

Detailed Instructions for Submitting a Dental Claim Form

The American Academy of Periodontology encourages the use of the current American Dental Association Dental Claim Form for paper claims. Electronic claims must be submitted using the HIPAA-standard claim (ANSI ASC X12N Transaction Set 837) and must be accepted by all third party payers. [Click here](#) for a sample of the Dental Claim Form or visit the [ADA's website](#) for more information. Forms can be purchased from the ADA or from dental form suppliers. It also may be included in dental software packages. To facilitate accurate reporting and processing of claims for dental treatment, the Academy encourages using the most recent version of the ADA's Code on Dental Procedures and Nomenclature. Use of an earlier version may result in the claim being denied or returned for correction by the carrier.

Forms provided to the patient by his/her carrier will be very similar to the ADA Dental Claim Form. Most government agencies, such as Medicaid, accept the standard ADA Dental Claim Form, although some still may require their own forms. Medicare claims must be submitted on a medical form (CMS-1500 (2-12)). Use of the Dental Claim Form in lieu of forms provided by these agencies will result in undue delays in processing and may even result in non-payment of the claim.

Section 36 of the Dental Claim Form authorizes release to the carrier of information relating to the claim. In that section, the patient also agrees "to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges." This statement becomes very important if a dispute over payment of fees arises between a third party carrier and a dentist. Box 1 on the Dental Claim Form should be completed to indicate whether the claim reports actual services or is a request for predetermination of benefits or both.

Claims for periodontal services should include the following information:

1. A list of the treatment(s) performed or planned, identified by proper code number. Appropriate codes and their descriptors may be obtained from the ADA CDT Code Book or [the Periodontal Codes on AAP Connect](#).
2. The actual fee for each procedure.

Reasons for unusual fees (higher or lower) should be noted on the Dental Claim Form in Section 35 (Remarks) or attached to the form. This section also should be used for brief, patient-specific narratives to describe "by report" codes and to provide treatment rationales (e.g., crown lengthening, soft tissue grafts) when the dentist feels such information will aid in proper adjudication of the claim. Even though that is its purpose, some carriers' data entry facilities are not able to transmit information contained in the Remarks section to consultants so it is better to attach the narrative to the paper claim form. That should not be a problem with electronic claims.

All procedures should be reported and benefited as accurately as possible. Any significant variation from the therapy described by a code should be reported in Section 35 of the Dental Claim Form. If the third party payer changes a procedure code reported by a dentist, the Explanation of Benefits (EOB) should clearly note such change and explain the reasons for it.

Dentist's Pretreatment Estimate

Predetermination of benefits allows the patient to determine how much financial assistance he/she can expect from the dental plan for the proposed treatment. Some carriers do not predetermine benefits, while others require it. Failure to predetermine benefits when required can result in denial of payment by the carrier. A predetermination of benefits is not an absolute commitment by a third party that the estimated payment will be made.

A written predetermination of benefits should be returned to the dentist by the carrier indicating those services covered by the plan, the benefit provided for each service, and the total estimated financial responsibility of both patient and carrier, taking into account deductibles, coinsurance, and yearly maximum.

Dentist's Statement of Actual Services

When submitting a claim for completed services, dates of treatment must be provided. This is essential because almost all plans have limitations relative to the effective date of coverage and annual maximum benefits. The patient must sign claim forms requesting payment of benefits to the dentist. Possession of a valid "signature on file" may be noted instead. The dentist also must sign the form certifying that the procedures have been completed.

The following is a step-by-step explanation of what information should be included in "Record of Services Provided" (Sections 24-58) of the Dental Claim Form:

24: The dates of services, if the services have been provided (Section 24)

25-26: The area of the oral cavity and tooth system where the procedure was performed:
JP for individual tooth submissions or JO for quadrant submissions

27: Tooth numbers or letters where the procedure was performed

28: Tooth surface

29: Current procedural codes to report the services to be performed

29a: ICD-9 Diagnosis Medical code (optional)

30: Description of procedure

31: The actual fee for each service performed

32: Total Fee

33: Missing teeth

34: Diagnosis Code List Qualifier:
ICD-9 = B; ICD-10 = AB

34a: Diagnosis Code(s):
Primary diagnosis in box A

35: Additional remarks

36: Patient Consent:

By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, the costs of treatment, and the release of any information necessary to carry out payment activities related to the claim.

37: Authorize Direct Payment:

The signature and date (or Signature on File" notice) are required when the Policyholder/Subscriber named in item 12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment.

38: Place of Treatment

39: Enclosures:

Number of attachments that are being submitted

40: Is Treatment for Orthodontics?

If no, skip 41-42; if yes, complete 41-42.

43: Replacement of Prosthesis:

No or Yes (complete 44)

45: Treatment Resulting from Occupational illness/injury; Auto accident; Other accident:

If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to items 46 and 47. If the services you are providing are not the result of an accident, this item does not apply; skip to item 48.

48: Billing Dentist or Dental Entity:

- Name
- Address
- City
- State
- Zip Code

49: Billing Dentist Provider Number (NPI):

Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice, or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.

50: License Number:

If the billing dentist is an individual, enter the dentist's license number. If a billing entity (e.g., corporation) is submitting the claim, leave blank.

51: Social Security or TIN Number:

Report the: 1) SSN or TIN if the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.

52: Phone Number:

Enter the business phone number of the billing dentist or dental entity.

52a: If you have additional Provider ID:

This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

53: Certification:

Signature of the treating or rendering dentist and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form. Dentists should be aware that they have an ethical and legal obligation to refund fees for services that are paid in advance but are not completed.

Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this item.

54: NPI (National Provider Identifier):

Enter the treating dentist's Type 1 – Individual Provider NPI in Item 54.

55: License Number:

Enter the license number of the treating dentist. This may vary from the billing dentist.

56: Address, City, State, Zip Code:

Enter the physical location where the treatment was rendered. This must be a street address, not a Post Office Box.

56a. Provider Specialty Code:

Enter the Provider Specialty code that indicates the type of dental professional who delivered the treatment. The specialty code for Periodontics is: 1223PO300X

57: Phone Number:

Enter the business telephone number of the treating dentist.

58: Additional Provider ID:

This is an identifier assigned to the treating dentist other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI.

Transactions and Code Sets

It is important to note that any dental practice that electronically sends or receives certain transactions must send or receive the information in a standard format. Dental practices must be sure that the clearinghouse they are using is HIPAA compliant. It is important to ask whether these changes will be made as part of a maintenance contract or if there will be additional charges for the service. Another important point to note is that all dentists will still be able to submit paper claims to a benefit carrier; however, if you submit even a single electronic transaction, you must comply with HIPAA standards or possibly face fines for non-compliance.

International Standards Organization System

The ADA recognizes two major systems used for tooth numbering:

- Universal/National system which is used primarily in the United States
- International Standards Organization System (ANSI/ADA/ISO Specification No. 3950 – 1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity), which is used in many countries outside the USA. Utilization of these designation systems began in conjunction with the onset of HIPAA compliance regulations and became mandatory on October 16, 2003 for all electronic or paper claims submitted to a benefit carrier.

Under the Universal/National System, a number from 1 to 32 identifies each tooth in sequential order across both arches with 1 being the patient's upper right third molar and 16 the upper left third molar. In the lower arch, 17 identifies the lower left third molar and 32 the patient's lower right third molar.

The International Standards Organization System (ANSI/ADA/ISO) identifies areas of the oral cavity as well as individual teeth and sextants.

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| 00 | Designates the whole area of the oral cavity |
| 01 | Designates the maxillary area |
| 02 | Designates the mandibular area |
| 10 | Designates the upper right quadrant |
| 20 | Designates the upper left quadrant |
| 30 | Designates the lower left quadrant |
| 40 | Designates the lower right quadrant |

Sextant designations should not be used for periodontal procedures, as they are based on single teeth or quadrants.

National Provider Identifier (NPI)

Effective May 23, 2007, all dentists who use standard electronic transactions such as electronic claims, eligibility verifications, claims status inquiries, and claim attachments, even if they use billing services to prepare the transactions, must include their NPI on those transactions. All health plans require NPIs on all claims. Some states also may require use of an NPI on prescriptions even though federal law does not require their use.

- Once implemented throughout the health care industry, the same NPI will be accepted by all dental plans as a valid provider on all standard electronic transactions.
- A single NPI will identify each dentist regardless of office location.
- Incorporated dentists or dentists billing under a partnership should obtain two NPIs: one for themselves and another for the billing entity.
- Dental plans no longer can require arbitrary identifiers.
- This standardization of electronic transactions should improve acceptance rates and speed their processing.

The National Provider Identifier does not

- Replace the DEA number used when prescribing controlled substances or other DEA-related activities.
- Replace state-issued licenses and certifications verifying a dentist's licensing or qualifications.
- Replace the Social Security Number (SSN), Tax Identification Number (TIN), or Employer Identification Number (EID) for tax purposes.

Additional information about NPIs may be obtained at <https://nppes.cms.hhs.gov> or by calling the NPI Enumerator at 1-800-465-3203.