

## ADA 2019 CLAIM FORM INSTRUCTIONS

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FIELD NUMBER	FIELD NAME	INSTRUCTIONS
1	Type of Transaction	<p>Enter an “X” in the appropriate box.</p> <p>1. Type of Transaction (Mark all applicable boxes)</p> <p style="text-align: center;"><input checked="" type="checkbox"/> Statement of Actual Services      <input type="checkbox"/> Request for Predetermination/Preauthorization</p>
2	Not Required	
3	Insurance Company Plan	<p>Enter the plan name (RI Medicaid), address, state and zip code.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="text-align: center; margin: 0;"><b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b></p> <p style="margin: 0;">3. Company/Plan Name, Address, City, State, Zip Code</p> <p style="margin: 0;">Gainwell Technologies – RI Medicaid</p> <p style="margin: 0;">P.O. Box 2010</p> <p style="margin: 0;">Warwick, RI 02887-2010</p> </div>
4	Other Coverage	<p>Check the appropriate box. If either box is checked, complete fields 5 through 11(<i>gray section</i>). If no box checked, skip to field 12.</p> <p style="margin-top: 5px;"><b>OTHER COVERAGE</b> (Mark applicable box and complete items 5-11. If none, leave blank.)</p> <p>4. Dental? <input checked="" type="checkbox"/>      Medical? <input type="checkbox"/>      (If both, complete 5-11 for dental only.)</p>
5	Name of Policy Holder	<p>Enter last, first name and middle initial of policy holder.</p> <p>5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)</p> <div style="border: 1px solid gray; padding: 2px; margin-top: 5px;"> <p style="margin: 0;">Jones, Mary A </p> </div>
6	Date of Birth	<p>Enter the date of birth of policy holder in MMDDCCYY format.</p> <p>6. Date of Birth (MM/DD/CCYY)</p> <div style="border: 1px solid gray; padding: 2px; margin-top: 5px;"> <p style="margin: 0;">10/05/1978</p> </div>
7	Gender	<p>Check the appropriate box for gender of policy holder.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="margin: 0;"><b>14. Gender</b></p> <p style="margin: 0;"><input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> U</p> </div>
8	Policy Holder ID	<p>Enter subscriber information.</p> <p>8. Policyholder/Subscriber ID (SSN or ID#)</p> <div style="border: 1px solid gray; padding: 2px; margin-top: 5px;"> <p style="margin: 0;">ABC123456</p> </div>
9	Plan/Group Number	<p>Enter policy or group number.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="margin: 0;">9. Plan/Group Number</p> <p style="margin: 0;">DEF789123</p> </div>

10	Patient's Relationship to Insured	<p>Check appropriate box.</p> <p>10. Patient's Relationship to Person named in #5</p> <p><input type="checkbox"/> Self    <input checked="" type="checkbox"/> Spouse    <input type="checkbox"/> Dependent    <input type="checkbox"/> Other</p>
11	Other Insurance Company	<p>Enter the three digit carrier code and name of any other insurance the patient has. Note: The other insurance carrier must be billed first.</p> <p>11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code</p> <p>22T - American Dental</p>
12	Policy Holder	Enter RI Medicaid policy holder name and address - <i>optional</i>
13	Date of Birth	Enter the date of birth of policy holder in MMDDCCYY format - <i>optional</i>
14	Gender	Check appropriate box - <i>optional</i>
15	Policy Holder ID	<p>Enter RI Medicaid identification number.</p> <p>15. Policyholder/Subscriber ID (SSN or ID#)</p> <p>1234567890</p>
16	Plan Number	Enter plan number- <i>optional</i>
17	Employer Name	Enter the name of employer <i>if applicable</i>
18	Relationship to Policy Holder	Check appropriate box - <i>optional</i>
19	Reserved for Future Use	
20	Patient's Name and Address	<p>Enter last name, first and middle initial of patient as it is displayed on their RI Medicaid ID card.</p> <p>Enter the street, city and zip code of the patient.</p> <p>20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code</p> <p>Jones, James, P</p> <p>123 Main St.</p> <p>Providence, RI 02901</p>
21	Date of Birth	<p>Enter the date of birth of patient in MMDDCCYY format.</p> <p>21. Date of Birth (MM/DD/CCYY)</p> <p>03/23/1973</p>
22	Gender	<p>Check appropriate box.</p> <p>14. Gender</p> <p><input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> U</p>
23	Patient ID	Enter patient account number (as assigned by provider) - <i>optional</i>
24	Procedure Date	<p>Enter the date for this service in MMDDCCYY numeric format.</p> <p>24. Procedure Date (MM/DD/CCYY)</p> <p>06/22/2014</p>

25	Area of Oral Cavity Code - Situational	<p>If CDT code is one of the following: D4210, D4211, D4341, D4342, D5986, D7320, D7340, D7350, or D7970. Then area of the oral cavity code (AOC) is required. Please enter the AOC code that applies.</p> <table border="1" data-bbox="813 359 1463 751"> <thead> <tr> <th data-bbox="813 359 1159 411">Area of Oral Cavity Code</th> <th data-bbox="1159 359 1463 411">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="813 411 1159 464">00</td> <td data-bbox="1159 411 1463 464">Entire Oral Cavity</td> </tr> <tr> <td data-bbox="813 464 1159 516">01</td> <td data-bbox="1159 464 1463 516">Maxillary</td> </tr> <tr> <td data-bbox="813 516 1159 569">02</td> <td data-bbox="1159 516 1463 569">Mandibular</td> </tr> <tr> <td data-bbox="813 569 1159 621">10</td> <td data-bbox="1159 569 1463 621">Upper right quadrant</td> </tr> <tr> <td data-bbox="813 621 1159 674">20</td> <td data-bbox="1159 621 1463 674">Upper left quadrant</td> </tr> <tr> <td data-bbox="813 674 1159 726">30</td> <td data-bbox="1159 674 1463 726">Lower left quadrant</td> </tr> <tr> <td data-bbox="813 726 1159 751">40</td> <td data-bbox="1159 726 1463 751">Lower right quadrant</td> </tr> </tbody> </table>	Area of Oral Cavity Code	Description	00	Entire Oral Cavity	01	Maxillary	02	Mandibular	10	Upper right quadrant	20	Upper left quadrant	30	Lower left quadrant	40	Lower right quadrant
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00	Entire Oral Cavity																	
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26	Not Required	
27	Tooth Number	<p>Enter the appropriate tooth number or letter. 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.</p> <p>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.</p> <p>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). To report a quadrant, enter UL, UR, LL or LR.</p> <p>27. Tooth Number(s) or Letter(s)</p> <p>_____</p> <p style="text-align: center;">2</p>

28	Tooth Surface	<p>When applicable, enter a tooth surface code. Enter the 1 digit code for the tooth surface.</p> <table border="1" data-bbox="818 300 1451 606"> <thead> <tr> <th>Code</th> <th>Surface</th> </tr> </thead> <tbody> <tr> <td>B</td> <td>Buccal</td> </tr> <tr> <td>D</td> <td>Distal</td> </tr> <tr> <td>F</td> <td>Facial</td> </tr> <tr> <td>I</td> <td>Incisal</td> </tr> <tr> <td>L</td> <td>Lingual</td> </tr> <tr> <td>M</td> <td>Mesial</td> </tr> <tr> <td>O</td> <td>Occusal</td> </tr> </tbody> </table>	Code	Surface	B	Buccal	D	Distal	F	Facial	I	Incisal	L	Lingual	M	Mesial	O	Occusal
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29	Procedure Code	<p>Enter the 5 character ADA CDT code that describes each procedure performed.  <b>PA instructions:</b> Enter the procedure code of the requested service.</p> <table border="1" data-bbox="818 905 922 1066"> <tr> <td>29. Procedure Code</td> </tr> <tr> <td>D0140</td> </tr> <tr> <td>D1110</td> </tr> <tr> <td>D2392</td> </tr> <tr> <td>D2393</td> </tr> </table>	29. Procedure Code	D0140	D1110	D2392	D2393											
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D0140																		
D1110																		
D2392																		
D2393																		
29a	Not Required																	
29b	Quantity	<p>Enter the number of times (01-99) that the procedure in field 29 is delivered to the patient on the date of service in field 24.</p> <p>29b. Qty. — 1</p>																
30	Description	<p>Enter description of procedure performed or procedure for which PA is being requested.</p> <p>30. Description      _____      Limited Oral Evaluation      _____      Prophylaxis-Adult</p>																
31	Fee	<p>Enter your usual and customary charge for each procedure.</p> <p>31. Fee      _____      100.00      _____      80.00</p>																
31a	Not Required																	

32	Total Fee	The sum of all fees from field 31, plus any fees in field 31a. <table border="1"> <tr> <td>32. Total Fee</td> <td>480.00</td> </tr> </table>	32. Total Fee	480.00
32. Total Fee	480.00			
33	Not Required			
34	Not Required			
34a	Not Required			
35	Not Required			
36	Authorization	<p>Patient/guardian signature or "signature on file". Enter date signature was acquired.</p> <p><small>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.</small></p> <p>X <u>Signature on file</u> <u>02/20/2014</u>  <small>Patient/Guardian Signature Date</small></p>		
37	Authorization	<p>Subscriber signature or "signature on file". Enter date signature was acquired.</p> <p><small>37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.</small></p> <p>X <u>Signature on file</u> <u>02/20/2014</u>  <small>Subscriber Signature Date</small></p>		

38	Place of Treatment	<p>Enter the two digit place of service code for professional claims, a HIPAA standard. Frequently used codes are:</p> <table border="1" data-bbox="815 302 1414 600"> <thead> <tr> <th>Code</th> <th>Location</th> </tr> </thead> <tbody> <tr> <td>11</td> <td>Office</td> </tr> <tr> <td>12</td> <td>Home</td> </tr> <tr> <td>21</td> <td>Inpatient Hospital</td> </tr> <tr> <td>22</td> <td>Outpatient Hospital</td> </tr> <tr> <td>31</td> <td>Skilled Nursing Facility</td> </tr> <tr> <td>32</td> <td>Nursing Facility</td> </tr> <tr> <td></td> <td></td> </tr> </tbody> </table> <p>38. Place of Treatment <input type="text" value="11"/></p>	Code	Location	11	Office	12	Home	21	Inpatient Hospital	22	Outpatient Hospital	31	Skilled Nursing Facility	32	Nursing Facility		
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42	Not Required																	
43	Not Required																	
44	Not Required																	
45	Treatment Resulting From	<p><i>If treatment is from accident or injury, mark the appropriate box.</i></p> <p>45. Treatment Resulting from</p> <p><input type="checkbox"/> Occupational illness/injury    <input checked="" type="checkbox"/> Auto accident    <input type="checkbox"/> Other accident</p>																
46	Date of Accident	<p>Complete date in MMDDCCYY format <i>if any box checked in field 45.</i></p> <p>46. Date of Accident (MM/DD/CCYY) 06/20/2014</p>																
47	Auto Accident State	<p>Enter the state of <i>accident if auto accident noted in field 45.</i></p> <p>47. Auto Accident State RI</p>																
48	Billing Dentist	<p>Enter the billing dentist last name, first name, address, and zip code.</p> <div data-bbox="815 1455 1378 1577" style="border: 1px solid black; padding: 5px;"> <p><small>48. Name, Address, City, State, Zip Code</small></p> <p>Smith, James DDS 456 Post Rd Cranston, RI 02910</p> </div> <p>Or if group:</p> <div data-bbox="815 1650 1130 1782" style="border: 1px solid black; padding: 5px;"> <p><small>48. Name, Address, City, State, Zip Code</small></p> <p>Great Smiles Dental Group 123 Main St. Providence, RI 02901</p> </div>																

49	NPI	Enter the NPI for the billing entity. If group, enter the group NPI. 49. NPI 1234567890
50	License Number	Enter taxonomy code corresponding to the NPI in field 49. 50. License Number 122300000X
51	SSN or TIN	Enter social security number or TIN of the billing provider. 51. SSN or TIN 123121234
52a	Not Required	
53	Signature	<b>Enter the original authorized signature of the billing provider or supplier. (Stamps or initials are not acceptable.) Also enter the date the claim was signed.</b>  <small>53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.</small> X <u>John Jones, DDS</u> 06/20/2014 Signed (Treating Dentist) Date
54	NPI	Enter the NPI of the treating dentist. <i>Required if a member of a group.</i>
55	License Number	Enter the treating provider license number.
56	Address	Enter address at which the services were rendered <i>if different than field 48.</i>
56a	Provider Specialty Code	Enter the corresponding taxonomy to the NPI entered in field 54.
57	Phone Number	Enter the phone number of treating dentist if different than field 52.
58	Not Required	