

Completing the Paper ADA Dental Claim Form 2006 for Alabama Medicaid

The instructions describe information that is required to be entered in each of the block numbers on the ADA Dental Claim Form 2006 for submission to EDS. The claim should be typewritten or computer-generated whenever possible. For program specific billing information, please refer to the Alabama Medicaid Provider Manual, Chapter 13, Dental, available on the Agency's website at: http://www.medicaid.alabama.gov/billing/provider_manuals_2008.aspx?tab=6

ADA Block Number	ADA Description Alabama Medicaid Use	Guidelines
3	Company/Plan Name, Address, City State, Zip Code	For Medicaid Claims enter: EDS, P.O. Box 244032, Montgomery, AL 36124-4032
4-11	Other Coverage <i>[These blocks are only required if the patient has other insurance].</i>	<p>4. Other Dental or Medical Coverage? Check the applicable box</p> <p>5. Name of Policyholder/subscriber in #4. Enter other insured's name (Last, First, Middle Initial, Suffix)</p> <p>8. Policy Holder/Subscriber Identifier (SSN or ID#) Enter the other insurance policy number</p> <p>9. Plan/Group Number Enter the plan/group number</p> <p>10. Relationship to Insured Check the applicable box</p> <p>11. Other insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code</p>
12	Policyholder/subscriber name (Last, first, Middle Initial, Suffix) Address, City, State, Zip Code <i>[Medicaid Recipient Information]</i>	<p>Enter the Medicaid recipient's name as last, first. Enter the name EXACTLY as it is given to you as a result of the eligibility verification transaction. Please note the name on the claim must match the information on the EDS system for the Medicaid number.</p> <p>If the recipient has two initials instead of a first name, enter the first initial with a space, then the second initial without periods.</p> <p>If a recipient's name contains an apostrophe, enter the first name including the apostrophe.</p> <p>Examples: For recipient A.B. Doe, enter Doe, A B without punctuation.</p> <p>For recipient D'Andre Doe, enter Doe, D'Andre with an apostrophe and no spaces.</p>
15	Subscriber Identifier (SSN or ID#)	Enter the recipient's 13-digit Medicaid Number (RID) from the Medicaid eligibility verification response. For instructions on performing eligibility verification transaction, please refer to Chapter 3 of the provider billing manual, verifying recipient eligibility.
24	Procedure Date (MM/DD/CCYY)	Enter numerically (MM/DD/CCYY) the date of service for each procedure provided.

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25	Area of Oral Cavity	<p>If applicable, enter the oral cavity designation code associated with the procedure being performed on a specific tooth.</p> <p>00-Full mouth 01 Upper Arch 02 Lower Arch 09 Other Area of Oral Cavity 10 Upper Right Quadrant 20 Upper Left Quadrant 30 Lower Left Quadrant 40 Lower Right Quadrant L-Left R-R</p> <p>There are few procedures that require an oral cavity designation code. Some of these include but are not limited to D4341, D4355, D4910, D7970 and D7971.</p>								
27	Tooth Number(s) or Letter(s)	<p>Enter the appropriate tooth number for the permanent teeth (01-32) or the appropriate letter for primary teeth (A-T) as indicated on the claim form.</p> <p>Enter AS-TS for children and 51-82 for adults with supernumerary teeth regardless of location in maxilla or mandible.</p> <p>Permanent teeth must be two-digit fields. For tooth number 1-9, you must indicate 01-09.</p>								
28	Tooth Surface	<p>Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL, MODBL).</p> <p>The block is left blank for exams, x-rays, fluoride and crowns.</p> <table border="0" data-bbox="846 1275 1370 1406"> <tr> <td>M-Mesial</td> <td>F-Facial, Labial</td> </tr> <tr> <td>O-Occusal</td> <td>L-Lingual or Cingulum</td> </tr> <tr> <td>D-Distal</td> <td>I-Incisal</td> </tr> <tr> <td>B-Buccal; Labial</td> <td></td> </tr> </table>	M-Mesial	F-Facial, Labial	O-Occusal	L-Lingual or Cingulum	D-Distal	I-Incisal	B-Buccal; Labial	
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29	Procedure Code	Enter the appropriate ADA procedure code(s) for the procedure.								
31	Fee	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.								
32	Other Fee(s)	Enter the amount paid by the other insurance or other third party sources known at the time of submission of the claim.								
33	Total Fee	Enter the total of the charges on the claim. DO NOT SUBTRACT the amount the other insurance pays (if applicable).								
35	Remarks	The only information that should be written in this section is "TPL Denial Attached" and the date of the third party denial (other insurance). Make sure the EOB denial statement is attached. No other comments should be written in this section.								

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38	Place of treatment	Check applicable box Use the Hospital box to indicate outpatient hospital or inpatient hospital
45-47	Treatments Resulting from	If applicable, check applicable box. If auto accident, provide date of accident (mm/dd/ccyy) and the two-digit state abbreviation of the state in which the accident happened.
48	Billing Dentist or Dental Entity (Name, Address, City, State, Zip Code)	Enter the billing provider's name, street address, city, state and zip code.
49	NPI	Enter the Organizational/ Billing NPI number.
52A	Additional Provider ID	Enter the billing provider's Alabama Medicaid provider number.
53	Treating Dentist and Treatment Location Information [provider's signature]	Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with EDS to omit signature requirement. Refer to the Alabama Medicaid Provider Manual, Chapter 5, section 5.1.7, Provider Signatures, for appropriate signature requirements.
54	NPI	Enter the NPI of the actual dentist performing the service, i.e. the treating (rendering or performing) NPI number.
56A	Provider Specialty Code	Enter the taxonomy code of the treating (rendering or performing) dentist.
58	Additional Provider ID	Enter the treating (rendering or performing) provider's Alabama Medicaid provider number.