Use of Medical Codes

Patients often request that periodontal services be reported to their medical insurance carrier, particularly when no dental benefits are available. Most medical plans have no annual maximum, or it is many times greater than that of the dental plan, so benefits are perceived to be much greater, but the deductible under the medical plan may be several thousand dollars rather than the lower amounts typically seen in dental plans. In addition, some dental benefit contracts require that periodontal surgical claims be submitted to the medical plan before they are adjudicated by the dental plan because of contract language with the plans.

Submission of claims for dental services to both medical and dental carriers is neither illegal nor unethical, as long as the services and fees match on each claim. When submitting to medical insurance utilize *Current Procedural Terminology (CPT*) codes whenever possible. If submitting a medical claim, you can call the AAP Third Party Specialist for assistance with finding appropriate medical codes at 800/282-4867 ext. 3241. Note that this guidance is not a substitute for *CPT* or ICD-10 CM medical coding systems; therefore the Academy cannot be held responsible for any misuse or misinterpretation of the information provided. When there is no appropriate CPT code, the American Dental Association *Current Dental Terminology (CDT)* codes may be used, if the medical carrier accepts ADA dental codes . These procedure codes, without narrative descriptors, should be listed in Section 24D of the CMS 1500 medical claim form.

Inappropriate use of CPT codes to report dental procedures to the patient's medical carrier or omission of pertinent facts about other coverage **is** illegal and unethical. When some periodontal procedures are covered under the patient's medical plan, claims may be filed concurrently with dental and medical carriers.
Medical claims must be submitted using the revised (2/12) CMS-1500 form. The form and instructions for its completion may be obtained at the National Uniform Claim Committee web site, at www.nucc.org.

Since diagnosis codes and procedure codes drive reimbursement, ICD-10-CM diagnostic codes must be entered in Item 21. Up to twelve diagnoses may be entered and must be related to the lines of service in Item 24E by line number, using the highest level of specificity. Do not provide a narrative description in this field. See the medical template file. A number of periodontal diagnostic codes appear in the current edition of the *International Classification of Diseases* (ICD-10-CM). Relevant medical conditions such as diabetes and cardiovascular disease, which would be received from their medical physician, also can be entered on these lines if applicable

Below is a listing of ICD-10-CM Diagnosis Codes related to periodontal conditions.

Disorders of tooth development and eruption

K00.0 – Anodontia
Absence of teeth (complete), (congenital) and (partial)

K00.6 – Disturbances of tooth eruption
Teeth embedded, impacted

Other specific diseases of hard tissues of teeth

K03.81 – Cracked tooth

S02.5xxA – Tooth (broken) (fractured) (due to trauma)

Diseases of pulp and periapical tissues

K04.7 – Periapical abscess without sinus
Abscess:
dental
dentoalveolar

K04.6 – Periapical abscess with sinus
Fistula:
alveolar process
dental

Gingival and periodontal diseases

K05.00 – Acute gingivitis, plaque induced
K05.01 – Acute gingivitis, non-plaque induced

K05.10 – Chronic gingivitis, plaque induced
K05.11 – Chronic gingivitis, non-plaque induced

Gingival recession

K06.0 for all gingival recession
Gingival recession, unspecified (narrative needed)
Gingival recession, minimal
Gingival recession, moderate
Gingival recession, severe
Gingival recession, localized
Gingival recession, generalized

Aggressive and acute periodontitis

K05.20 – Aggressive periodontitis, unspecified (narrative needed)
K05.21 – Aggressive periodontitis, localized
K05.22 – Aggressive periodontitis, generalized

Chronic periodontitis

K05.30 – Chronic periodontitis, unspecified (narrative needed)
K05.31 – Chronic periodontitis, localized
K05.32 – Chronic periodontitis, generalized

K03.6 – Accretions on teeth
Dental calculus:
subgingival
supragingival

Accessory muscle attachment, buccal frenum pull

Q79.8

Anxiety
F41.9

Bisphosphonate related osteonecrosis of the jaw
M87.180

Cancer chemotherapy history
Z92.21

Chronic obstructive pulmonary disease (COPD)
J44.9

Major anomalies of jaw size

M26.01 – Maxillary hyperplasia
M26.03 – Mandibular hyperplasia

Anomalies of tooth position of fully erupted teeth

M26.32 – Diastema of teeth
M26.31 – Crowding of teeth
M26.32 – Excessive spacing of teeth
M26.33 – Horizontal displacement of teeth
M26.34 – Vertical displacement of teeth
Q38.1 – Tongue-tied

Dental caries – Chewing surface
K02.51 – Limited to enamel
K02.52 - Penetrating into dentin
K02.53 - Penetrating into pulp

Dental caries – Root
K02.61 – Limited to enamel
K02.62 – Penetrating into dentin
K02.63 – Penetrating into pulp

Diabetes
O24.419 – Gestational
E10.638 – Type 1 with oral complication
E10.630 – Type 1 with periodontal disease
E11.638 – Type 2 with oral complication
E11.630 – Type 2 with periodontal disease

Heart failure (congestive)
I50.9

Kidney disease
N28.9

N18.9 Chronic

Mucocele, salivary gland
K11.6

Rheumatic heart disease
I09.9

Seizure disorder
G40.909

Sleep apnea
G47.30
Obstructive
G47.33

Sore mouth
K13.79

Toothache
K08.8

Other Diseases and Conditions of the Teeth and Supporting Structures

K08.111 – Complete loss of teeth due to trauma, class I
K08.112 – Complete loss of teeth due to trauma, class II
K08.113 – Complete loss of teeth due to trauma, class III
K08.114 – Complete loss of teeth due to trauma, class IV

K08.121 – Complete loss of teeth due to periodontal disease, class I
K08.122 – Complete loss of teeth due to periodontal disease, class II
K08.123 – Complete loss of teeth due to periodontal disease, class III
K08.124 – Complete loss of teeth due to periodontal disease, class IV

K08.131 – Complete loss of teeth due to caries, class I
K08.132 – Complete loss of teeth due to caries, class II
K08.133 – Complete loss of teeth due to caries, class III
K08.134 – Complete loss of teeth due to caries, class IV

K08.411 – Partial edentulism due to trauma, class I
K08.412 – Partial edentulism due to trauma, class II
K08.413 – Partial edentulism due to trauma, class III
K08.414 – Partial edentulism due to trauma, class IV

K08.421 – Partial edentulism due to periodontal disease, class I
K08.422 – Partial edentulism due to periodontal disease, class II
K08.423 – Partial edentulism due to periodontal disease, class III
K08.424 – Partial edentulism due to periodontal disease, class IV

K08.431 – Partial edentulism due to caries, class I
K08.432 – Partial edentulism due to caries, class II

K08.433 – Partial edentulism due to caries, class III
K08.434 – Partial edentulism due to caries, class IV

Atrophy of edentulous alveolar ridge

K08.21 – Minimal atrophy of the mandible
K08.22 – Moderate atrophy of the mandible
K08.23 – Severe atrophy of the mandible

K08.24 – Minimal atrophy of the maxilla
K08.25 – Moderate atrophy of the maxilla
K08.26 – Severe atrophy of the maxilla

Endosseous dental implant failure

M27.61 – Ossesintegration failure of dental implant
Due to:
Complications of systemic disease, and infection

M27.62 – Post-osseointegration biological failure of dental implant
Due to:
Lack of attached gingiva, and occlusal trauma

Additional Endosseous Implant Failure Codes

M27.63 – Post-osseointegration mechanical failure of dental implant
Due to:
Failure of dental prosthesis causing loss of dental implant
Fracture of dental implant
Mechanical failure of dental implant

M27.69 – Other endosseous implant failure (narrative needed)
Dental implant failure

K08.8 or M26.79 – Other specified disorders of the teeth and supporting structures
Enlargement of alveolar ridge
Irregular alveolar process

M27.8 – Exostosis of jaw
Torus mandibularis
Torus palatinus

Medical CPT Codes

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41800 – Drainage of abscess, cyst, hematoma from dentoalveolar structures
41820 – Gingivectomy – excision gingiva, each quadrant
40819 – Excision of frenum, labial or buccal
41115 – Excision of lingual frenum
41828 – Excision of hyperplastic alveolar mucosa, each quadrant
41870 – Periodontal mucosal grafting
41872 – Gingivoplasty, each quadrant
21210 – Graft, bone; nasal maxillary or malar areas (includes obtaining graft)
21215 – Graft, mandibular or mandible (includes obtaining graft)
21046 – Excision of benign tumor or cyst of mandible, requiring intra-oral osteotomy
70300 – Radiologic examination, teeth; single view
70310 – Radiologic examination, teeth; partial examination, less than full mouth
70320 – Radiologic examination, teeth; complete, full mouth
70355 – Orthopantogram
70486 – Computed tomography, maxillofacial area; without contrast material
76376 – 3d rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post processing or an independent workstation.
21248 – Reconstruction of mandible, or maxilla endosteal implant, partial
21249 – Reconstruction of mandible, or maxilla endosteal implant, complete
41822 – Excision of fibrous tuberosities dentoalveolar structure
99144 – Moderate sedation services first 30 minutes
99145 – Each additional 15 minutes
40808 – Biopsy, vestibule of mouth
41108 – Biopsy of floor of mouth
42100 – Biopsy of palate, uvula
11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure) unless otherwise listed; single lesion
21031 – Excision of torus mandibularis
21032 – Excision of maxillary torus palatines
41899 – Unlisted procedure, dentoalveolar structures, (with narrative)

CPT Evaluation Codes
Here is a description in how to utilize the CPT Evaluation Codes:

- **New** – Patient, referred by another patient or has been away from the practice for more than 2 years.
- **Established –** Patient with an ongoing relationship with the practice.

All exams and consults start with the numbers "992__"
New Patient – **99201-99205**
Established Patient – **99211-99215**
FIFTH digit reflects the LEVEL of Difficulty, NUMBER of Areas involved, and the TIME it takes to make a Diagnosis:

- 1 = **brief, simple**
- 2 = **expanded**
- 3 = **detailed**
- 4 = **comprehensive**
- 5 = **extensive, difficult**

BRIEF EXAM – last digit is a "1"

- Problem focused
- Straightforward
- Self-limited or minor severity
- New patient – **99201**
- Established patient – **99211**

EXPANDED EXAM – last digit is a "2"

- Low to moderate severity
- Straightforward diagnosis
- New patient – **99202**
- Established patient – **99212**

DETAILED EXAM – last digit is a "3"

- Expanded, problem focused
- Moderate severity
- New patient – **99203**
- Established patient – **99213**

DETAILED/COMPREHENSIVE EXAM – Last digit is a "4"

- Moderate decision making
- Moderate to high severity
- New patient – **99204**
- Established patient – **99214**

COMPREHENSIVE EXAM – last digit is a "5"

- High decision making
- Moderate to high severity
- New patient – **99205**
- Established patient – **99215**

V, W, X and Y CODES

Purpose: To report external factor that caused patient's condition

- Secondary codes
- Injury, trauma, adverse reaction to therapeutic drug
- No effect on reimbursement level

Z CODES

Purpose: To validate a diagnosis. To report a condition affecting patient's health status

- Secondary codes

MODIFIERS

To alter the procedure code without changing the definition of procedure

- Attach to procedure code with a hyphen

LIST OF MODIFIERS

- **-22** Increased procedural services – When the work required to provide a service is substantially greater than typically required
- **-25** Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service
- **-47** Anesthesia by surgeon
- **-50** Bilateral procedure (same procedure done on both sides of the same jaw)
- **-51** Multiple surgical procedures
- **-52** Reduced services
- **-57** An E/M service that resulted in the initial decision to perform the surgery
- **-59** Main procedure, different site

MEDICARE MODIFIERS

- **GY –** The GY modifier is reported in addition to the CPT code on a Medicare claim to show that the item or service is statutorily excluded or does not meet the definition of any Medicare benefit. This should be used when a Medicare patient insists that a statutorily excluded routine dental service be submitted to Medicare

- **GJ –** The GJ modifier is reported in addition to the CPT code on a Medicare claim to indicate that an opt-out provider is submitting a claim for services that were performed in an emergency or urgent care situation.

CMS-1500 Medical Claim Form Instructions

(Copy of Medical claim form at nucc.org)

Item 1: Show the type of health insurance coverage applicable to the claim by placing an X in the appropriate box. Only one box can be marked.

Item 1a: Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted.

Item 2: Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt. Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the same name.

Item 3: Enter the patient's 8-digit birth date (MM/DD/YYYY) Enter an X in the correct box to indicate sex (gender) of the patient. Only one box can be marked.

Item 4: Enter the insured"s full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

For Workers Compensation Claims: Enter the name of the Employer

Item 5: Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street) When entering a 9-digit ZIP code, include the hyphen.

If the patient's address is the same as the insured's address, then it is not necessary to report the patient's address.

Item 6: Enter an X in the correct box to indicate the patient's relationship to insured when item Number 4 is completed. Only one box can be marked.

The "Patient Relationship to Insured" indicates how the patient is related to the insured. "Self" would indicate that the insured is the patient. "Spouse" would indicate that the patient is the husband or wife or qualified partner, as defined by the insured's plan. "Child" would indicate that the patient is the minor dependent, as defined by the insured's plan. "Other" would indicate that the patient is other than the self, spouse, or child, which may include employee, ward, or dependent, as defined by the insured's plan.

Item 7: Enter the insured's address. If Item Number 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street) when entering a 9-digit ZIP code, include the hyphen.

The "Insured's Address" is the insured's permanent residence, which may be different from the patient's address in Item Number 5.

Item 8: Leave Blank

Item 9: If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Item 9a: Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number.

Item 9b: Leave Blank

Item: 9c: Leave Blank

Item 9d: Enter the other insured's insurance plan or program name.

Item 10a-c: When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked.

The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident". Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.

This information indicates whether the patient's illness or injury is related to employment, auto accident, or other accident. "Employment (current or previous)" would indicate that the condition is the result of an automobile accident. "Other accident" would indicate that the condition is the result of any other type of accident.

Item 10d: Leave Blank

Item 11: Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item Number 4 is completed, then this field should be completed. Do not use a hyphen or space as a separator within the policy or group number.

Item 11a: Insured's Date of Birth, Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

Item 11b: Leave Blank

Item 11c: Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field.

Item 11d: "Is there another Health Benefit Plan? When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.

Item 12: Enter "Signature on File," SOF, or legal signature. When legal signature, enter date signed in 6-digit (MM/DD/YY) or 8-digit format (MM/DD/YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File".

The "Patient's or Authorized Person's Signature" indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.

Item 13: Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File."

The "Insured's or Authorized Person's Signature" indicates that there is a signature on file authorizing payment of medical benefits.

Item 14: N/A

Item 15: Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) format. Enter the qualifier between the left-hand set of vertical, dotted lines.

454 – Initial Treatment
304 – Latest Visit or Consultation
453 – Acute Manifestation of a Chronic Condition
439 – Accident
455 – Last X-ray
471 – Prescription
090 – Report Start (Assumed Care Date)
091 – Report End (Relinguished Care Date)
444 – First Visit or Consultation

Item 16: Dates Patient unable to work in current condition, If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date must be shown for the

“from-to” dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Item 17: Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply (ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN – Referring Provider
DK – Ordering Provider
DQ – Supervising Provider

Enter the qualifier to the left of the vertical, dotted line.

The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service (s) or supply (ies) on the claim. The qualifier indicates the role of the provider being reported.

Item 17a: The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

OB – State License Number
1G – Provider UPIN Number
G2 – Provider Commercial Number
LU – Location Number (This qualifier is used for Supervising Provider only).

The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code.

Item 17b: Enter the NPI of the referring/ordering, or supervising provider in item 17b.

Item 18: Hospitalization Dates Related to Current Services Enter the in patient 6-digit (MM/DD/YY or 8-digit (MM/DD/YYYY) hospital admission date followed by the discharge date (if discharge has occurred). This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19: Additional Claim Information: Please refer to the most current instructions from the public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field. If identifiers are reported in this field, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and the number.

The NUCC defines the following qualifiers used in 5010A1:

OB	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (This qualifier is used for Supervising Provider only).
N5	Provider Plan Network Identification Number
SY	Social Security Number (The social security number may not be used for Medicare).
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.

Item 20: Outside lab

If the lab is billing the office – a charge is indicated here. Enter the amount in the field to the LEFT of the vertical line. Use 00 for the cents if the amount is a whole number. Leave the right-hand field BLANK next to the "$ Charges" column. Do not use commas, decimal points, or dollar signs. i.e., $95.00 should be stated as 9500 to the LEFT of the vertical line.

Item 21: Diagnosis or Nature of Illness or Injury:

Enter the applicable ICD indicator to identify which version of ICD codes is being reported;

9	ICD-9-CM
0	ICD-10-CM

Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

Item 22: Resubmission and/or Original Reference Number:

List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field (e.g., code).

When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

7	Replacement of prior claim
8	Void/cancel of prior claim

This Item Number is not intended for use for original claim submissions.

"Resubmission" means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

Item 23: Prior Authorization Number:

The "Prior Authorization Number" is the payer assigned number authorizing the service(s).

Do not enter hyphens or spaces within the number.

Item 24:

The top area of the six service lines is shaded and is the location for reporting supplemental information.

Item 24a: Enter date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under "From". Leave "To" blank or re-enter "From" date. In the shaded area on this line item if necessary, add the tooth numbers and areas of the oral cavity with the applicable qualifier JO – area of the oral cavity or JP – individual tooth submissions. Do not enter a space or hyphen between the qualifier and the number/code/ information.

Item 24b: Place of Service, 11 – Office

Item 24c: Emergency Treatment – Check with the payer to determine if this information (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field.

Item 24d: Enter the appropriate CPT or HCPCS code. You can submit up to four modifiers, if needed. If you are submitting a 41899, which is an unspecified code a narrative is required, either in box 19 or as a separate attachment.

Item 24e: Enter the diagnosis code reference numbers from Item 21. If more than one diagnosis code relates to that line item submit as A-L. When multiple services are performed, the primary diagnosis code is submitted first.

Enter letters justified in the field. Do not use commas between the letters.

Item 24f: Enter the charge for each listed service. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Item 24g: Enter the number of days or units. If you are treating two teeth, submit 2 in this field. Example: CPT code 41870, periodontal mucosal grafting, treated teeth 3, 4, 5. The number 3 would go in this field.

Item 24h: Enter N (No) in this field. This related to Family Planning.

Item 24i: This line should be left blank. All AAP members have NPI Numbers.

Item 24j: Enter the rendering provider's NPI number in the non-shaded area.i.

Item 25: Enter the provider of service or supplier Federal Tax I.D. (Employer Tax Identification number or Social Security Number) and check the appropriate box. **Only one box can be marked.**

Item 26: Patient Account Number, enter the patient's account number assigned by the provider. This field is optional if the provider does not assign patient account numbers. Do not enter hyphens with numbers.

Item 27: Accept assignment, check the appropriate block to indicate whether the provider of service accepts assignment of benefits. **Check no if you do not accept assignment of benefits.**

Item 28: Enter total charges for the services (total of all charges in item 24f). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Item 29: Enter total amount the patient and/or other payers paid on the covered services only. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Item 30: Leave blank

Item 31: Enter the signature of the provider, and the date signed. "Signature on File", "SOF". Enter either the 6-digit date (MM/DD/YY, 8-digit date (MM/DD/YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

Item 32: Enter the name, address, city, state and zip code of the location where the services were rendered.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code, including the hyphen.

Item 32a: Enter the NPI number of the service facility location in 32a.

Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

Item 32b: Leave Blank

Item 33: Enter the provider's or supplier's billing name, address, zip code, and telephone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

1st Line – Name
2nd Line – Address
3rd Line – City, State and ZIP code

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.

Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code, including the hyphen. Do not use a hyphen or space as a separator within the telephone number.

Item 33a: Enter the NPI of the billing provider or group

Item 33b: Leave Blank