Dental Billing Instructions

Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
4/23/04	2.3	The statement in field 59 under Quantity, “If blank, a quantity of 1 will be auto plugged” has been removed.
3/10/07	2.3	Update to billing instructions to reflect changes related to NPI
8/30/07	2.2, 2.3, 2.5	Clarification has been made to the billing instructions.
2/12/09	2.3	Added required legal wording for use of ADA coding.

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Dental Billing Instructions

Table of Contents

Main Menu

1.0 Introduction

2.0 Billing Instructions

- 2.1 Introduction
- 2.2 General Procedures
- 2.3 Completion of the Dental Form
- 2.4 Dental Claim Form
- 2.5 Inclusions

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1.0 Introduction

The Delaware Division of Medicaid and Medical Assistance (DMMA) establishes all policies and procedures governing the Delaware Medical Assistance Program (DMAP). The General Policy and Provider Specific Policy manuals are to be referenced for all program guidelines.

HPES is the DMAP Fiscal Agent. Providers are to bill HPES for the care and services rendered to DMAP clients.

This Billing Manual is designed as a reference tool to be utilized by DMAP providers when submitting claims for payment. This manual should be used in conjunction with the General Policy and Provider Specific Policy Manuals. The submission of proper and complete billing documents by providers is essential for timely and accurate claims processing and payment.

Initially, providers should carefully read this manual and become familiar with the contents. The manual should then be referenced when completing billing documents or forms. HPES will periodically update the Billing Manual on the DMAP Web site. Providers can opt to have paper updates sent through the mail. Revised pages should be promptly inserted into the manual for quick and accurate future reference.

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2.0 Billing Instructions

2.1 Introduction

The ADA dental claim form (1999 edition) is used by dental providers in billing the DMAP for services provided to eligible DMAP clients. Each client's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important.

2.2 General Procedures

- Verify client eligibility through the Voice Response System (VRS), Internet, Provider Electronic Solutions or Swipe Card Reader
- File claims within time limits specified in the General Policy Section of this manual.
- Use only original dental claim forms.
- Include only what is required in Section 2.3 (e.g., no stickers, no stamps, no unnecessary handwritten comments).
- Ensure that all claims submitted for Medical Assistance payment are signed in black ink or a Signed Trading Partner Agreement is on file at HPES.
- Ensure that handwritten claims are completed using black ink.
- Ensure that all required inclusions are submitted, i.e. – EOBs from third-party insurance coverage.
- Mail the completed dental claim form to the following address:

HPES

P.O. Box 909, Manor Branch

New Castle, Delaware 19720-0909

2.3 Completion of the Dental Form

This section provides specific instructions for completing the dental claim form for the Delaware Medical Assistance Program. The numbered items correspond to numbered fields on the claim form. Ditto marks (" ") are not allowed to reference the information on the preceding line. A sample claim form is included for your reference.

Field Number	Name	Instructions for Completion
1a	Dentist's statement of actual services	Check the box marked "Dentist's Statement of Actual Services".
2	Medicaid Claim	Check this box. "Prior Authorization" field is optional.
3	Carrier Name	Not required
4	Carrier Address	Not required
5	City	Not required
6	State	Not required
7	ZIP	Not required
8	Patient Name (Last, First, MI)	Required field. Enter the client's last name followed by the first name. Middle initial is optional.
9	Address	Optional field
10	City	Optional field
11	State	Optional field
12	Date of Birth	Optional field
13	Patient Account#	Optional field
14	Sex	Check M for male and F for female
15	Phone Number	Not required
16	ZIP Code	Not required
17	Relationship to subscriber	Not required. If there is other insurance primary coverage for the client, note the information.
18	Employer/School	If there is other primary insurance coverage for the client, note the employer's name.
19	Subs./Emp ID#SSN#	This is the Client ID Number found on the patient's plastic card. Enter the patient's 10-digit Medicaid ID number.
20	Employer Name	Not required. If there is other primary insurance for the client, note the employer's name.
21	Group#	Not required. If there is other primary insurance, enter the Group number.
22	Subscriber/Employer Name	Not required. If there is other primary insurance, enter the subscriber/employer name.
23	Address	Not required
24	Phone Number	Not required
25	City	Not required
26	State	Not required
27	ZIP Code	Not required
28	Date of Birth	Not required
29	Marital Status	Not required

Field Number	Name	Instructions for Completion
30	Sex	Not required
31	Is Patient Covered by Another Plan	If no other plan covers the patient, skip to Field 42. If Yes, complete Fields 31, 32, 33 and 36. If Yes is selected and the other insurance made a payment, indicate the payment amount in Field 60–"Payment by other plan."
32	Policy#	Enter the policy number for the primary policy
33	Other Subscriber's Name	Enter the name of the policyholder of the primary policy
34	Date of Birth	Not required
35	Sex	Not required
36	Plan/Program Name	Enter the NEIC number for the primary policy
37	Employer/School	Not required
38	Subscriber/Employee Status	Not required
39	Signature	Not required
40	Employer/School	Not required
41	Signature	Not required
42	Name of the Billing Dentist or Dental Entity	Enter the name of the billing dentist or group as it appears on your Medicaid Provider Enrollment application
43	Phone Number	Enter the provider's phone number
44	Provider ID#	If part of a Group, enter the 10-digit "performing" dentist's NPI #. This number identifies which dentist performed the actual service. If not part of a Group, leave this field blank and enter the sole practitioner NPI # in Field 45. See below.
45	Dentist Soc. Sec. Or T.I.N.	This is the field for the Provider's Group NPI #, OR the sole practitioner NPI# (which serves as both the performing NPI # and the billing NPI#).
46	Address	Not required
47	Dentist License#	Not required
48	First visit date of current series	Not required
49	Place of treatment	Check the appropriate box
50	City	Not required
51	State	Not required
52	ZIP Code	Not required
53	Radiographs or models	Not required
54	Is treatment for orthodontics?	Not required
55	If prosthesis, is this	Not required

Field Number	Name	Instructions for Completion
	initial placement?	
56	Is treatment the result of illness or injury?	Check yes box if applicable
57	Is treatment result of auto/other accident?	Check yes box if applicable
58	Diagnosis Code Index	Not required. Use only ICD-9 codes. Do not use SNODENT codes.
59	Date Tooth Surface Diagnosis Procedure Code Quantity Description Fee	Enter the date of service in the following format: MMDDCCYY. Enter the Primary or Permanent Tooth Number OR the appropriate code for the Quadrant Number when required. Quadrant values are: 10-Upper right; 20-Upper left; 30-Lower left; 40-Lower right. Enter the appropriate Surface value (I-Incisal; F-Facial; O-Occlusal; L-Lingual; B-Buccal; M-Mesial; D-Distal). Not Required. Use only ICD-9 codes or enter the diagnosis indicator # (1-8) from field 58. Do not use SNODENT codes. Enter the CDT procedure code that best describes the service*. *Current Dental Terminology, fourth edition (CDT) (including procedure codes, definitions (descriptors), and other data) is copyrighted by the American Dental Association. ©2008 American Dental Association. All rights reserved. Applicable FARS/DRARS apply. Enter the Units of Service. Not required Enter the billed amount for the service provided
60	Identify all missing teeth Total Fee Payment by Other Plan	Not required Enter the sum of all detail billed amounts on the claim. If other insurance made a payment prior to Medicaid (as indicated in Fields 31-36 above), enter the amount of that carrier's payment.

Field Number	Name	Instructions for Completion
	Maximum Allowable	Not required
61	Deductible Carrier % Carrier Pays Remarks	Not required Not required If applicable, subtract the “payment by other plan” from the “Total Fee” and enter that difference in this field. Enter remarks only if program service limitations require additional explanation of the service provided.
62	Signature	Provide original signature of the dentist or other authorized signer and the date of completion of the claim form.
63-66	Address Where Treatment Performed	Not required

2.4 Dental Claim Form

Dental Claim Form

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1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City 6. State 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) 9. Address 10. City 11. State
12. Date of Birth (MM/DD/YYYY) / / 13. Patient ID # 14. Sex ☐M ☐F 15. Phone Number ( ) 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other____
18. Employer/School Name____ Address____

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# 20. Employer Name 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address 24. Phone Number ( )
25. City 26. State 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / 29. Marital Status ☐Married ☐Single ☐Other 30. Sex ☐M ☐F

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / 35. Sex ☐M ☐F 36. Plan/Program Name
37. Employer/School Name____ Address____
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

39. 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 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 under applicable law, I authorize release of any information relating to this claim.

X____ Signed (Patient/Guardian) Date (MM/DD/YYYY)

40. Employer/School Name____ Address____
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X____ Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity 43. Phone Number ( ) 44. Provider ID # 45. Dentist Soc. Sec. or T.I.N.
46. Address 47. Dentist License # 48. First visit date of current series: 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City 51. State 52. Zip Code 53. Radiographs or models enclosed? ☐Yes, How many?____ ☐No 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed____ Total mos. of treatment remaining____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No If no, reason for replacement: Date of prior placement:____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates____
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates____

58. Diagnosis Code Index (optional) 1.____ 2.____ 3.____ 4.____ 5.____ 6.____ 7.____ 8.____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent		Primary	
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16	A B C D E	F G H I J
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17	T S R Q P	O N M L K

61. Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X____ Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City 65. State 66. Zip Code

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J590 (Same as ADA Dental Claim Form) J588 J589 J591
To Reorder, call 1-800-947-4746

2.5 Inclusions

When a client has third party insurance coverage, you must include a copy of the EOB or remittance from the third party insurance carrier. If the carrier denied the claim, you must include the denial EOB or remittance to show you have filed the claim.