MSA
MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 07-02

Distribution: Dentists & Dental Clinics

Issued: January 1, 2007

Subject: Implementation of the ADA 2006 Claim Form; Implementation and use of NPI on Claim Form

Effective: March 1, 2007

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS)

Conversion to the ADA 2006 Claim Form
The Michigan Department of Community Health (MDCH) currently processes the American Dental Association (ADA) 2002 claim form. Effective March 1, 2007, the ADA 2002 claim form will no longer be accepted. In preparation for the National Provider Identifier (NPI) implementation, all paper dental claims must be submitted on the ADA 2006 claim form, regardless of the date of service. Claims received on the ADA 2002 claim form on or after March 1 will be returned to the provider.

NPI Information
Bulletin MSA 06-73, issued October 16, 2006, references Medicaid provider deadlines for the NPI and additional NPI information. For application and registration, providers must register for their NPI at https://nppes.cms.hhs.gov/. More information on the NPI can be found at the MDCH website. Go to http://www.michigan.gov/mdch, click on Providers, then click on National Provider Identifier (NPI).

Dentists may purchase the ADA 2006 claim form directly from the American Dental Association or through ADA-approved vendors. The ADA claim forms are not supplied by the Medicaid Program. To order from the ADA, call 1-800-947-4746. A facsimile of the ADA 2006 claim form that will be accepted by the Medicaid Program is attached to this bulletin. In addition, the CDT 2007/2008 coding book includes completion instructions and information on the NPI.

ADA 2006 Claim Form

New Fields to be Completed for Dates of Submission Prior to May 23, 2007
The Billing & Reimbursement for Dental Providers Chapter of the online version of the Michigan Medicaid Provider Manual will be updated in April, 2007 to include the ADA 2006 claim form instructions. Every effort will be made to use standard completion instructions. While the NPI is not required until May 23, 2007, providing MDCH the NPI prior to the effective date will aid in updating the provider enrollment file.

- **Box 49, NPI:** Insert the 10 digit NPI of the Billing Dentist. This is a recommended field for completion.

- **Box 52A, Additional Provider ID:** This box corresponds to the legacy Provider Type (12 or 74) and the Provider ID number assigned to the provider by the Medicaid Program for billing purposes. Box 52A is a 9-digit field, with the first two digits the Provider Type and the last seven digits the Provider ID number. This is a **mandatory** field for completion. Claim forms completed incorrectly will be returned to the provider.

- **Box 54, NPI:** Insert the 10 digit NPI of the Treating Dentist. This is a recommended field for completion. (This may or may not be the same NPI as the Billing Dentist).

- **Box 56, Address, City, State, Zip Code:** Insert the mailing address of the treating dentist. This is a **mandatory** field for completion.

- **Box 56A, Provider Specialty Code:** This box captures the Provider Specialty code or taxonomy code. This is a recommended field.

- **Box 58, Additional Provider ID:** This box corresponds to the legacy Provider Type (12 or 74) and the Provider ID number assigned by the Medicaid Program for treatment identification. Box 58 is a 9-digit field, with the first two digits the Provider Type and the last seven digits the Provider ID number. This is a **mandatory** field for completion. Claim forms completed incorrectly will be returned to the provider.

  Note: The legacy ID required in boxes 52A and 58 may be the same ID number.

Fields to be Completed for Dates of Submission On and After May 23, 2007

- **Box 49, NPI:** Insert the 10 digit NPI of the Billing Dentist. This is a **mandatory** field for completion.

- **Box 54, NPI:** Insert the 10 digit NPI of the Treating Dentist. This is a **mandatory** field for completion. (This may or may not be the same NPI as the Billing Dentist).

- **Box 56A, Provider Specialty Code:** This box captures the Provider Specialty code or taxonomy code. This is a recommended field.

  Note: Boxes 52A and 58 are no longer required.

Claim Form Testing Information
The Invoice Processing system does not accept photocopies. Do not submit photocopies of the ADA form. Do **not** submit the copy from the Michigan Medicaid Provider Manual. Photocopies of the form will be returned to the provider.

Providers are encouraged to submit test claims to the Computer Operations staff to determine how well the OCR scanner will process the provider's claims. Testing claims helps increase the correct processing of claims and alleviate a delay in payments to providers. In order to submit test claims:

- Submit a minimum of 10 claims.
- Double-check the alignment on the forms to insure that the data does not touch the lines and is centered in the appropriate boxes.
- Do not fold the claim. Send them in 9" x 12" (or larger) envelopes.

These claims will be for testing purposes only. They will not be paid claims.

To submit claims for test purposes, providers should submit the claims to:

ADA 2006 Testing
DIT/DCH Operations
Operations Center, 1NE
7285 Parsons Drive
Lansing, Michigan 48913

Electronic Billing
The 837 Dental Companion Document posted on the MDCH website will be updated to reflect the Billing Provider and Pay-To Provider reported in Loop 2010AA and Loop 2010AB and the Rendering Provider reported in Loop 2310B.

For dental providers interested in submitting claims electronically, contact the Automated Billing Unit via e-mail at AutomatedBilling@michigan.gov for further information on electronic claims and a listing of approved service bureaus. Providers are encouraged to bill electronically. Advantages of electronic billing include decreased errors in claim submission which result in faster turnaround for payment.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

ADA Dental Claim Form

MSA 07-02
Attachment 1

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

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
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. Student Status ☐ FTS ☐ PTS
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)

fold

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	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

32. Other Fee(s)

33. Total Fee

fold

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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date 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

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

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

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J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org