21, 5/1/21, 7/4/21, 12/1/21, 9/2/22, 9/2/23, 1/1/24, 7/15/24

10.0 INTRODUCTION

BCBSAZ Health Choice requires the use of the most current ADA claim form. It is required to report all patient treatment provided by the dental office. Claim forms must be filed for all services provided. This chapter covers paper claim submission only, for additional information on electronic claim submission, please see Chapter 7 *General Billing Rules*.

Any updates to the ADA Dental Claim Form completion instructions will be posted on the ADA's website at: www.ada.org/en/publications/cdt/ada-dental-claim-form

10.1 GENERAL INSTRUCTIONS

- The form is designed so that the name and address (item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- All Items in the form must be completed unless it is noted on the form or in the comprehensive instructions posted on the ADA's web site (ADA.org) that completion is not required.
- When a name and address field is required, the **full name** of an individual or a full business name, and **complete** address and zip code must be entered.
- All dates must include the four-digit year.
- If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.
- Gender codes (items 7, 14 and 22) – M = Male; F = Female; U = Unknown

10.2 COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item 35).

10.3 NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Identifier): This is an identifier assigned by the Federal government to all providers considered HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation.

An NPI is unique to an individual dentist or dental entity and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the Centers for Medicare & Medicaid Services: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand.

Additional Provider Identifier

52a and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

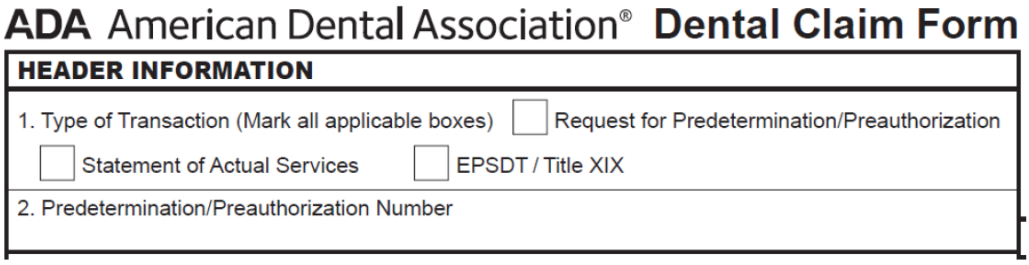
DATA ELEMENT SPECIFIC INSTRUCTIONS

Form completion instructions are provided for each data item, which is identified by a number. Please note that data items are in groups of related information. These instructions explain the reasons for such groupings, and the relationships (if any) between groups.

COMPLETING THE ADA FORM

Header Information

The 'header' provides information about the type of submission being made. This information applies to the entire transaction.


ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

1. Type of Transaction **Required**

There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box marked "Request for Predetermination/Preauthorization". If the claim is through the **E**arly and **P**eriodic **S**creening, **D**iagnostic and **T**reatment Program, check the box marked "EPSDT/Title XIX".

2. Predetermination/Preauthorization Number **Required if applicable**

If you are submitting a claim for a procedure that has been pre-authorized by a third-party payer, enter the preauthorization or predetermination number provided by the insurance company (include leading zeros).

Insurance Company/Dental Benefit Plan Information

DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code
3a. Payer ID

DENTAL BENEFIT PLAN INFORMATION

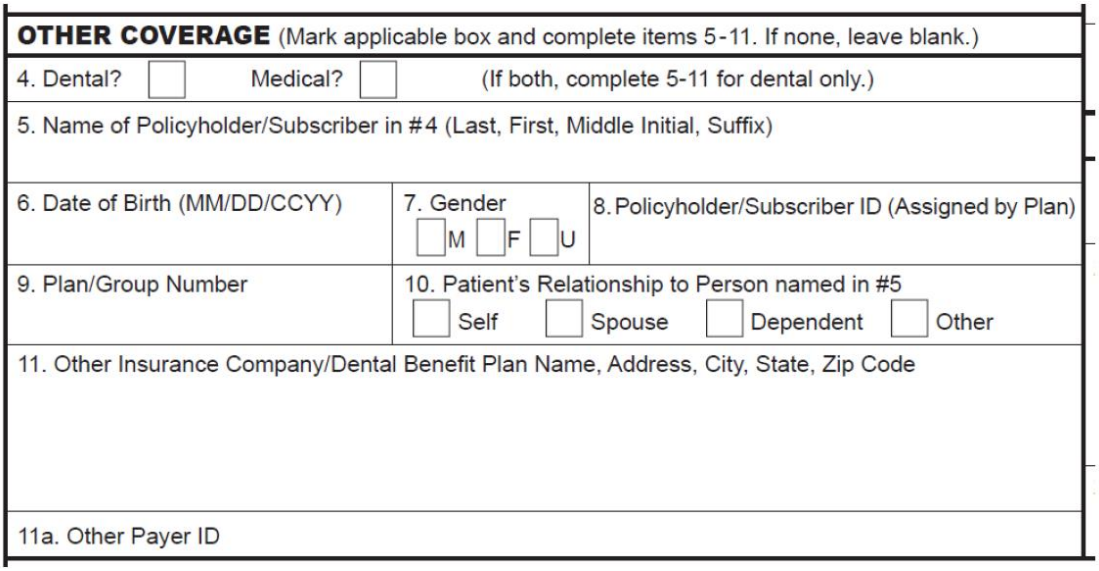
3. Name, Address, City, State, Zip Code

BCBSAZ HEALTH CHOICE
P.O. Box 52033
Phoenix, AZ 85072-2033

3. Company/Plan Name, Address, City, State, Zip Code **Required**
Enter the information for the insurance company or dental benefit plan that is the third-party payer receiving the claim. If the patient is covered by more than one plan, enter the primary insurance company information here the initial claim submission. When submitting a claim to the secondary carrier, place that company/plan name here.

3a. Payer ID:
Enter the Payer Identification Number for the Company/Plan specified in "3." above (leave blank if unknown). This identifier may be found on the patient's insurance card or in the provisions of the participation provider contract. It is intended to provide additional routing information for claims which may be sent to a centralized mailing address.

Other Coverage
The 'other coverage' area of the claim form provides information on the existence of additional dental or medical insurance policies. This is necessary to determine if multiple coverages are in effect, and the possibility of coordination of benefits.



OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		
4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F ☐U	8. Policyholder/Subscriber ID (Assigned by Plan)
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		
11a. Other Payer ID		

When the claim form is being prepared for submission to the primary carrier the information in "Other Coverage" applies to the secondary carrier.

When the claim form is being prepared for submission to the secondary carrier the information in "Other Coverage" applies to the primary carrier.

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

Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage. A response is required based on information available to the Dentist.

- Leave blank when the dentist is not aware of any other coverage(s).
- When either box is marked, complete Items 5 through 11 in the "Other Coverage" section for the applicable benefit plan.
- If both Dental and Medical are marked, enter the information about the dental benefit plan in Items 5 through 11.

5. Name of Policyholder/Subscriber with Other Coverage Indicate in #4 (Last, First, Middle Initial, Suffix): **Required if applicable**

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.

6. Date of Birth (MM/DD/CCYY) **Required if applicable**

Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day, and four digits for the year of birth.

7. Gender **Required if applicable**

Mark the gender of the person who is listed in Item #5. Check "M" for Male or "F" for Female, or "U" for Unknown as applicable.

8. Policy/Subscriber Identifier (Assigned by Plan) **Required if applicable**
Enter the unique identifying number assigned by the third-party payer (e.g. insurance company) of the person who is listed in Item #5 from their identification card.

9. Plan/Group Number **Required if applicable**
Enter the group plan or policy number of the person identified in Item #5.

10. Patient's Relationship to Person Named in Item #5 **Required if applicable**
Mark the patient's relationship to the other insured named in Item #5.

11. Other Dental Benefit/Medical Insurance Carrier Name, Address, City, State, Zip Code
Required if applicable
Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

11a. Payer ID
Enter the Payer Identification Number for the Other Insurance Company/Dental Benefit Plan specified in "11." Above (leave blank if not known). This identifier may be found on the patient's insurance card or in the provisions of a participating provider contract. It is intended to provide additional routing information for claims which may be sent to a centralized mailing address.

Policy/Subscriber Information (For Insurance Company Named in Item #3)
This section documents information about the insured person who may or may not be the patient. When the claim form is being prepared for submission to the primary carrier the information supplied applies to the person insured by the primary carrier.

When the claim form is being prepared for a submission to the secondary carrier the information entered applies to the person insured by the secondary carrier.

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip **Clause, Santa J.** **1234 N. Pole Place** **Phoenix, AZ 85001**		
13. Date of Birth (MM/DD/CCYY) **10/05/1999**	14. Gender ☐ M ☐ F ☐ U	15. Policyholder/Subscriber Identifier (Assigned by Plan) **HCIA987654321**
16. Plan/Group Number	17. Employer Name	

12. Policyholder/Subscriber Name, Address, City, State, Zip Code **Required**
Enter the complete name, address and zip code of the policyholder/subscriber with coverage from the company/plan named in #3 (recipient as shown on the BCBSAZ Health Choice ID Card).

13. Date of Birth (MM/DD/CCYY) **Required**
A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year.

14. Gender **Required**
This applies to the primary insured. Mark "M" for Male, "F" for Female, or “U” for Unknown as applicable.

15. Policyholder/Subscriber Identifier (ID Assigned by Plan) **Required**
Enter the BCBSAZ Health Choice ID number of the person named in Item #12, which is on their identification card.

16. Plan/Group Number **Not Required**
Enter the policyholder/subscriber’s group plan/policy number.

17. Employer Name **Not Required**
If applicable, enter the name of the policyholder/subscriber's employer.

Patient Information
The information in this section of the claim form pertains to the patient.

PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 above □ Self □ Spouse □ Dependent Child □ Other		19. Reserved For Future Use
20. Name (Last, First, Middle, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender □ M □ F □ U	23. Patient ID/Account# (Assigned by Dentist)

18. Relationship to Policyholder/Subscriber in Item #12 Above **Not Required**
Mark the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. If the patient is also the primary insured, mark the box titled **"Self" and skip to item #23.**

19. Reserved For Future Use **Not Required**

20. Name (Last, First, Middle, Suffix), **Address, City, State, Zip Code** **Not Required**
Enter the complete name, address and zip code of the patient.

21. Date of Birth (MM/DD/CCYY) **Not Required**
A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.

22. Gender **Not Required**

This applies to the patient. Mark “M” for male, "F" for female, or “U” for Unknown as applicable.

23. Patient ID/Account # (Assigned by Dentist) **Not Required**

Enter if the dentist's office has assigned a number to identify the patient.

Record of Services Provided

The "Record of Services Provided" contains information regarding the treatment performed (actual services), or proposed treatment (predetermination/preauthorization).

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Numbers(s) or Letter(s)	28. Tooth Surfaces	29. Procedure Code	29a. Diag Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Informaiton (Place an "X" on each missing tooth.)		31a. Other Fee(s)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosis Code(s) A _____ C	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diagnosis in "A") B _____ D	32. Total Fee
35. Remarks		

NOTE: Items 24 through 31, following, apply to each of the 10 available lines on the claim form for reporting dental procedures provided to the patient. **The remaining Items in this section of the form (33-35) do not repeat.**

A NOTE regarding multi-page claims and fields 24-31:

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-10) under fields 24-31 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) BCBSAZ Health Choice has received claims where page 1 has had lines (for example) 1-8 filled out, but lines 9 and 10 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

24. Procedure Date (MM/DD/CCYY) **Required**

Enter the procedure date for actual services performed or leave blank if the claim is for preauthorization/predetermination. The date, if included, must have two digits for the month, two for the day, and four for the year.

The presence or absence of a Procedure Date should be consistent with the type of transaction(s) marked in Item #1. (e.g., actual services; predetermination/preauthorization).

25. Area of Oral Cavity **Required**

Use of this field is conditional. Always report the area of the oral cavity when the procedure reported is Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. For example:

- Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as **D4263 bone replacement graft-first site in quadrant**.
- Do not report the applicable area of the oral cavity when the procedure either: 1) incorporates a specific area of the oral cavity in its nomenclature, such as **D5110 complete denture – maxillary**; or 2) does not relate to any position of the oral cavity, such as **D9222 deep sedation/general anesthesia-first 15 minutes.**

NOTE: Detailed guidance on reporting Area of the Oral Cavity, Tooth Numbers and Tooth Surfaces by CDT code is posted on the ADA Dental Claim Form web page: www.ada.org/en/publications/cdt/ada-dental-claim-form

Area of the oral cavity is designated by a two-digit code, selected from the following code list:

CODE	AREA
00	entire oral cavity
01	maxillary arch
02	mandibular arch
10	upper right quadrant
20	upper left quadrant
30	lower left quadrant
40	lower right quadrant

26. Tooth System **Required**

Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation System (1-32 for **permanent** dentition and A-T for **primary** dentition).

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

Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank. Numbers or letters reported are based on tooth morphology, not anatomic position. This is the traditional and important concept to understand

for accurate documentation and reporting. For instance, a tooth may migrate into an edentulous space, but that movement does not change its morphology.
Similarly, placement of an implant body need not be in an anatomic tooth position, but the prosthesis placed is the morphological equivalent of a missing toother or range of teeth.

If the same procedure is performed on more than a single tooth on the same date of service, there are two options for reporting –

- Report each procedure and tooth involved, and the fee on separate service lines on the claim form.
- Report the procedure on a single service line with the teeth involved in #27, the number of times the procedure was delivered in the #29b (Quantity), and the total fee for all in #31 (Fee).

When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "–" to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10; 3-5, 22-27).

Supernumerary teeth in the **permanent** dentition are identified in the ADA's Universal/National Tooth Designation System ("JP") by the numbers 51 through 82, beginning in the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32). This enumeration is illustrated in the following chart:

Upper Arch (commencing in the upper right quadrant and rotating counter-clockwise)

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"). This enumeration is illustrated in the following chart:

Upper Arch (commencing in the upper right quadrant and rotating counter-clockwise)

Tooth#	A	B	C	D	E	F	G	H	I	J

"Super"	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Arch

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 **Required**

This Item is necessary when the procedure performed by a tooth involves one or more tooth surfaces. The following single-letter codes are used to identify surfaces:

SURFACE	CODE
Buccal	B
Distal	D
Facial (or labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

Do not leave any spaces between surface designations in multiple surface restorations (e.g. MOD).

The Incisal ("I") surface of an anterior tooth (analogous to the Occlusal surface of a posterior teeth for reporting purposes) may incorporate the Incisal Angle. A restoration involving the incisal angle will include multiple surfaces. The size of the affected area and the anatomy of the tooth will dictate the number of surfaces involved in this restoration.

For example, a small fracture involving the angle could be perceived clinically as two surface restoration (e.g., M-I; D-I). A larger fracture involving the angle that requires restoring a greater portion of the tooth would require a multi-surface restoration (e.g., M-I-F-L: D-I-F-L). The clinician determines what type of restoration was placed, and the code to report the procedure delivered to the patient.

29. Procedure Code **Required**

Enter the appropriate procedure code found in the version of the *Code* on *Dental Procedures and Nomenclature* in effect on the "Procedure Date" (Item #24).

29a. Diagnosis Code Pointer **Required if applicable**

Enter the letter(s) from Item #34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

29b. Quantity **Required**

Enter the number of times (01-99) the procedure identified in Item #29 is delivered to the patient on the date of service in Item #24. The default value is "01".

30. Description **Required**

Provide a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).

31. Fee **Required**

Report the dentist's full fee for the procedure.
(Note: Item #31 above is the last of the repeating 'service line' items.)

31a. Other Fee(s) **Not Required**

When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.

32. Total Fee **Required**

The sum of all fees from lines in Item #31, plus any fee(s) entered in Item #31a.

33. Missing Teeth Information **Required**

Mark an "X" on the number of the missing tooth – for identifying missing permanent dentition only. Missing teeth should be reported when pertinent to Periodontal, Prosthodontics (fixed and removable), or Implant Services procedures on a particular claim. Numbers marked are based on tooth morphology, not anatomic position.

34. Diagnosis Code List Qualifier **Required if applicable**

Enter the appropriate code to identify the diagnosis code source:

AB = ICD-10

34a. Diagnosis Code(s) **Required if applicable**

Enter up to four applicable diagnosis codes after each letter (A. – D.). The primary diagnosis code is entered adjacent to the letter "A."

This information is required when a) the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risk associated with the connection between the patient's oral and systemic health conditions; or b) when required by state regulation (e.g., Medicaid) or third-party payer contract provisions.

35. Remarks **Required if applicable**

This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim (e.g., for a secondary claim, the amount the primary carrier paid).

Remarks should be concise and pertinent to the claim submission. Claimants should note that an entry in "Remarks" may prompt review by a person as part of claim adjudication, which may affect overall time to process the claim.

The standard format is as follows (with parentheses removed):
(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Indicator)\(Any other additional information)

Enter the appropriate code ("7" or "8") to indicate whether the claim is a replacement (resubmission/7) of a denied or paid claim, an adjustment of a previously paid or denied claim (7), or a void (8) of a paid claim. Enter the BCBSAZ Health Choice Claims Reference Number (CRN) for the denied or paid claim that you want to replace.

If the provider is an FQHC and the claim is for a professional practitioner, indicate here. Enter in standard format, **after the CRN format described above and separated by a backslash** in the following format (with the parentheses removed):
(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Information in the Standard FQHC Format)

The standard FQHC format is as follows:

- If the provider has a NPI: XXNPIProviderName; *or*
- If the provider does not have a NPI: 999999999ProviderName
    - Example: XX1234567890Smith, Hillary

Authorizations

This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.

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

36. Patient Consent **Not Required**

The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.

By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.

Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.

37. Authorize Direct Payment (Insured's Signature) **Not Required**

The signature and date (or "Signature on File" notice) are required when the insured (named in Item #12) wishes to have benefits paid directly to the dentist/ provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company.

Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this Item.

Ancillary Claim/Treatment Information

This section of the claim form provides additional information to the third-party payer regarding the claim.

<table>
<tr><td colspan="4">ANCILLARY CLAIM/TREATMENT INFORMATION (alll dates in MM/DD/CCYY format)</td></tr>
<tr><td colspan="3">38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital)
(Use "Place of Service Codes for Professional Claims")</td><td>39. Enclosures (Y or N)
39a. Date Last SRP</td></tr>
<tr><td colspan="3">40. Is Treatment for Orthodontics?
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)</td><td>41. Date Appliance Placed (MM/DD/CCYY)</td></tr>
<tr><td>42. Months of Treatment</td><td>43. Replacement of Prosthesis
☐ No ☐ Yes (Complete 44)</td><td>44. Date of Prior Placement (MM/DD/CCYY)</td><td></td></tr>
<tr><td colspan="4">45. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident</td></tr>
<tr><td colspan="3">46. Date of Accident (MM/DD/CCYY)</td><td>47. Auto Accident State</td></tr>
</table>

38. Place of Treatment **Required**

Enter the 2-digit Place of Service Code for Professional Claims, a HIPPA standard. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

All current codes are available online from the Centers for Medicare and Medicaid Services (search for CMS place of service codes downloads).

39. Number of Enclosures (00 to 99) **Required if applicable**
Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).

39a. Date Last SRP
Enter the date of service for the last Scaling and Root Planing procedure (e.g., D4341) delivered to the patient in the space immediately to the right of this data element caption; date format MM/DD/CCYY (leave blank if not applicable to claim or if not known).

40. Treatment for Orthodontics? **Required**
If no, skip to Item #43. If yes, answer Items #41 & #42.

41. Date Appliance Placed (MM/DD/CCYY) **Required if applicable**
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 **Required if applicable**
Enter the total number of months required to complete the orthodontic treatment.
(Note: This is the total number of months from the beginning to the end of the treatment plan).

43. Replacement of Prosthesis? **Required**
This Item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures). Please review the following three situations in order to determine how to complete this Item.

- If the claim does not involve a prosthetic restoration mark "NO" and proceed to Item #45.
- If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Item #45.
- If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete section #44.

44. Date of Prior Placement (MM/DD/CCYY) **Required if applicable**
Complete if the answer to Item #43 was yes.

45. Treatment Resulting From (Check applicable box) **Required if applicable**
If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box in this item, and proceed to Items #46 and #47. **If the services you are providing are not the result of an accident, this Item does not apply; skip to Item #48.**

46. Date of Accident (MM/DD/CCYY) **Required if applicable**
Enter the date on which the accident noted in Item #45 occurred. Otherwise, leave blank.

47. Auto Accident State **Required if applicable**
Enter the state in which the auto accident noted in Item #45 occurred. Otherwise, leave blank.

Billing Dentist or Dental Entity
The "Billing Dentist" or "Dental Entity" section provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist. If the patient is submitting

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 **Another Dentist Office** **9876 N. Scottsdale Rd.** **Scottsdale, AZ 22554**		
49. NPI **3453211234**	50. License Number **4647**	51. SSN or TIN **10-1021111**
52. Phone Number (**480**) **355-2222**		52a. Additional Provider ID **132456**

the claim directly, do not complete Items 48 – 52a.

48. Name, Address, City, State, Zip Code **Required**
Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).

49. NPI (National Provider Identifier) **Required**
Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioner's Type 1 NPI.

Note: The NPI is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentist who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation. An NPI is unique to an individual dentist or dental entity, and has no intrinsic meaning. There are two types of NPI available to dentists and dental practices.

Type 1 – Individual Provider: All individual dentists are eligible to apply for Type 1 NPI's, regardless of whether they are covered by HIPAA.

Type 2 – Organizational Provider: A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.

On paper, there is no way to distinguish a Type 1 from a Type 2 in the absence of any associated data; they are identical in format. Additional information on NPI and enumeration can be obtained from the Centers for Medicare & Medicaid Services: https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand.

50. License Number **Required**

If the billing dentist is an individual, enter the dentist's license number. If a billing entity (e.g., corporation) is submitting the claim, leave blank.

51. SSN or TIN **Required**

Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.

52. Phone Number **Not Required**

Enter the business phone number of the billing dentist or dental entity.

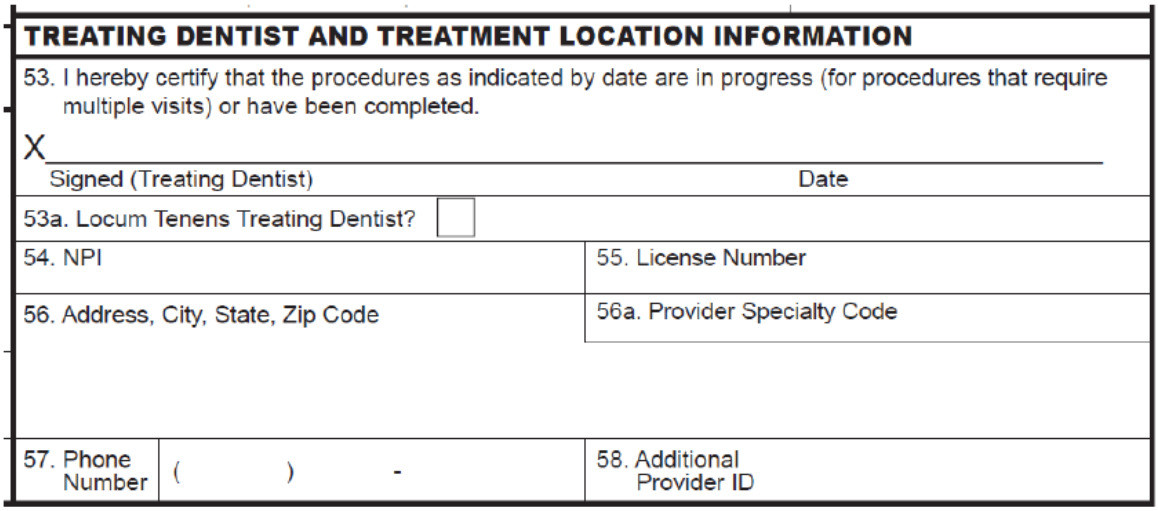
52a. Additional Provider ID **Required if applicable**

This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third party payer, Federal government). Some Legacy IDs have an intrinsic meaning. BCBSAZ Health Choice's provider ID is the 6-digit AHCCCS Provider Registration Number.

Treating Dentist and Treatment Location Information

This section must be completed for all claims. Information that is specific *to* the dentist or practitioner acting within the scope of their state licensure who has provided treatment is entered in this section.



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		
53a. Locum Tenens Treating Dentist? ☐		
54. NPI		55. License Number
56. Address, City, State, Zip Code		56a. Provider Specialty Code
57. Phone Number	( ) -	58. Additional Provider ID

53. Certification **Required**

Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary

for the dentist to sign the form. Dentists should be aware that they have an ethical a legal obligation to refund fees for services that are paid in advance but are not completed. Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this item.

53a. Locum Tenens Dentist
Mark box if the treating dentist is providing services in a locum tenens capacity (leave blank if not applicable).

54. NPI (National Provider Identifier) **Required**
Enter the treating dentist's Type 1 – Individual Provider NPI in Item #54. This will be the "locum tenens" dentist's NPI when applicable.

55. License Number **Required**
Enter the license number of the treating dentist. This may vary from the billing dentist.

56. Address, City, State, Zip Code **Required**
Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.

56a. Provider Specialty Code **Not Required**
Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists follow. The general code listed as "Dentist" may be used instead of any other dental practitioner codes.

Provider specialty codes (also known as "provider taxonomy codes") come from the "Dental Service Providers" section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions.

57. Phone Number **Not Required**
Enter the treating dentist's telephone number.

58. Additional Provider ID **Required if Applicable**
This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third party payer, Federal government). Some Legacy IDs have an intrinsic meaning. **BCBSAZ Health Choice's provider ID** is the six (6) digit AHCCCS Provider Registration Number.