Medicaid Billing Requirements for the ADA 2002

Form Locator	Field Name	Medicaid Requirement	Information Requirement
1	Type of Transaction	Required	Place an "X" in the field marked "Dentist's statement of actual services." This form should only be used to report services already rendered.
2	Predetermination/Prior Authorization #	Conditional	Required if claim is a resubmission. Enter an “A” to adjust or a “V” to void. Also include the original claim reference #.
3	Primary Payer Information	Not required	
4	Other dental or medical coverage	Conditional	Place an "X" in the appropriate box. If yes, attach EOB from TPL.
5	Subscriber’s name	Conditional	If patient is covered by another policy then enter policy holder's name.
6 – 8	Date of Birth – Subscriber Identifier	Not required	
9	Plan/Group Number	Conditional	If patient is covered by another policy then enter the policy number.
10	Relationship to primary subscriber	Conditional	If patient is covered by another policy then enter the patient’s relationship to the policy holder, e.g. self, spouse, mother, father, etc.
11	Other carrier name and address	Conditional	If patient is covered by another policy then enter the policy name. Address is not required.
12	Primary subscriber information – name (last, first, middle initial, suffix) address, city, state, zip code	Required	Enter the patient’s last name, first name, & middle initial as it appears on the Medicaid ID card or coupon. Do not use nicknames. Address is not required.
13	Date of Birth	Required	Month, date & year of patient's birth. It must match DOB stated on Medicaid ID card.
14	Gender	Required	Place an "X" in the appropriate box.
15	Subscriber Identifier	Required	Enter recipient's 10-digit Medicaid ID #. Include all leading zeros; do not enter a check digit.
16 – 23	Plan – Patient ID	Not Required	
24	Procedure Date	Required	Enter completion date for each service rendered.
25	Area of Oral Cavity	Not required	
26	Tooth System	Required	This box is the equivalent of the quantity/units field. Enter the # of services or visits for each procedure.
27	Tooth Number or Letters	Conditional	Used when performing procedures on specific teeth. Identify the tooth using 2-digit numeric characters for permanent teeth & a single-digit alpha character for primary teeth.
28	Tooth Surface	Conditional	When applicable, identify the proper tooth surface. Up to 4 different tooth surfaces may be indicated.
29	Procedure Code	Required	Enter the appropriate CDT-3 or CDT-4 dental procedure code & when applicable a modifier.
30	Description	Required	Provide a narrative description of the services, including materials used.
31	Fee	Required	Enter the total charge for each procedure.
32	Other Fee(s)	Not required	
33	Total Fee	Required	Enter total fees charges.
34	Missing Teeth Info	Not Required	
35	Remarks	Conditional	Used for adult emergency cases only. ICD-9-CM diagnosis code, 525.9, is used to indicate the services are for an adult emergency service. Also may be used to indicate the services are not

			covered by any other insurance carrier “Not a covered Medicare/TPL service.”

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36	Authorizations	Required	Patient's or authorized person's signature, releases any medical or other information necessary to process this claim. If signature is on file indicate “signature on file.”
37		Not required	
38	Place of treatment	Required	Place an "X" in the appropriate box.
39		Not required	
40	Is treatment for Orthodontics?	Required	Place an "X" in the appropriate box.
41 - 44	Date Appliance Paid – Date Prior Placement	Not required	
45	Treatment Resulting from	Conditional	Complete only if treatment is a result of an occupational illness or injury, an auto accident, or other accident **AND** the recipient has another insurance that will cover the services. Otherwise, leave the field blank even if the service is associated with an accident.
46	Date of Accident	Conditional	Complete only if box 45 is completed.
47	Auto Accident Date	Conditional	Complete only if box 45 is completed.
48	Billing Dentist’s Name, Address, City, Ste, Zip Code	Required	Enter provider name and complete address.
49	Provider ID	Required	Enter 8-digit provider ID # (6-base digits & 2-digit location code separated by a dash.)
50	License Number	Required	Enter the dentist’s license number.
51	SSN or TIN	Required	Dentist’s Social Security # or Tax ID #. Must use information used on enrollment form.
52	Phone Number	Not required	
53	Treating Dentist Signature	Required	Signature must be legal names. Must match authorized signature on file with provider application. May use rubber stamp of authorized signature, but it must be initialed by person authorized to sign for provider.
54	Provider ID	Conditional	Required for referrals only, enter referring provider's 8-digit Medicaid Provider ID #.

Last revised: October 4th, 2004