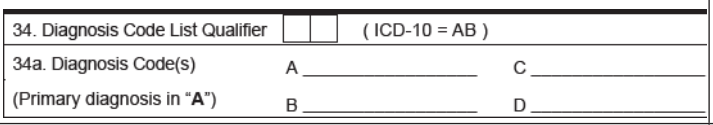
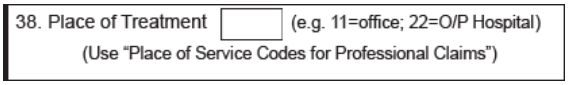
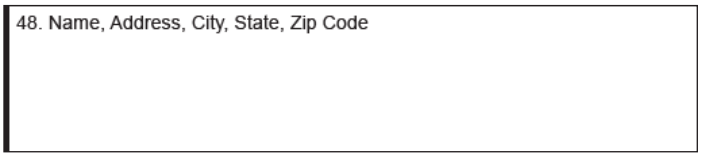
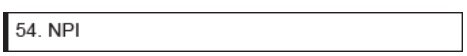
# 2019 ADA Dental Claim Form – Detailed Instructions

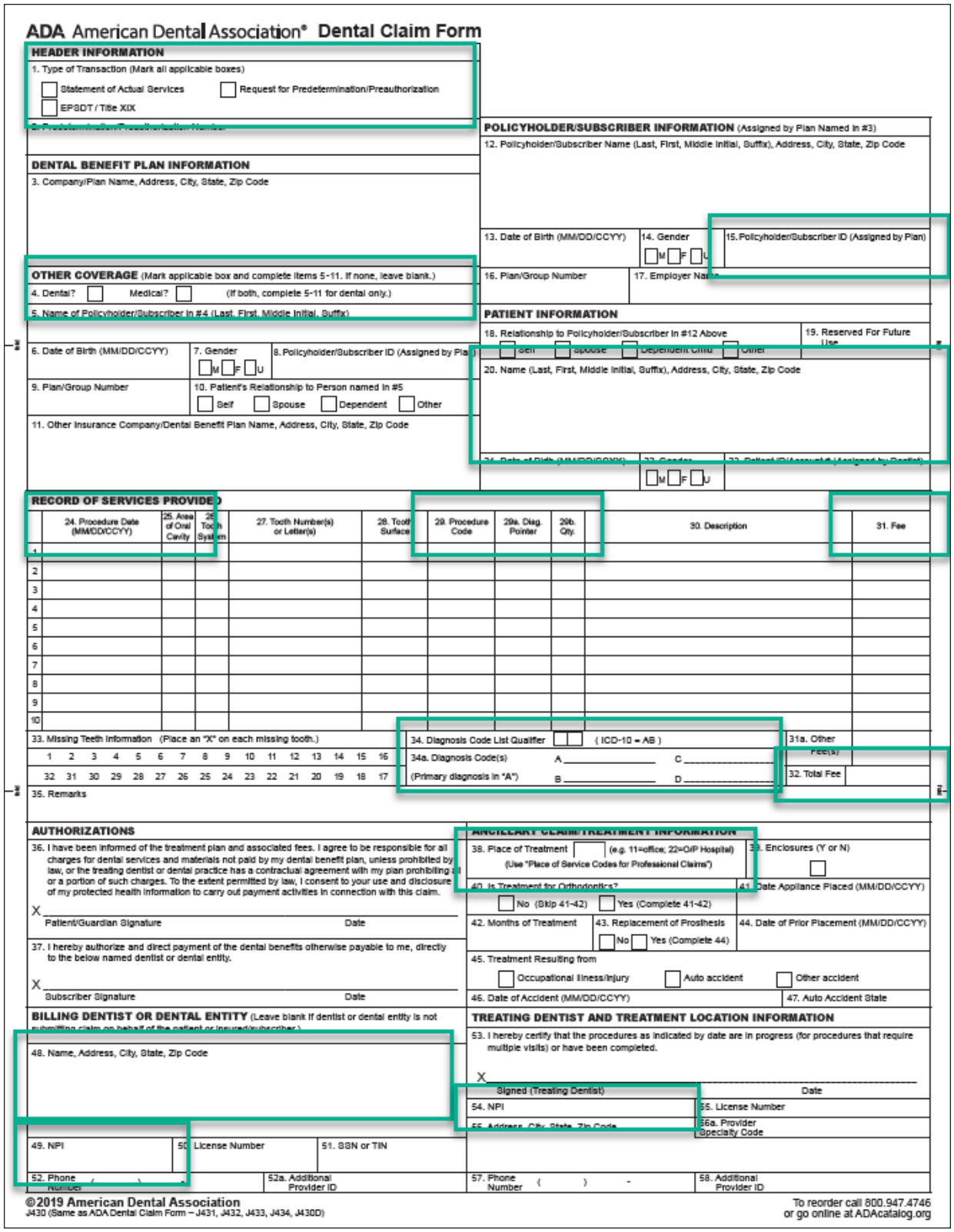
All information on the dental claim form should be typed or legibly printed. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. The only fields used in the Vermont Medicaid program are listed below; other fields do not need to be completed.

Though dental practitioners are not required to include a diagnosis code when submitting claims to Vermont Medicaid, if they choose to include codes, they must be valid. Valid codes can be found in ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification. The use of appropriate diagnosis codes is the sole responsibility of the dental provider.

| Field Locator | Required Information |
|---|---|
| 1. VERMONT MEDICAID/EPSDT*<br>**HEADER INFORMATION**<br>1. Type of Transaction (Mark all applicable boxes)<br>☐ Statement of Actual Services ☐ Request for Predetermination/F<br>☐ EPSDT / Title XIX | Check EPSDT/Title XIX if it is appropriate to the age of the member. |
| 3. PRIMARY PAYER INFORMATION | Enter "Vermont Medicaid". |
| 4. OTHER COVERAGE*<br>**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If non<br>4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental ( | Mark the box "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, regardless of whether the claim will be submitted to that other coverage. If both are marked, enter the information about the dental benefit in items 5 – 11. |
| 11. OTHER CARRIER NAME | If the patient has other health insurance (excluding Medicare), enter the insurance carrier's name. |
| 12. Policyholder/Subscriber Name*<br>**POLICYHOLDER/SUBSCRIBER INFORMATION** (Assigned by Plan N<br>12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, C | Enter the patient's last name, first name and middle initial. |
| 15. SUBSCRIBER ID NUMBER*<br>15. Policyholder/Subscriber ID (Assigned by Plan) | Enter the patient's Vermont Medicaid ID #. |
| 18. Relationship to Policyholder/Subscriber*<br>18. Relationship to Policyholder/Subscriber in #12 Above<br>☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | Select the relationship to the Policyholder/ Subscriber identified in field #12 and check the applicable box. |

| Field Locator | Required Information |
|---|---|
| 20. PATIENT NAME*<br>20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code | Enter the patient's last name, first name and middle initial ONLY if the relationship to Policy-holder/Subscriber box in field #12 selected is other than Self. |
| 21. PATIENT DATE OF BIRTH | Enter the patient's date of birth in a MM/DD/CCYY format. |
| 23. PATIENT ID/ACCOUNT # | Enter the patient identification/account number. |
| 24. PROCEDURE DATE* 24. Procedure Date (MM/DD/CCYY) | Enter the date of each service provided in MM/DD/CCYY. |
| 25. AREA OF ORAL CAVITY* 25. Area of Oral Cavity | Please refer to the Area of Oral Cavity section for more information. |
| 27. TOOTH NUMBER(S) OR LETTER(S) | Enter the appropriate tooth number or letter as indicated on the chart in box 34 when the procedure code reported involves a tooth. |
| 28. TOOTH SURFACE | Enter the appropriate letter(s) to indicate the surface(s) of the tooth on Which the service is performed, if applicable.<br>This field is also used to indicate quadrant location: UL (Upper Left); UR (Upper Right); LL (Lower Left); LR (Lower Right)<br>Enter up to five of the following codes:<br>B (Buccal); D (Distal); F (Facial); I (Incisal); L (Lingual); M (Mesial); O (Occlusal) |
| 29. PROCEDURE CODE* 29. Procedure Code | Enter the appropriate procedure code (and any modifier if appropriate). |
| 29a. DIAGNOSIS POINTER* 29a. Diag. Pointer | 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. QTY.* 29b. Qty. | Enter the number of times (01-99) the procedure identified in item 29 was delivered to the patient on the date-of-service in item 24. If a value is not entered, the default value of 01 will apply. |
| 30. DESCRIPTION OF SERVICE | Describe the procedure. |
| 31. FEE* 31. Fee | Enter the usual and customary charge for the service rendered. |
| 31a. OTHER FEES | Report Other Insurance in top box, and spend-down and/or GA Voucher amounts in bottom box. |

| Field Locator | Required Information |
|---|---|
| 32. TOTAL FEES*   | Calculate the sum of all the detail charges in field number 31. Other payments should not be deducted from the total. |
| 34. DIAGNOSIS CODE LIST QUALIFIER (Optional) | Enter AB to identify the diagnosis code source. AB = ICD-10-CM. |
| 34a. DIAGNOSIS CODE(S) (Optional)   | Enter up to 4 diagnosis codes after each letter (A-D). The primary Diagnosis code is entered adjacent to the letter "A". |
| 35. REMARKS | Enter comments specific to claim and to indicate "page x of y" of a multiple page claim. |
| 38. PLACE OF TREATMENT*   | Enter the 2-digit Place of Service Code for Professional Claims. |
| 39. ENCLOSURES Y OR N | Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with claim submission. |
| 45. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS/INJURY, AUTO ACCIDENT OR OTHER ACCIDENT? | Check the appropriate box. |
| 46. DATE OF ACCIDENT | If applicable; enter the date of the accident indicated in box 45. |
| 48. NAME AND BILLING ADDRESS (BILLING DENTIST/GROUP)*   | Enter individual dentist with last name, first name or enter group names as it appears on your enrollment form. |
| 49. BILLING PROVIDER NPI NUMBER*   | Enter the billing provider NPI. Use your group provider NPI if you are a provider in a group practice. Use your individual NPI if you are not a provider in a group practice. |
| 52a. ADDITIONAL PROVIDER ID (INDIVIDUAL OR GROUP) | Enter the applicable taxonomy for the billing provider as necessary. |
| 53. SIGNED DATE | Enter the Vermont Medicaid signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature. |
| 54. ATTENDING PROVIDER ID*   | Enter the attending provider NPI. Use the NPI of the attending dentist that performed the service. |



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

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 Pla
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
☐M ☐F ☐U

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 |
|---|---|---|---|---|---|---|---|---|---|---|
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| 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) A _____ C _____
(Primary diagnosis in "A") B _____ 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

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

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

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
55. Address, City, State, Zip Code | 56a. Provider Specialty Code
57. Phone Number ( ) - | 58. Additional Provider ID

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J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)
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