



DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN

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DENTAL BULLETIN

CONTENTS

- **AMERICAN DENTAL ASSOCIATION (ADA) 2002, 2004 CLAIM FORM AND FILING INSTRUCTIONS**

The American Dental Association (ADA), Dental Claim Form 2002, 2004 version is now available for use. Please continue to use the supply currently on hand, when supply is exhausted, begin using the new ADA 2002, 2004 Dental Claim Form. The claim form should be typed or legibly print-med. Claims should be mailed to Infocrossing Healthcare Services, P.O. Box 5300, Jefferson City, MO 65102 or submitted electronically at www.emomed.com. Filing instructions for the electronic version may be found on the above Web site.

The **unit's field** has been eliminated by the ADA. Should a quantity greater than one (1) need to be billed each unit must be billed on a separate line.

FIELD NUMBER & NAME

INSTRUCTIONS FOR COMPLETION

Note: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim will be denied. All other fields should be completed as applicable. Two (2) asterisks (**) beside the field number indicates a field is required in specific situations.

1-2.

Not Required

*3. Primary Payer Information

Enter Name, Address, City, State and Zip Code for the insurance company or third-party payer.

**4-11. Other Coverage

Required only if recipient has second dental policy. Leave blank if there is no other Dental Coverage.

****12-17. Primary Insured Information**

When verifying the recipient's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in field #32, section: "Other Fees". Leave blank if there is no other dental coverage.

18-19.

Not Required

*20. Patient Name

Enter the recipients last name, first name and middle initial as shown on the recipient's Medicaid ID card. Enter the recipient's street address, city of residence and state.

21. Date of Birth

Not Required

22. Sex

Not Required

*23. Patient ID/Account Number

Enter the patient's eight-digit Medicaid or MC+ identification number (DCN) exactly as shown on the patient's ID card.

*24. Procedure Date

Enter the actual date services were rendered in MM/DD?CCYY numeric format. Reminder: The date of service for dentures (full or partial is the date of placement.

25. Oral Cavity

Not Required

26. Tooth system

Not Required

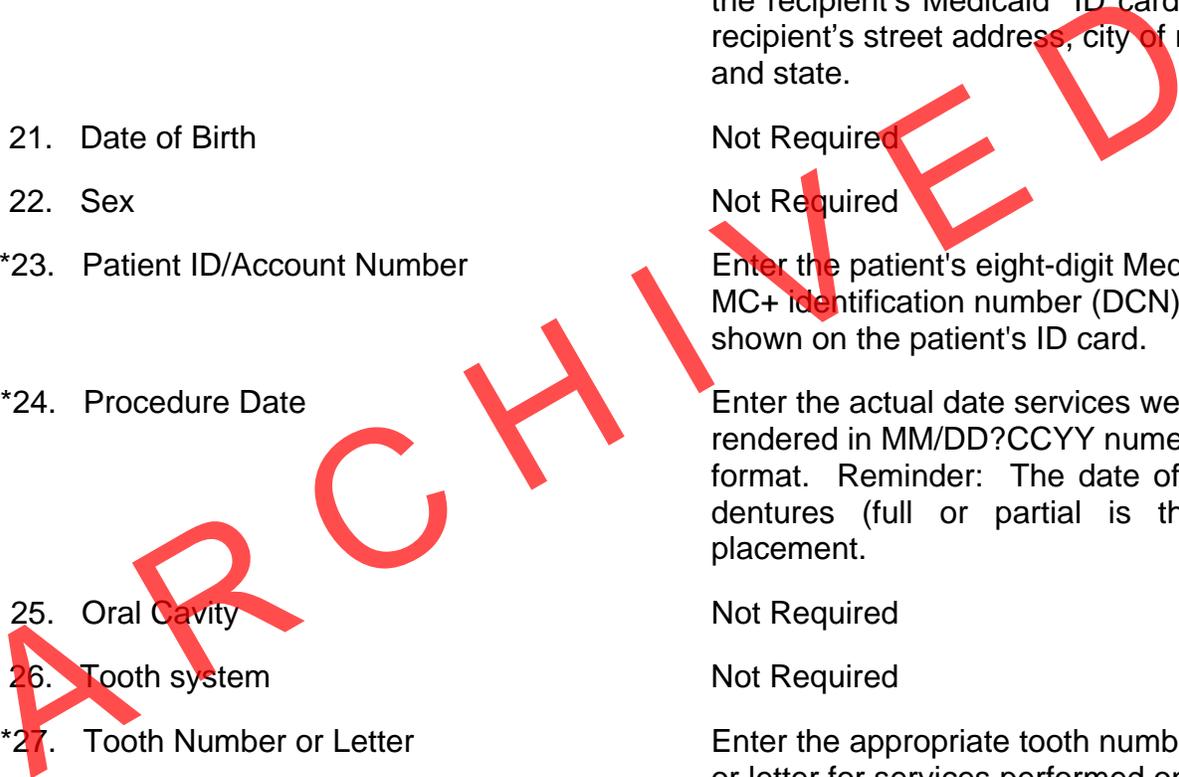
*27. Tooth Number or Letter

Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, this field may be left blank.

The valid values are:

- A-T Deciduous teeth
- 1-32 Permanent teeth
- AS-TS Deciduous supernumerary teeth
- 51-82 Permanent supernumerary teeth

When billing for partial dentures, enter the tooth number for one of the



teeth being replaced in this field. Alveoplasties should be billed using tooth number 1 for upper right quadrant, 9 for upper left quadrant, 17 for lower left quadrant and 25 for lower right quadrant.

**28. Tooth Surface

Enter the appropriate surface code, if applicable. Otherwise, leave blank. The valid values are:

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

*29. Procedure Code

Enter the five digit procedure code for the service performed, as well as any applicable modifiers.

**30. Description

Only required in specific situations.

*31. Fee

Enter the provider's usual and customary fee for the procedure(s) performed. Do not subtract the copay or coinsurance amounts from the charge.

32. Other fees

When other charges are applicable to dental services provided, this field must be reported. Enter the amount here.

*33. Total Fee

Enter the total of the charges shown.

34. Missing Teeth

Not Required.

**35. Remarks

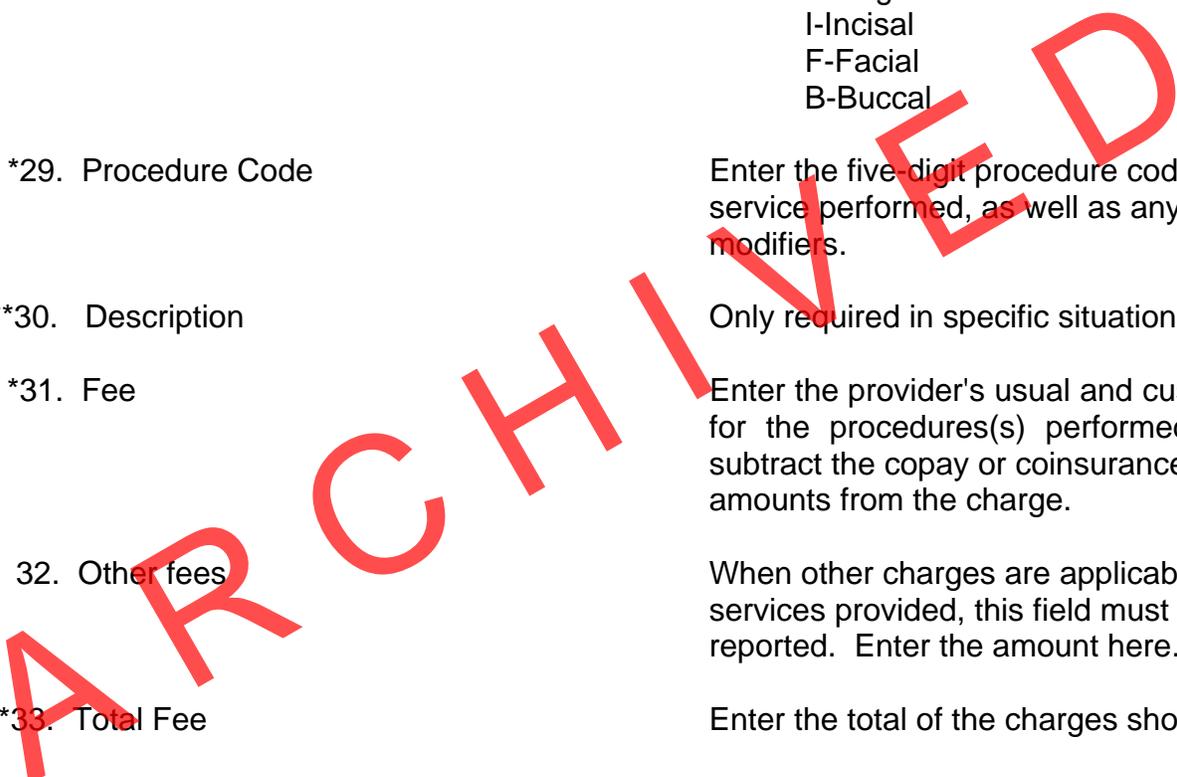
For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.

36-38.

Not Required.

**39. Number of Enclosures

Complete whether or not radiographs,



oral images, or study models are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore no possible attachments are missing.

40. Is treatment for Orthodontics?

If no, skip to #43. If yes, answer #41.

41. Date Appliance placed.

Date orthodontic appliance was placed.

42. Months of Treatment Remaining

Not Required

43. Replacement of Prosthesis.

This item applies to crowns and all fixed or removable prostheses:

- a. If claim does not involve a prosthetic restoration check "no" and proceed to #45
- b. If claim is for the initial placement of a crown or fixed or removable prosthesis, check "no" and go to #45
- c. The patient has previously had these teeth replaced by a crown, check "yes" and go to #44.

44. Date of Prior Placement

Complete if the answer to #43 was yes.

45. Treatment Resulting From

If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box and proceed to items #46 & 47. The valid values are:

- AA auto accident
- EM employment related
- OA other accident

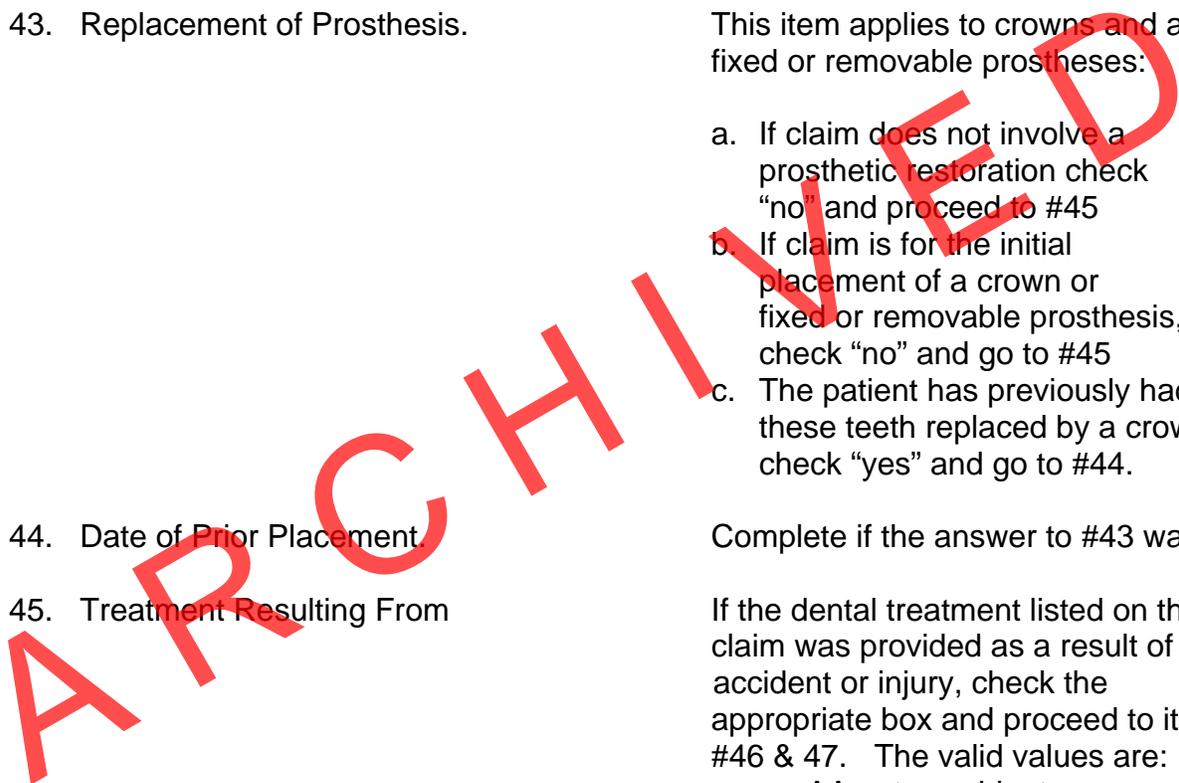
If services are not the result of an accident, skip to item #48.

46. Accident Date

Enter the date on which the accident in #45 occurred. Otherwise leave blank.

47. Auto Accident State

Enter the state in which the auto accident in #45 occurred. Otherwise



| | |
|---|---|
| | leave blank. |
| *48. Name, Address, City, State | Enter the name and complete address of the billing dental provider. |
| *49. Provider ID# | This number is an identifier assigned to the billing dental provider. |
| 50. Dentist License # | Not Required |
| 51. Dentist SS# or T.I.N | Not Required |
| 52. Phone Number | Enter provider's phone number |
| 53. Signature & Date | Not Required |
| 54. Provider ID# (Performing Provider) | Not Required |
| 55. License # | Not Required |
| 56. Address, City, State, MO | Not Required |
| 57. Phone Number | Not Required |
| 58. Treating Provider Specialty | Not Required |

Provider Bulletins are available on the DMS Web site at <http://dss.mo.gov/dms/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletins page.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Web site at <http://dss.missouri.gov/dms/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via E-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896