

# DENTAL CLAIM INSTRUCTIONS

## OVERVIEW

The following is a block-by-block explanation of how to prepare an American Dental Association (ADA) claim form when Medicaid is the primary or only payer. The ADA claim form and complete claim form instructions are available on the ADA website at <https://www.ada.org/en/publications/cdt/ada-dental-claim-form>. Mandatory blocks must be completed. Conditionally mandatory blocks must be completed if applicable. Do not put social security numbers on the claim form. For other Dental claim guidance, please refer to the [Dental Provider Manual](#).

## CLAIM SAMPLE

**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  
 BPSDT / TMA XXX

2. Predetermination/Preauthorization Number

**DENTAL BENEFIT PLAN INFORMATION**

3. Company/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    15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number    17. Employer Name

**OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)**

4. Dental?  Medicaid?  (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    8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number    10. Patient's Relationship to Person named in #5  
 Self     Spouse     Dependent Child     Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**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    23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

	24. Procedure Date (MM/DD/CCYY)	25. Area of Care (Code)	26. Tooth (Code)	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Unit/Procedure	29b. City	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. 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)    31a. Other Fee(s)

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

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. (If 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. In-office, 24-Hr Hospital)    39. Enclosures (Y or N)   
 (Use "Place of Service Codes for Professional Claims")

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 Inevitable 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

56. Address, City, State, Zip Code    55a. Provider Specialty Code

57. Phone Number    58. Additional Provider ID

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 J432 (Same as ADA Dental Claim Form - J432, J431, J433, J434, J435C)

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 or go online at [adacatalog.org](http://adacatalog.org)

## CLAIM INSTRUCTIONS

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- ITEM 1 TYPE OF TRANSACTION (MANDATORY).**  
Check the box that describes the type of claim submission.
- ITEM 2 PREDETERMINATION/PREAUTHORIZATION NUMBER (SITUATIONAL)**  
Required if you received a predetermination voucher for the services. Enter the predetermination voucher number for the services.
- ITEM 3 COMPANY/PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE**  
Optional – no entry is required.
- ITEM 4 OTHER COVERAGE (CONDITIONALLY MANDATORY)**  
Check the applicable box if the recipient has other medical or dental insurance. If checked, Items 5-11 must be completed.
- As the payer of last resort. Medicaid should be billed only after other coverage has been billed.
- ITEM 5 NAME OF POLICYHOLDER/SUBSCRIBER IN #4 (CONDITIONALLY MANDATORY)**  
If the recipient has other coverage, list the policyholder/subscriber.  
Enter as Last, First, Middle Initial, Suffix.
- ITEM 6 DATE OF BIRTH (CONDITIONALLY MANDATORY)**  
Enter the date of birth of the person listed in Item 5. Entry must be in the MM/DD/CCYY format.
- ITEM 7 GENDER (CONDITIONALLY MANDATORY)**  
Mark the gender of the person listed in Item 5. Mark “M” for Male, “F” for Female, or “U” for Unknown.
- ITEM 8 POLICYHOLDER/SUBSCRIBER ID (CONDITIONALLY MANDATORY)**  
Enter the unique identifying number assigned by the third-party payer to the person listed in Item 5.
- ITEM 9 PLAN/GROUP NUMBER (CONDITIONALLY MANDATORY)**  
Enter the group plan or policy number of the person named in Item 5.
- ITEM 10 PATIENT’S RELATIONSHIP TO PERSON NAMED IN 5 (CONDITIONALLY MANDATORY)**  
Mark the patient’s relationship to the other insured listed in Item 5.
- ITEM 11 OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN (CONDITIONALLY MANDATORY)**

Enter the complete information of the additional payer, benefit plan or entity for the insured listed in Item 5.

**ITEM 12 POLICYHOLDER/SUBSCRIBER NAME, ADDRESS, CITY, STATE, ZIP CODE (MANDATORY)**

Enter the complete name of the Medicaid recipient as it appears on the Medicaid ID Card (last name, first name, and middle initial). Do not use nicknames.

**ITEM 13 DATE OF BIRTH (MANDATORY)**

Enter the date of birth of the Medicaid recipient. Entry must be in the MM/DD/CCYY format.

**ITEM 14 GENDER (MANDATORY)**

This applies to the patient. Mark "M" for Male, "F" for Female, or "U" for Unknown.

**ITEM 15 POLICYHOLDER/SUBSCRIBER ID (MANDATORY)**

Enter the Medicaid recipient's 9-digit Medicaid Identification number.

**ITEM 16 PLAN/GROUP NUMBER (MANDATORY)**

Enter the Medicaid group number as 1900

**ITEM 17 EMPLOYER NAME (MANDATORY)**

Enter "Medicaid" as Employer name

**ITEM 18 RELATIONSHIP TO POLICYHOLDER/SUBSCRIBER IN ITEM 12 ABOVE**

Optional

**ITEM 19 RESERVED FOR FUTURE USE**

Optional

**ITEM 20 NAME, ADDRESS, CITY, STATE, ZIP CODE**

Optional

**ITEM 21 DATE OF BIRTH**

Optional. If entered, entry must be in the MM/DD/CCYY format.

**ITEM 22 GENDER**

Optional

**ITEM 23 PATIENT ID/ACCOUNT #**

Optional

**ITEM 24 PROCEDURE DATE (MANDATORY)**

Enter procedure date for actual services performed or leave blank is claim is for predetermination. Entry must be in the MM/DD/CCYY format.

**ITEM 25 AREA OF ORAL CAVITY (CONDITIONALLY MANDATORY)**

Report the area of the oral cavity when the procedure reported in Item 29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.

Area of the oral cavity is designated by a two-digit code, selected from the following code list:

Code	Area
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

**ITEM 26 TOOTH SYSTEM**  
 Optional

**ITEM 27 TOOTH NUMBER(S) OR LETTER(S) (CONDITIONALLY MANDATORY)**

Enter the appropriate tooth number or letter when the procedure directly involves a tooth.

If the same procedure is performed on more than one tooth on the same date of service, report each procedure and tooth designation on *separate lines* on the claim form

**ITEM 28 TOOTH SURFACE (CONDITIONALLY MANDATORY)**

When billing an applicable procedure code, enter the standard ADA designation of the tooth surfaces. The following single letter codes are used to identify surfaces:

Surface	Code
Buccal	B
Distal	D
Facial (or labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

Do not leave any spaces between surface designations in multiple surface restorations (e.g. MOD).

- ITEM 29      PROCEDURE CODE (MANDATORY)**  
Enter the appropriate procedure code found in the version of the code on dental procedures and Nomenclature in effect on the “procedure date” (Item 24).
- ITEM 29a      DIAGNOSIS CODE POINTER  
Optional
- ITEM 29b      QUANTITY  
Optional
- ITEM 30      DESCRIPTION (MANDATORY)**  
Enter a description of the procedure
- ITEM 31      **FEE (MANDATORY)**  
Report the dentist’s full, usual and customary fee for each procedure. Do not enter the fee from the Medicaid fee schedule.
- ITEM 31a      OTHER FEE(S) (CONDITIONALLY MANDATORY)**  
When other charges applicable to dental services provided must be reported, enter the amount here.
- ITEM 32      TOTAL FEE (MANDATORY)**  
Enter the sum of all fees listed in Item 31. This field should be completed on the last page of the claim only. Do not subtract any amount paid by other insurance.
- ITEM 33      MISSING TEETH INFORMATION (CONDITIONALLY MANDATORY)**  
Place an “X” on the letter or number of each missing tooth.
- ITEM 34      DIAGNOSIS CODE LIST QUALIFIER (CONDITIONALLY MANDATORY)**  
If a diagnosis code is entered in Item 34a, enter the appropriate code to identify the diagnosis code source. AB = ICD-10-CM.
- ITEM 34a      DIAGNOSIS CODE(S) (CONDITIONALLY MANDATORY)**  
Enter up to four applicable ICD-10 diagnosis codes. The primary diagnosis is entered adjacent to the letter “A”.
- ITEM 35      REMARKS (CONDITIONALLY MANDATORY)**  
This space may be used to convey additional information for a procedure code that requires a report to convey additional information believed necessary to process the claim. Remarks should be concise and pertinent to the claim submission.
- ITEM 36      PATIENT CONSENT

Optional

ITEM 37 AUTHORIZE DIRECT PAYMENT  
 Optional

**ITEM 38 PLACE OF TREATMENT (MANDATORY)**

Enter the 2-digit Place of Service code for Professional Claims, a HIPAA standard.

Frequently used codes are:

Code	Place of Service
03	School
11	Office
15	Mobile Unit
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility

Note: The 2-digit code entered must match the place where the service was physically provided (i.e., if the claim contains D9410 or D9420, the place of service would not be “11”).

**ITEM 39 ENCLOSURES (CONDITIONALLY MANDATORY)**

Enter a “Y” or “N” to indicate whether there are enclosures of any type included with the claim submission.

**ITEM 40 IS TREATMENT FOR ORTHODONTICS? (CONDITIONALLY MANDATORY)**

Mark the appropriate box. If yes, complete Items 41 and 42

**ITEM 41 DATE APPLIANCE PLACED (CONDITIONALLY MANDATORY)**

Enter the date an orthodontic appliance was placed. Entry must be in the MM/DD/CCYY format.

**ITEM 42 MONTHS OF TREATMENT (CONDITIONALLY MANDATORY)**

Enter the total number of months required to complete the orthodontic treatment, from the beginning to the end of the treatment plan.

**ITEM 43 REPLACEMENT OF PROSTHESIS (CONDITIONALLY MANDATORY)**

This Item applies to Crowns and all Fixed or Removable Protheses (e.g., bridges and dentures). If checked Yes, indicate the reason for replacement under Item 35 Remarks.

**ITEM 44 DATE OF PRIOR PLACEMENT (CONDITIONALLY MANDATORY)**

Required if Item 43 is marked "Yes". Enter the date of prior placement in MM/DD/CCYY format.

**ITEM 45 TREATMENT RESULTING FROM (CONDITIONALLY MANDATORY)**

If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box and complete Items 46 and 47.

**ITEM 46 DATE OF ACCIDENT (CONDITIONALLY MANDATORY)**

If applicable, enter the date on which the accident noted in Item 45 occurred.

**ITEM 47 AUTO ACCIDENT STATE (CONDITIONALLY MANDATORY)**

If applicable, enter the state in which the auto accident noted in Item 45 occurred.

**ITEM 48 BILLING DENTIST NAME, ADDRESS, CITY, STATE. ZIP CODE (MANDATORY)**

Enter the name and complete address of the billing dentist or the billing entity.

Note: the address must contain the zip code associated with the billing dentist/entity's NPI. The zip code must match the zip code confirmed during NPI verification.

**ITEM 49 BILLING DENTIST NPI (MANDATORY)**

Enter the NPI of the billing entity.

**ITEM 50 BILLING DENTIST LICENSE NUMBER**

Optional

**ITEM 51 BILLING DENTIST SSN OR TIN (MANDATORY)**

Enter the TIN of the billing entity.

**ITEM 52 BILLING DENTIST PHONE NUMBER**

Optional

**ITEM 52a ADDITIONAL PROVIDER ID**

Optional

**ITEM 53 TREATING DENTIST SIGNATURE (MANDATORY)**

Enter the name of the treating dentist and the date the form is signed.

**ITEM 54 TREATING DENTIST NPI (MANDATORY)**

Enter the individual NPI of the treating dentist.

**ITEM 55 TREATING DENTIST LICENSE NUMBER (MANDATORY)**

Enter the license number of the treating dentist.

**ITEM 56 TREATING DENTIST ADDRESS, CITY, STATE. ZIP CODE (MANDATORY)**

Enter the physical location where the treatment was rendered. Must be a street address and address must match an address associated with the provider during SD Medicaid provider enrollment.

**ITEM 56a PROVIDER SPECIALTY CODE (MANDATORY)**

Enter the taxonomy code associated with the billing entity's NPI. The taxonomy code entered must match the taxonomy code associated with the billing provider during SD Medicaid provider enrollment.

ITEM 57 BILLING DENTIST PHONE NUMBER  
Optional

ITEM 58 ADDITIONAL PROVIDER ID  
Optional

## QUICK ANSWERS

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**1. Do I have to use the 2018 version of the ADA Claim Form?**

The use of the 2018 ADA Claim Form is recommended, but not required. The Dental Vendor accepts all versions of the ADA claim form or claim forms developed by provider offices as long as all mandatory information is submitted.

**2. Where do I find my taxonomy number?**

When completing claims for a Medicaid recipient, the provider should use the same taxonomy number used to complete provider enrollment with South Dakota Medicaid in SDMEDX.

**3. Do I need to enroll with South Dakota Medicaid in order to submit a claim?**

Yes, a dentist must be enrolled with South Dakota Medicaid in order to be reimbursed for services provided to a South Dakota Medicaid recipient.

**4. The dental hygienist in our office has an Individual NPI, can I list that NPI in Item 54?**

No, hygienists cannot be considered the treating dentist. Services rendered by a hygienist must be submitted under the supervising dentist's NPI number.