ADA Claim Form – Version 2006 Completion Aid for Dentists

Prior Authorization

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the ADA claim form-Version 2006: for authorization of dental and orthodontia services.

Dentists – Provider Type 27

Document format

The document is divided into eleven sections that correspond to the sections of the ADA claim form. They are:

- Header Information (Items 1-2)
- Insurance Co/Dental Benefit Plan Information (Item 3)
- Other Coverage (Items 4-11)
- Policy Holder/Subscriber Information (Items 12-17)
- Patient Information (Items 18-23)
- Record of Services Provided (Items 24-33)
- Missing Teeth Information (Item 34- 35)
- Authorizations (Items 36-37)
- Ancillary Claim/Treatment Information (Items 38-47)
- Billing Dentist or Dental Entity (Items 48-52A)
- Treating Dentist and Treatment Location Information (Items 53-58)

Each section contains a table with four columns. Each column provides a specific piece of information as explained below:

Item Number – Provides the item number as it appears on the claim form.

Item Name – Provides the item name as it appears on the claim form.

Item Code – Lists one of four codes that denote how the claim form item should be treated. They are:

- **M** – Indicates that the item **m**ust be completed.
- **A** – Indicates that the item must be completed, if **a**pplicable.
- **O** – Indicates that the item is **o**ptional.
- **LB** – Indicates that the item should be **l**eft **b**lank.

Notes – Provides important information specific to completing the item.

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Item No.	Item Name	Item Code	Notes
Header Information			
1.	Type of Transaction	M	Check the **Request for Predetermination/Preauthorization** box if this is a **prior authorization** or post-operative review request. Check the **Request for Predetermination/Preauthorization** box if this is a **Benefit Limit Exception** request. Check the Statement of Actual Services box if this is a claim for completed services. Check the Statement of Actual Services box if this is a claim adjustment to correct a previously approved (or paid) claim.
2.	Predetermination/ Preauthorization Number	LB	
Insurance Company/Dental Benefit Plan Information			
3.	Name, Address, City, State, Zip Code	O	MA does not require that you complete this item.
Other Coverage			
4.	Other Dental or Medical Coverage	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
5.	Name of Policyholder/ Subscriber in #4 Name (Last, First, Middle Initial, Suffix)	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
6.	Date of Birth (MM/DD/CCYY)	O	MA does not require that you complete this item.
7.	Gender	O	MA does not require that you complete this item.

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Item No.	Item Name	Item Code	Notes
8.	Policyholder/ Subscriber ID # (SSN or ID#)	O	MA does not require that you complete this item.
9.	Plan/Group Number	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
10.	Patient's Relationship to Person Named in #5	O	MA does not require that you complete this item.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
Policyholder/ Subscriber Information			
12.	Policyholder/ Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	O	MA does not require that you complete this item.
13.	Date of Birth (MM/DD/CCYY)	O	MA does not require that you complete this item.
14.	Gender	O	MA does not require that you complete this item.
15.	Policyholder/ Subscriber ID# (SSN or ID#)	O	MA does not require that you complete this item.
16.	Plan/Group Number	O	MA does not require that you complete this item.
17.	Employer Name	O	MA does not require that you complete this item.

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Item No.	Item Name	Item Code	Notes
Patient Information			
18.	Relationship to Policyholder/ Subscriber in #12 above	O	MA does not require that you complete this item.
19.	Student Status	O	MA does not require that you complete this item.
20.	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	M	Enter the recipient's last name, first name, and middle initial (if any). Address, City, State, Zip Code are optional.
21.	Date of Birth (MM/DD/CCYY)	M	Enter the date of birth in the displayed format.
22.	Gender	O	MA does not require that you complete this item.
23.	Patient ID/Account Number	M	Enter the recipient's 10-digit identification number as it appears on the recipient's ACCESS Card. If the recipient number is not available, access EVS by using the recipient's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit recipient number to complete this item. **Eligibility of dental benefits must be verified at each visit.**
Record of Services Provided			
24.	Procedure Date (MM/DD/CCYY)	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission or Benefit Limit Exception request. Enter date of service if submitting a retrospective Benefit Limit Exception request.
25.	Area of Oral Cavity	O	MA does not require that you complete this item.
26.	Tooth System	O	MA does not require that you complete this item.
27.	Tooth Number(s) or	A	Enter only one tooth number, letter or quadrant per line. **This item must be completed whenever**

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Item No.	Item Name	Item Code	Notes
	Letter(s)		**a particular tooth or quadrant is involved.** Use numerical identification **1 through 32** for permanent teeth; use capital letter identification **A through T** for primary teeth. For permanent supernumerary teeth, use numerical identification **51 through 82**. For primary supernumerary teeth; use capital letter identification **AS through TS.** For periodontal services (**Procedure Codes D4210 and D4341**), enter the appropriate code to identify the quadrant on which the service was provided: **10** – Upper Right Quadrant **20** – Upper Left Quadrant **30** – Lower Left Quadrant **40** – Lower Right Quadrant
28.	Tooth Surface	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
29.	Procedure Code	M	Enter the code for the procedure performed. Only those codes listed in the MA Program Fee Schedule are covered by the MA Program. **Note**: **Authorization for Orthodontic Services** Procedure Code **D8080** is to be requested in conjunction with first quarter of treatment. Procedure Code **D8670** is to be requested for each quarter treatment. Only one treatment quarter may be billed per line.
30.	Description	A	Enter the terminology to describe the service provided.
31	Fee	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.

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Item No.	Item Name	Item Code	Notes
32.	Other Fee(s)	O	MA does not require that you complete this item.
33.	Total Fee	O	MA does not require that you complete this item. If you complete this item and the total is incorrect, your claim will be denied.
Missing Teeth Information			
34.	(Place an 'X' on each missing tooth)	M	Indicate all missing teeth by marking an "X" on the chart. Use a slash (/) to indicate any teeth requiring extraction.
Remarks			
35.	Remarks	M	This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is required, use another 8.5" by 11" sheet of paper and attach it to the prior authorization with a paperclip. Include the recipient's name and 10-digit recipient identification number in the upper right-hand corner of each additional sheet. Prior authorization of dental services must be performed as a part of a complete dental treatment program and must be accompanied by a detailed treatment plan. **Note:** For those Service Programs where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided. If this is a resubmission of a previously denied prior authorization request, enter "Resubmission of a previously denied request" and the denied P.A. Reference Number in this item. If this is a Benefit Limit Exception request, enter "Benefit Limit Exception" Also, place the 7-digit number appearing on the left side of the X-ray envelope (ENV 98) and the

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Item No.	Item Name	Item Code	Notes
			words "X-Ray Envelope Number" in this item.
Authorizations			
36.	Patient/Guardian signature and Date	LB	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
37.	Subscriber signature and Date	LB	Do not complete this item.
Ancillary Claim/Treatment Information			
38.	Place of Treatment	O	MA does not require that you complete this item.
39.	Number of Enclosures	O	MA does not require that you complete this item.
40.	Is Treatment for Orthodontics?	O	MA does not require that you complete this item.
41.	Date Appliance Placed (MM/DD/CCYY)	O	MA does not require that you complete this item.
42.	Months of Treatment Remaining	O	MA does not require that you complete this item.
43.	Replacement of Prosthesis?	A	MA does not require that you complete this item.
44.	Date Prior Placement (MM/DD/CCYY)	O	MA does not require that you complete this item.
45.	Treatment Resulting from	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
46.	Date of Accident (MM/DD/CCYY)	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
47.	Auto Accident State	O	MA does not require that you complete this item for prior authorization; however, this may be

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Item No.	Item Name	Item Code	Notes
			necessary for claims submission.
Billing Dentist Or Dental Entity			
48.	Name, Address, City, State, Zip Code	O	Enter the name of the enrolled group, corporation, or organization **designated to receive payment** for the service provided. The **payee** must be enrolled with the Department and must be listed as payee on the individual dentist's Provider Notice Information Form.
49.	NPI Number	M	Please enter the NPI number of the enrolled group, corporation, or organization **designated to receive payment** for the service provided.
50.	License Number	O	MA does not require that you complete this item.
51.	SSN or TIN	O	MA does not require that you complete this item.
52.	Phone Number	O	Enter the telephone number of the enrolled group, corporation, or organization other than the individual provider of the service, **designated to receive payment** for the service provided.
52A.	Additional Provider ID	M	**Enter the 9-digit PROMISe™ ID number and the 4-digit service location code of the enrolled group, corporation, or organization designated to receive payment.** Do not use slashes, hyphens or spaces.***Payment will be made to the ID number appearing in this item**.
Treating Dentist and Treatment Location Information			
53.	Signature (Treating Dentist) and Date (MMDDYYYY)	M	The provider rendering the service **must sign and date** the claim. The signature certifies that the service has been provided in accordance with MA regulations. A signature stamp is acceptable if the provider authorizes its use and assumes responsibility for the information on the claim.
54.	NPI Provider ID	M	Please enter the NPI number of the treating dentist.

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Item No.	Item Name	Item Code	Notes
55.	License Number	M	Enter the complete alpha numeric license number of the dentist rendering the service. Example: **DS-012345L** **Do Not Enter the PROMISe™ ID number.**
56.	Address, City, State, Zip Code	M	Enter the address (Street Address, City, State, and ZIP Code) where the service was performed.
56A.	Provider Specialty Code	O	MA does not require that you complete this item.
57.	Phone Number	O	Enter the telephone number of the rendering/treating dentist that provided the service.
58.	Additional Provider ID	O	MA does not require that you complete this item.