

# ADA Version 2006

Claim form billing instructions for the  
Department of Human Services

# Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the ADA Version 2006 billing form correctly the first time. If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~ DHS ~

# MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted.

# Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

# Before you bill

- Read your provider guidelines.
- Verify recipient eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.
- Use the commercially available ADA Version 2006 claim form.

# A few tips!

- When submitting handwritten claim forms, you must use blue or black ink.
- Make sure your handwriting is legible.
- If possible, submit no more than ten lines of services per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

# Form suppliers

- ADA forms are not supplied by DHS.
- Forms are available by contacting one of the following:
  - Local business forms suppliers
  - American Dental Association (800-947-4746) or on the Web at <[www.adacatalog.org](http://www.adacatalog.org)>

# Services billed on ADA Version 2006

- Dental services provided by a:
  - Dentist
  - Denturist
  
- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
  - Toll free:                   800-336-6016
  - E-mail:                        DMAP.providerservices@state.or.us

# Introducing ADA Version 2006



# ADA Version 2006

- Not sure if you are using the correct form?

The bottom left corner will look like this.

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# Top section

## ADA Dental Claim Form

HEADER INFORMATION			POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
1. Type of Transaction (Mark all applicable boxes)			12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
<input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX			13. Date of Birth (MM/DD/CCYY)		
2. Predetermination/Preauthorization Number			14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			16. Plan/Group Number		
3. Company/Plan Name, Address, City, State, Zip Code			17. Employer Name		
OTHER COVERAGE			PATIENT INFORMATION		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)			18. Relationship to Policyholder/Subscriber 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
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)			20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)	21. Date of Birth (MM/DD/CCYY)		
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		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code					

Red = Required

Yellow = Optional

# Box 1 - Optional

1. Type of Transaction (Mark all applicable boxes)



Statement of Actual Services



Request for Predetermination / Preauthorization



EPSDT/Title XIX

## Type of Transaction

- Indicate whether the claim is for pre-treatment or for actual services.

# Box 2 - Optional

2. Predetermination/Preauthorization Number

**#####**

## Preauthorization Number

- If the service you provided required prior authorization (PA), enter the ten-digit prior authorization number that was issued for the service.
- Only use one prior authorization number per claim form.

# Box 15 - Required

15. Policyholder/Subscriber ID (SSN or ID#)

**X X # # # X # X**

## Recipient ID Number

- Enter the recipient's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.
- Do not use the recipient's Social Security Number.

# Box 20 - Required

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

**Patient, Your**

## Recipient Name

- Enter the recipient's name exactly as it is printed on the Medical Care Identification.
- Use your recipient's last name first.
- Do not use nicknames.

# Middle section

RECORD OF SERVICES PROVIDED																			
1	24. Procedure Date (MM/DD/CCYY)		25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)		28. Tooth Surface	29. Procedure Code		30. Description								31. Fee	
	2	3			4	5		6	7	8	9	10	11	12	13	14	15	16	17
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			

MISSING TEETH INFORMATION		Permanent																Primary										32. Other Fee(s)	
34. (Place an 'X' on each missing tooth)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33.Total Fee	
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks
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Red = Required

Yellow = Optional

# Box 24 - Required

24. Procedure Date (MM/DD/CCYY)
<b>120108</b>

## Procedure Date

- This box must list numeric dates of service for each line item.

# Box 25 - Optional

25. Area  
of Oral  
Cavity

## Area of Oral Cavity

- If appropriate, use one of the following codes for each line item.

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

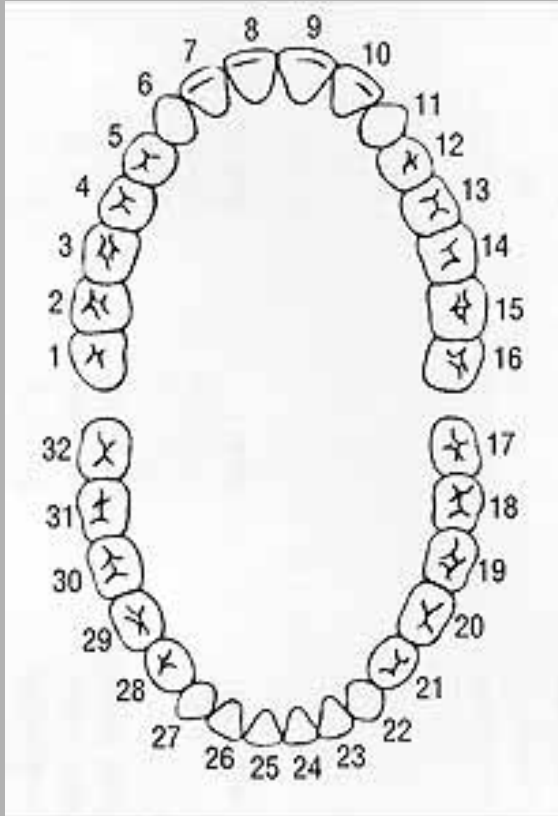
# Box 27 - Optional

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

## Tooth Numbers or Letters

- If appropriate, enter the tooth number or letter.
- Leave blank if the procedure does not directly involve a tooth or range of teeth.
- Refer to tooth chart appearing on the following page.
  - A-T Deciduous teeth
  - 1-32 Permanent teeth
  - 51-82 Supernumerary teeth

# Tooth Chart



1. 3rd Molar (wisdom tooth)
2. 2nd Molar (12-year molar)
3. 1st Molar (6-year molar)
4. 2nd Bicuspid (2nd premolar)
5. 1st Bicuspid (1st premolar)
6. Cuspid (canine/eye tooth)
7. Lateral incisor
8. Central incisor
9. Central incisor
10. Lateral incisor
11. Cuspid (canine/eye tooth)
12. 1st Bicuspid (1st premolar)
13. 2nd Bicuspid (2nd premolar)
14. 1st Molar (6-year molar)
15. 2nd Molar (12-year molar)
16. 3rd Molar (wisdom tooth)

17. 3rd Molar (wisdom tooth)
18. 2nd Molar (12-year molar)
19. 1st Molar (6-year molar)
20. 2nd Bicuspid (2nd premolar)
21. 1st Bicuspid (1st premolar)
22. Cuspid (canine/eye tooth)
23. Lateral incisor
24. Central incisor
25. Central incisor
26. Lateral incisor
27. Cuspid (canine/eye tooth)
28. 1st Bicuspid (1st premolar)
29. 2nd Bicuspid (2nd premolar)
30. 1st Molar (6-year molar)
31. 2nd Molar (12-year molar)
32. 3rd Molar (wisdom tooth)

# Box 28 - Optional

28. Tooth Surface

## Tooth Surface

- If appropriate, list the tooth surface code for each service.

B	Buccal
M	Mesial
D	Distal
O	Occlusal
L	Lingual
I	Incisal
F	Facial

# Box 29 - Required

29. Procedure Code
<b>D0120</b>

## Procedure Code

- For each line, list the five-character ADA procedure code for each individual tooth/service that was provided.
- ADA procedure codes always begin with D.





# Box 33 - Required

33. Total Fee		23	23
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## Total Fee

- Enter the total for all fees listed in Box 31.

# Box 35 - Optional

35. Remarks

## Remarks

- If appropriate, enter “Payment by other plan” information, if any; or leave blank and attach a copy of plan’s Remittance Advice (RA).
- You can also use this area for documentation when requesting prior authorization, or for unusual circumstances when filing a claim.

# Bottom section

AUTHORIZATIONS		ANCILLARY CLAIM/TREATMENT INFORMATION	
<p>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.</p> <p>X _____ Patient/Guardian signature Date</p>		<p>38. Place of Treatment  <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other</p>	
<p>37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.</p> <p>X _____ Subscriber signature Date</p>		<p>39. Number of Enclosures (00 to 99)            Radiograph(s) <input type="checkbox"/> Oral image(s) <input type="checkbox"/> Model(s) <input type="checkbox"/></p>	
		<p>40. Is Treatment for Orthodontics?  <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)</p>	
		<p>41. Date Appliance Placed (MM/DD/CCYY)</p>	
		<p>42. Months of Treatment Remaining</p>	
		<p>43. Replacement of Prosthesis?  <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)</p>	
		<p>44. Date Prior Placement (MM/DD/CCYY)</p>	
		<p>45. Treatment Resulting from  <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident</p>	
		<p>46. Date of Accident (MM/DD/CCYY)</p>	
		<p>47. Auto Accident State</p>	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)		TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
<p>48. Name, Address, City, State, Zip Code</p>		<p>53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.</p> <p>X _____ Signed (Treating Dentist) Date</p>	
<p>49. NPI</p>		<p>54. NPI</p>	
<p>50. License Number</p>		<p>55. License Number</p>	
<p>51. SSN or TIN</p>		<p>56. Address, City, State, Zip Code</p>	
<p>52. Phone Number ( ) -</p>		<p>56A. Provider Specialty Code</p>	
<p>52A. Additional Provider ID</p>		<p>57. Phone Number ( ) -</p>	
		<p>58. Additional Provider ID</p>	

Red = Required

Yellow = Optional

# Box 48 - Required

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

**Dental Clinic**

**PO Box ###**

**Anytown, OR 97###**

## Billing Provider Name

- Enter the name and address of the billing provider.

# Box 49 - Required

49. NPI

**#####**

## Billing Provider National Provider Identifier (NPI)

- Enter the ten-digit NPI of the billing provider.

# Box 52A - Required

52A. Additional  
Provider ID

**#####**

## Additional Provider ID

- Enter the six (6)-or nine (9)-digit DHS provider number.
- Beginning 12/09/2008, newly enrolled providers will have a 9-digit provider number.
- Do not enter the billing provider's license number in this box.

# Box 54 - Optional

54. NPI      # # # # # # # # # #

## Treating Provider National Provider Identifier (NPI)

- If the billing provider identified in box 48, 49 and 52A is a billing clinic, enter the ten-digit NPI of the treating dentist.
- Or, if the treating dentist is already identified in box 48, 49, and 52A, leave this box blank.

# Box 58 - Optional

58. Additional Provider ID	#####
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## Additional Treating Provider ID

- If the billing provider identified in box 48, 49 and 52A is a billing clinic, enter the six (6)-or nine (9)-digit DHS provider number of the treating dentist.
- Or, if the treating dentist is already identified in box 48, 49 and 52A, leave this box blank.
- Do not use license numbers in this box.



# Resources

# Where to mail your claim

- Mail your ADA 2006 claim form to:

DMAP

PO Box 14953

Salem, OR 97309-4957

# Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or questions concerning your ADA 2006 claim form.
- They can be reached at:
  - Toll free: 800-336-6016
  - E-mail: [DMAP.providerservices@state.or.us](mailto:DMAP.providerservices@state.or.us)

Thank You!