ADA 2012 Dental Claim Form

For dental claim filing purposes, deviations from the standard national claim form coding instructions are indicated by comments in the claim form directions on the following pages.

ADA 2012 Instructions
Dental and orthodontic services must be billed on the ADA 2012 Dental Claim Form.

Required Field:

Blank = Not Required
C = Conditionally Required
R = Required Field

Form Locator	Required Field	Field Name	Comments
1		Type of Transaction	
2	C	Predetermination/Prior Authorization	Enter predetermination number if applicable.
3	C	Insurance Company	Enter primary payer information. If the patient has a primary insurance, then an attached EOB is required.
4	C	Other Dental or Medical Coverage	Check 'Yes' to indicate other insurance coverage. If yes, complete 5-11.
5	C	Name of Policy Holder / Subscriber	Enter name of subscriber • Last, First, Middle Initial and Suffix if applicable
6	C	Date of Birth	Enter subscriber date of birth. • Format = MM/DD/CCYY
7	C	Gender	Enter subscriber gender. • M = Male • F = Female • U = Default
8	C	Policyholder/Subscriber ID	Enter subscriber ID/social security number.
9	C	Plan/Group Number	Enter plan/group number of subscriber.
10		Patient's Relationship to Person in #5	No entry required.
11	C	Other Insurance Company/Dental Benefit Plan	Enter other insurance co/dental benefit plan name and address.

Form Locator	Required Field	Field Name	Comments
12	R	Policyholder/Subscriber Name	Enter member's name and address. • Last, First, Middle Initial and Suffix if applicable • Member Street Address • Member City • Member State • Member ZIP (must be 9-digit ZIP Code)
13	R	Date of Birth	Enter member's date of birth in this format: MM/DD/CCYY.
14	R	Gender	Select the correct gender for member. Check the M (male) or F (female) box.
15	R	Policyholder/Subscriber ID	Enter member's 11-digit THP ID number.
16		Plan/Group Number	No entry required.
17		Employer Name	No entry required.
18		Relationship to Primary Subscriber	No entry required.
19		Student Status	No entry required.
20		Patient Name and Address	No entry required.
21		Patient Date of Birth	No entry required.
22		Patient/Member's Gender	No entry required.
23	R	Patient ID/Account #	Enter account number, or Last Name First Name as assigned by the dentist's office.
24	R	Procedure Date	Enter the date of service in this format: MMDDCCYY.
25	C	Area of Oral Cavity or Quadrant	Valid values for arches and quadrants are: • UA = Upper or Maxillary Arch • LA = Lower or Mandibular Arch • UL = Upper Left Quadrant • LL = Lower Left Quadrant • UR = Upper Right Quadrant • LR = Lower Right Quadrant
26		Tooth System	No entry required.

Form Locator	Required Field	Field Name	Comments
27	C	Tooth Number(s) or Letter(s)	List in order by tooth number or letter. • Valid tooth values are: 1-32 or A-T. • Permanent supernumerary teeth are 50-82. Primary supernumerary is AS – TS. • For permanent teeth or deciduous teeth add 50 to the tooth number. Example – permanent tooth number 1 would be 51, tooth 12 would be 62. • For primary teeth add 'S' to the tooth number. Example: Primary tooth would be AS. ** Note: Leading 0's are not valid or allowed.
28	C	Tooth Surface	Enter surface if applicable. Valid values for surface are: • B = Buccal • D = Distal • F = Facial • I = Incisal • L = Lingual • M = Mesial • O = Occlusal
29	R	Procedure Code	Enter procedure code (ADA 5-character code starting with the letter D).
29a		Diagnosis Code Pointer	Enter the letters from block 34 that identify the diagnosis codes. Applicable to the dental procedure billed on the line. Specific reference letters A, B, C, D are required if diagnosis is present. • List pointer for primary diagnosis first.
29b	R	Quantity	Enter the number of times the procedure for which you are billing was performed. • Default is '01'. • D9223 or D9243 must be billed on 1 claim line in units; 15 minutes=1 unit. (Ex: 45 minutes = 3 units)
30		Description	Enter the description of the procedure code.

Form Locator	Required Field	Field Name	Comments
31	R	Fee	Enter charges for that procedure code. • 0.00 amount is acceptable. • Decimal amounts will only be captured if present. Examples • 100 will be captured as 100.00 • 10.00 will be captured as 10.00 • 10.10 will be captured as 10.10
31a		Other Fee(s)	No entry required.
32	R	Total Fee	Enter total charges. • Amount is acceptable. • Decimal amounts will only be captured if present. Examples • 100 will be captured as 100.00 • 10.00 will be captured as 10.00 • 10.10 will be captured as 10.10
33		Missing Teeth Information	No entry required.
34	C	Diagnosis Code List Qualifier	Enter B for ICD-9, enter AB for ICD-10. **Required when a diagnosis code is entered.
34a	R	Primary Diagnosis	Enter up to four applicable diagnosis codes after each letter. (A-D). *Note: Letters are vertically aligned on the claim. (Down then across).*
35	C	Remarks	Can be used to indicate service facility location; use NPI followed by a dash then the three-digit service location &/or can be used for claim adjustment resubmission codes and original reference number (ICN). Valid format and order are as followed: Resubmission Code and Original ICN. Enter Resubmission Code 7 or 8 then a space, followed by Original Reference Number (ICN)
36		Patient/Guardian Signature	No entry required.
37		Subscriber Signature	No entry required.
38	R	Place of Treatment	Enter the appropriate two-digit Place of service indicator in the box. For example: • 11 - Office • 12 - Home

Form Locator	Required Field	Field Name	Comments
			• 21 - Inpatient Hospital • 22 - Outpatient Hospital • 31 - Skilled Nursing Facility • 32 - Nursing Facility The full list of POS codes is available at CMS.gov
39		Number of Enclosures	No entry required.
40	C	Is Treatment for Orthodontics?	Required when reporting the date orthodontic appliances were placed.
41	C	Date Appliance Placed	Required if box 40 is checked yes. Valid date format: MM/DD/CCYY
42	C	Months of Treatment Remaining	Required if box 40 is checked yes.
43	C	Replacement of Prosthesis	Only required to indicate the placement status of the prosthesis.
44	C	Date Prior Placement	Only required if box 43 is checked yes. Must be valid format: MM/DD/CCYY.
45	C	Treatment Resulting From	Check appropriate box(es) for occupational illness/Injury, auto accident, and other accident.
46	C	Date of Accident	Required if box for auto accident or other accident is checked in Block 45
47	C	Auto Accident State	Required if box for auto accident is checked in Block 45. Enter state abbreviation.
48	R	Billing Dentist Name, Address, Phone Number	Enter required information as follows: • Provider Name • Address: City, State & 9-digit ZIP Code • Phone
49	R	NPI	Enter the provider or group practice NPI.
50		License Number	Enter the dentist's license number.
51	R	SSN or TIN	Enter the dentist's 9-numeric Federal Tax ID.
52A	C	Additional Provider ID	Enter the qualifier and provider's legacy Medicaid if NPI is missing in box 49. • EI - qualifier with Employer's Identification Number • SY- qualifier with SSN **Required if NPI is missing in box 49.

Form Locator	Required Field	Field Name	Comments
53	R	Treating Dentist's Signature	Signature of person authorized to certify this claim. By signing the Provider Enrollment Agreement (included in the enrollment/re-enrollment packet) you have certified that all information listed on a claim for reimbursement from Medicaid is true, accurate and complete. Therefore, you may endorse your claim with a computer-generated, manual or stamped signature.
54	R	NPI	Enter the treating dentist's NPI.
55		License Number	No entry required.
56	C	Treating Provider Address	Required if service facility location indicated in Block 35. Address City, State & 9-digit ZIP Code
56A	C	Provider Specialty Code	Enter the taxonomy code of the individual dentist (if applicable). **Note: 56A is REQUIRED when:** • A rendering provider is used. • The billing dentist is a One-To-Many.
57		Treating Provider Phone #	No entry required.
58	C	Additional Provider ID	

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

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

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐M ☐F ☐U	15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number	17. Employer Name

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 Initial, 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)

RECORD OF SERVICES PROVIDED

	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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

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

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

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) -	52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

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

54. NPI	55. License Number

56. Address, City, State, Zip Code	56a. Provider Specialty Code

57. Phone Number ( ) -	58. Additional Provider ID

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

GENERAL INSTRUCTIONS

A. 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 (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

COORDINATION OF BENEFITS (COB)

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

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

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

The full list is available online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/