April 2017

ND Health Enterprise MMIS ADA-Dental Claim Form Instructions

These instructions address the North Dakota Health Enterprise MMIS paper claim requirements.

You must be an enrolled ND Medicaid provider to submit a claim. If you are not an enrolled provider, you can apply at: https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment.

Enrollment instructions, updates, billing manuals, and companion guides are available online at http://www.nd.gov/dhs/info/mmis.html.

Questions

If you have any questions, please call the ND Health Enterprise MMIS Call Center at 1-877-328-7098.

Claims Mailing Address

ND Department of Human
Services Medical Services Division
Department 325
600 East Boulevard Ave
Bismarck, ND 58505-0250

Field Requirement Definitions

Required

Fields marked **Required** in the claim form instructions are required on all paper claim submissions. The claim will be denied if a **Required** field is incomplete.

Not Required

Fields marked Not Required are not used in processing the claim. Providers are free to populate the field if desired.

Recommended

Fields marked Recommended are not required, but will be returned with the provider's remittance advice if supplied on the claim. For example, if the provider's in-house patient account number is provided, it will be returned on the remittance advice, thereby allowing billing staff to cross reference the claim with the provider's records.

Situational

Fields marked *Situational* are required when they apply to the claim

Field	Requirement	Field Name and Description
1	**Required**	Type of Transaction: Check statement of actual services. Also check EPSDT/Title XIX box if this claim is for a member under age 21.
2	*Situational*	Predetermination/Preauthorization Number: Enter the 12-digit authorization number if you are submitting a claim for a service that was prior authorized. Only enter one authorization number per claim form.
3	Not Required	Company/Plan Name, Address, City, State, ZIP Code
4	*Situational*	Other Coverage: Mark the box after "Dental" if a member has coverage under any other dental plan. When the dental box is marked, complete Fields 5 through 11.
5	*Situational*	Name of Policyholder/Subscriber with other Coverage Indicated in #4 (Last, First, Middle Initial): If the member has other coverage through a spouse, or if a child through both parents, enter the name of the policyholder of the other coverage.
6	*Situational*	Date of Birth (MM/DD/YYYY): If there is TPL, enter the birth date of the policyholder.
7	*Situational*	Gender: If there is TPL, mark the appropriate box to specify the policyholder's gender.
8	*Situational*	Policyholder/Subscriber Identifier (SSN or ID#): If there is TPL, enter the policyholder's unique identifier for that policy.
9	*Situational*	Plan/Group Number: Enter the group plan/policy number of the person named in Field 5.
10	*Situational*	Patient's Relationship to Person Named in Field 5: Mark the relationship of the member to the policyholder identified in Field 5.
11	*Situational*	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, and ZIP Code: If the member has dental insurance, enter the name and address of the other carrier.
12	**Required**	Subscriber/Policyholder name (Last, First, Middle Initial), Address, City, State, and ZIP Code: Enter the member's full name and complete address.
13	**Required**	Date of Birth (MM/DD/YYYY): Enter the member's birth date.
14	**Required**	Gender: Mark the appropriate box to specify the member's gender.
15	**Required**	Policyholder/Subscriber Identifier (SSN or ID#): Enter the member's 9-digit member ID. Do Not include punctuation on Member ID
16	Not Required	Plan/Group number
17	Not Required	Employer Name
18	Not Required	Relationship to policyholder/subscriber in Field 12 above

19	Not Required	Reserved for future use
20	Not Required	Name (Last, First, Middle Initial), Address, City, State, ZIP Code
21	Not Required	Date of Birth (MM/DD/YYYY)
22	Not Required	Gender
23	Recommended	Patient ID/Account #: Enter the member's unique control number assigned by the provider (internal patient account number).
24	**Required**	Procedure Date (MM/DD/YYYY): Enter the date the service was provided.
25	*Situational*	Are of Oral Cavity: Enter the quadrant when applicable. Ex: 10, 20, 30, 40.
26	Not Required	Tooth System
27	*Situational*	Tooth Number(s) or Letter(s): • When the procedure directly involves a tooth or range of teeth, enter tooth number(s) 1-32 for permanent dentition, 51-82 for supernumerary teeth, A-T for primary dentition or AS-TS for primary supernumerary teeth. • If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. • When reporting a range of teeth, use a hyphen "-"to separate the first and last tooth in the range (e.g., 1-4, 7-10, 22-27), or use commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). Do not to use tooth #33 (Whole Mouth).
28	*Situational*	Tooth Surface: Enter a tooth surface code. The following single letter codes are used to identify surfaces: B for Buccal, D for Distal, F for Facial, I for Incisal, L for Lingual, M for Mesial and O for Occlusal. Do not use tooth surface A or S.
29	**Required**	Procedure Code: Enter the appropriate procedure code for the service provided.
29a	Not Required	Diagnosis Pointer: Enter the diagnosis pointer (A-D) on this claim line for diagnosis codes entered in Field 34a.
29b	Not Required	Quantity
30	**Required**	Description of Service
31	**Required**	Fee: Enter your usual and customary charge for the procedure on each claim line.
31a	*Situational*	Other Fee(s): Enter the exact TPL payment (do not include contractual write-offs).

32	**Required**	Total Fee: Single page claim or last page of a multi-page claim. • If Medicaid is primary; enter the amount of total covered charges for all pages on Line A. • If there is TPL, enter the total charges less prior payment. Do not include write-off or contractual adjustment amounts.
33	Not Required	Missing Teeth Information
34	Not Required	Diagnosis Code List Qualifier
34a	Not Required	Diagnosis Code(s): Enter up to 4 applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered adjacent to the letter "A".
35	*Situational*	Remarks: Field is used to submit a Void or Replacement claim. Complete this Field to replace or void a previously paid claim. Otherwise, leave this Field blank. See Void and Replace information on page 7.
36	Not Required	Patient/Guardian Signature, Date
37	Not Required	Subscriber Signature, Date
38	**Required**	Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims. Frequently used codes are 11 = office; 12 = home; 21 = inpatient hospital; 22 = outpatient hospital; 31 = skilled nursing facility; 32 = nursing facility.
39	Not Required	Number of enclosures
40	Not Required	Is Treatment for Orthodontics?
41	Not Required	Date Appliance Placed (MM/DD/YYYY)
42	Not Required	Months of Treatment Remaining
43	Not Required	Replacement of Prosthesis
44	Not Required	Date Prior Placement (MM/DD/YYYY)
45	*Situational*	Treatment Resulting From: If treatment/services were provided as a result of an occupational illness/injury, auto accident, or other accident, check the appropriate box and complete Field 46. If treatment is a result of an auto accident, also complete Field 47.
46	*Situational*	Date of Accident (MM/DD/YYYY): Enter the date on which the accident noted in Field 45 occurred.
47	*Situational*	Auto Accident State: Enter the state in which the auto accident noted in Field 45 occurred.
48	**Required**	Billing Dentist or Dental Entity: Enter the name and address of the billing provider.
49	**Required**	NPI (National Provider Identifier): Enter the 10-digit NPI of the billing provider or group.
50	Not Required	License Number

51	**Required**	SSN or TIN: Enter the federal tax ID number of the billing provider or entity. If a billing provider does not have a federal tax ID number, a Social Security Number may be used.
52	Not Required	Phone Number
52a	**Required**	Additional Provider ID. Enter the Taxonomy for the billing provider. Example: 1223G0001X
53	**Required**	Treating Dentist and Treatment Location Information. Certification: The provider who rendered the service(s) must sign and date this Field. Original, rubber-stamped and electronic signatures are acceptable.
54	**Required**	NPI (National Provider Identifier): Enter the NPI of treating provider.
55	Not Required	License Number
56	**Required**	Address, City, State, ZIP Code: Enter the address where the services were rendered.
56a	**Required**	Provider Specialty Code: Enter the servicing provider's Taxonomy code. Example: 1223G0001X
57	Not Required	Phone Number: Enter the servicing provider's phone number.
58	Not Required	Additional Provider ID

Replacing a Claim

A claim replacement may be submitted to modify a previously paid claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below:

- Field 35: Enter the Resubmission Code of 7 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).
  - If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
  - If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

  Example:
  Legacy ICN: 1015015320010
  Replaced Legacy ICN: 10**20**15015320010

Voiding a Claim

Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below:

- Field 35: Enter the Resubmission Code of 8 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).
  - If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
  - If voiding a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

  Example:
  Legacy ICN: 1015015320010
  Replaced Legacy ICN: 10**20**15015320010

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

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

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

4. Dental? ☐ Medical? ☐ (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 ☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company 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 ☐ M ☐ F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

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 ☐ M ☐ F

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

RECORD OF SERVICES PROVIDED

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

33. 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-9 = B; ICD-10 = AB)

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

31a. Other Fee(s)

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, or 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

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

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 illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

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

56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

Revision History

Section	Topic	Location	Revision Date
All	Change header revision date from June 2015 to Oct 2015	All pages	10/26/15
Intro	Updated contact history.	Page 1	10/26/15
52a	Remove reference to qualifier code of ZZ and remove reference to ZZ on example	Page 6	10/26/15
54	Remove reference to qualifier code of XX	Page 6	10/26/15
56a	Remove reference to qualifier code of ZZ and remove reference to ZZ qualifier on example	Page 6	10/26/15
All	Change header revision date from Oct 2015 to Dec 2015	All pages	12/08/15
15	Added; Do Not include punctuation on Member ID	Page 3	12/08/15
27	Added; Do Not include leading zeroes on Tooth numbers Added; Do not to use tooth #33 (Whole Mouth)	Page 4	12/14/15
28	Added; Do not use tooth surface A or S	Page 4	12/08/15