Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Health and Recovery Services Administration (HRSA)

ABCD
Access to Baby and Child Dentistry

Supplemental Billing Instructions

[WAC 388-535-1245]

Copyright Disclosure

About this publication

These are ***supplemental*** billing instructions. Please refer to DSHS's ***Dental Program for Clients Through Age 20 Billing Instructions*** for a complete listing of dental services for which ABCD children qualify.

This publication supersedes all previous DSHS ABCD Dental Billing Instructions and is published by the Washington State Department of Social and Health Services, Health and Recovery Services Administration

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

Fee Schedule

You may access DSHS's Dental Fee Schedule at: http://maa.dshs.wa.gov/RBRVS/Index.html.

DSHS's Billing Instructions and Numbered Memoranda

To obtain DSHS's provider numbered memoranda and billing instructions, go to DSHS's website at http://maa.dshs.wa.gov/download/index.htm.

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Important Contacts

A provider may use DSHS's toll-free lines for questions regarding its programs; however, DSHS's response is based solely on the information provided to the [DSHS] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern DSHS's programs. **[WAC 388-502-0020(2)]**

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

Click ***Sign up to be a DSHS WA state Medicaid provider*** and follow the on-screen instructions.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

- Click ***Sign up to be a DSHS WA state Medicaid provider***
- Click ***I want to sign up as a DSHS Washington State Medical provider***
- Click ***What happens once I return my application?***

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***I want to make a change to my provider information***

Find out about payments, denials, claims processing, or DSHS managed care organizations?

Visit the Customer Service Center for Providers at:
http://maa.dshs.wa.gov/provrel

- Click ***I'm already a current Provider***
- Click ***Frequently Asked Questions***

or call/fax:
1-800-562-3022, Option 2 (toll free)
1-360-725-2144 (fax)

or write to:
Medical Assistance Customer Service Center (MACSC)
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on…

Becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
1-800-562-3022 (toll free)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on… (cont.)

Private insurance or third-party liability, other than DSHS managed care?

Office of Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136 (toll free)

How do I find out about Internet billing (electronic claims submission)?

Call the DSHS/HIPAA E-Help Desk at:
1-800-562-3022 (toll free) and choose option #2, then option #4

or e-mail to:
hipaae-help@dshs.wa.gov

- or -

visit:
WinASAP and WAMedWeb:
http://www.acs-gcro.com

Click ***Medicaid*** then ***Washington State***.

All other HIPAA transactions:
https://wamedweb.acs-inc.com

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:
http://www.acs-gcro.com

Click ***Medicaid***, then ***Washington State***, then ***Enrollment***.

or call ACS EDI Gateway, Inc. at:
1-800-833-2051 (toll free)

After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 1-800-833-2051.

How can I access the DSHS Dental web site?

Visit:
http://maa.dshs.wa.gov/ProvRel/Dental/Dental.html

Where can I view and download DSHS fee schedules?

Visit:
http://maa.dshs.wa.gov/rbrvs

How do I check on a client's eligibility status?

Call ACS at:
1-800-833-2051 (toll free)

or call DSHS at:
1-800-562-3022 (toll free) and choose option #2

You may also access the WAMedWeb Online Tutorial at:
http://maa.dshs.wa.gov/wamedwebtutor

Where do I write to get prior authorization?

Program Management &
Authorization Section-Dental Program
PO Box 45506
Olympia WA 98504-5506

For procedures that do not require radiographs - Fax: 1-360-725-2123

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit:
http://maa.dshs.wa.gov

Click ***Billing Instructions/Numbered Memoranda***

Definitions & Acronyms

This section defines terms, abbreviations, and acronyms used in these billing instructions that relate to the ABCD Program. The definitions in DSHS's current *Dental Program for Clients Through Age 20 Billing Instructions* apply unless modified by these definitions for the purposes of the ABCD Program.

Access to Baby and Child Dentistry (ABCD) – A program to increase access to dental services for Medicaid-eligible clients age five and younger.

Anterior – The maxillary and mandibular incisors and canines and tissue in the front of the mouth.

- Permanent maxillary anterior teeth include teeth 6, 7, 8, 9, 10, and 11.
- Permanent mandibular anterior teeth include teeth 22, 23, 24, 25, 26, and 27.
- Primary maxillary anterior teeth include teeth C, D, E, F, G, and H.
- Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

Current Dental Terminology (CDT) - A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

Dental Home – The ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referrals to specialists when appropriate.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

Medical Identification (ID) Card – The form the Department of Social and Health Services uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

Medically necessary - See WAC 388-500-0005.

Posterior – The maxillary and mandibular incisors and canines and tissue in the front of the mouth.

- Permanent maxillary posterior teeth include teeth 1, 2, 3, 4, 5, 12, 13, 14, 15, and 16.
- Permanent mandibular posterior teeth include teeth 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32.
- Primary maxillary posterior teeth include teeth A, B, I, and J.
- Primary mandibular posterior teeth include teeth K, L, S, and T.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated);
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
c) First five letters of the last name (and spaces if the name is fewer than five letters); and
d) Alpha or numeric character (tiebreaker).

Usual and Customary – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill DSHS.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Access to Baby and Child Dentistry (ABCD) Program

What Is the ABCD Program? [Refer to WAC 388-535-1245]

The Access to Baby and Child Dentistry (ABCD) program is a program established to increase access to dental services for Medicaid-eligible clients through age five. The program's goal is to ensure that positive dental experiences in early childhood will lead to lifelong practices of good oral health. This is done in part by identifying and removing obstacles to early preventive treatment, such as the lack of transportation to a dental office, language interpretation issues, etc. For further information, see "***How Does the ABCD Program Work?"***

The ABCD program is a partnership between the public and private sectors, including:

- The Department of Social and Health Services (DSHS), Health and Recovery Services Administration (HRSA);
- The Washington State Department of Health;
- The University of Washington School of Dentistry;
- The Washington Dental Service Foundation;
- The Washington State Dental Association;
- Local dental societies;
- Local health jurisdictions; and
- Other funding sources.

The **mission** is to identify eligible infants and toddlers (see "***Who is eligible?"***) before age one and to match each child to an ABCD-certified dentist. Children will remain in the ABCD program until their sixth birthday. **[Refer to WAC 388-535-1245 (1)(a)]**

Primary care medical providers are also key to early intervention, as these providers see young children at least eight times before age three and opportunities exist to do early detection and promote dental preventive care. Primary care medical providers are encouraged to become credentialed and deliver dental disease prevention services.

Health care providers and community service programs identify and refer eligible clients to the ABCD program.

If enrolled in the ABCD program, the client and an adult family member may receive:

- Oral health education;
- Anticipatory guidance;
- Assistance with transportation, interpreter services, and other issues related to dental services; and
- Dental services. **[Refer to WAC 388-535-1245 (2)]**

> **Note:** ABCD children are entitled to the full scope of care as described in DSHS's ***Dental Program for Clients Through Age 20 Billing Instructions***. These ***ABCD Program Billing Instructions*** identify those specific services that are eligible for higher reimbursement.

Who May Provide ABCD Dentistry? [WAC 388-535-1245 (3)]

Dentists who are certified through the continuing education program at the University of Washington School of Pediatric Dentistry or graduate after 2006 from the University of Washington School of Dentistry are eligible for ABCD program enhanced reimbursement rates.

Primary care medical providers who are certified through Washington Dental Service Foundation are eligible for select ABCD program enhanced reimbursement rates.

How Does the ABCD Program Work?

The following chart lists the people/agencies involved in the ABCD program and shows how they interact to ensure eligible children receive preventive dental services.

Who . . .	Responsibility. . .
Community service programs including Local Health Jurisdictions	Identify Medicaid-eligible clients and refer them to the program.
Local community ABCD enrollment units. This function may not be available in all counties.	Provide an orientation to the client and/or parent(s)/guardian(s) and prepares the family and child for the dental visit. Enroll the client and family into the ABCD program and encourage timely and appropriate dental visits.

Who . . .	Responsibility. . .
Local community ABCD enrollment units. This function may not be available in all counties. (cont.)	Provide the client with an ABCD program identification (ID) card. The client's parent(s)/guardian(s) must show this ID card to the dentist to prove the client is eligible for the program. Address obstacles to care, such as lack of transportation and limited English proficiency. Coordinate with local agencies in providing outreach and linkage services to eligible clients.
ABCD Program-Certified Dentists	Provide preventive and restorative treatment for an eligible client. Bill DSHS for provided services according to these ***ABCD Program Billing Instructions***.
Certified Primary Care Medical Providers	Provide periodic oral evaluation, family oral health education, and topical application of fluoride. Bill DSHS for provided services according to these ***ABCD Program Billing Instructions***.
Local Dental Societies	Encourage and support participation from members.
Health and Recovery Services Administration (HRSA)	Reimburse program-certified dentists for services covered under this program.
University of Washington School of Dentistry	Provide technical and procedural consultation on the enhanced treatments and conduct continued provider training and certification.
Washington Dental Service Foundation	Provide management services, funding, and technical assistance to support client outreach, linkage, and provider recruitment. Provide training to primary care medical providers and certify them to receive enhanced reimbursement for delivering dental disease prevention services.

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Client Eligibility

Who Is Eligible? [Refer to WAC 388-535-1245 (1)(a)(b)]

Clients 5 years old and younger are eligible. In addition to an ABCD identification card, eligible clients will have a DSHS Medical IDentification (ID) Card containing DSHS eligibility information. ***Before*** you provide any service to a DSHS client, be sure to check the client's current monthly DSHS Medical ID Card.

Clients whose Medical ID Cards have one of the following identifiers are eligible for dental services under the ABCD program:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP	Children's Health Program
CNP **CHIP**	State Children's Health Insurance Program
LCP-MNP	Limited Casualty Program/ Medically Needy Program

Are Clients Enrolled in a DSHS Managed Care Organization Eligible? [Refer to WAC 388-535-1245 (1)(c)]

Clients, **5 years old and younger**, who are enrolled in a managed care organization (MCO) should have an identifier in the *HMO* column on their DSHS Medical ID Card. These clients **are eligible for all Medicaid-covered dental services and the ABCD Program under the fee-for-service program.**

Note: See DSHS's ***Dental Services for Clients Through Age 20 Billing Instructions*** for eligibility information regarding services other than those outlined in this manual.

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Coverage

What Is Covered? [Refer to WAC 388-535-1245 (3)]

ABCD-Certified Participating Dental Providers

DSHS pays enhanced fees only to ABCD-certified dental providers and other DSHS-approved participating providers (e.g., ARNPs and physicians) for furnishing ABCD program services. ABCD program services include all of the following, when appropriate:

- Family oral health education. An oral health education visit:
  - ✓ Is limited to one visit per day, per family, up to two visits per child in a 12-month period, per provider or clinic; and
  - ✓ Must include all of the following:
    - ➢ **"Lift Lip" Training:** Show the "Lift Lip" videotape or flip chart provided at the certification workshop. Have the parent(s)/guardian(s) practice examining the child using the lap position. Ask if the parent(s)/guardian(s) feel comfortable doing this once per month.
    - ➢ **Oral hygiene training:** Demonstrate how to position the child to clean the teeth. Have the parent(s)/guardian(s) actually practice cleaning the teeth. Record the parent's/guardian's response.
    - ➢ **Risk assessment for early childhood caries:** Assess the risk of dental disease for the child. Obtain a history of previous dental disease activity for this child and any siblings from the parent(s)/guardian(s). Also note the dental health of the parent(s)/guardian(s).
    - ➢ **Dietary counseling:** Talk with the parent(s)/guardian(s) about the need to use a cup, rather than a bottle, when giving the child anything sweet to drink. Note any other dietary recommendations made.

- **Discussion of fluoride supplements:** Discuss fluoride supplements with the parent(s)/guardian(s). The dentist, physician, or ARNP must write a fluoride prescription for the child, if appropriate. Let the parent/guardian know fluoride supplements are covered under DSHS's Prescription Drug Program. Fluoride prescriptions written by the dentist, physician, or ARNP may be filled at any Medicaid-participating pharmacy. Ensure that the child is not already receiving fluoride supplements through a prescription written by the child's primary care medical provider.

- **Documentation** in the client's file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided and duration of the oral education visit.

Note: Bill DSHS under the Patient Identification Code (PIC) of the first child seen in the family. **Do not use the parent's PIC.** Family Oral Health Education **must be billed using ADA/HCPCS code D9999 with expedited prior authorization (EPA) number 870000997**. See page C.6.

- Application of fluoride gel or varnish.
- Periodic oral evaluations, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
- Comprehensive oral evaluations, once per client, per provider or dental clinic, as an initial examination.
- Amalgam and resin restorations on primary teeth, as specified in current DSHS-published documents.

Note: DSHS reimburses amalgam and resin restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar.

Note: DSHS reimburses resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth.

- Fabricated resin crowns for anterior primary teeth as specified in current DSHS-published documents.
- Therapeutic pulpotomy.
- Prefabricated stainless steel crowns on primary teeth, as specified in current DSHS-published documents.
- Resin-based composite crowns on anterior primary teeth.

- Glass ionomers used for Immediate Restorative Treatment (IRT). This is allowed for children through age 5 when provided in the dental office or dental clinic.

- Other dental-related services, as specified in current DSHS-published documents.

Note: The client's file must show documentation of the ABCD program services provided. **[WAC 388-535-1245 (5)]**

ABCD-Certified Primary Care Medical Providers

DSHS pays enhanced fees to certified participating primary care medical providers for furnishing ABCD program services. ABCD program services include all of the following, when appropriate:

- Family oral health education. An oral health education visit:

  - ✓ Is limited to one visit per day, per family, up to two visits per child in a 12-month period, per provider or clinic; and

  - ✓ Must include all of the following, when appropriate:

    - ➢ **"Lift the Lip" Training:** Show the "Lift the Lip" videotape or flip chart provided at the certification workshop, as appropriate. Show the parent(s)/guardian(s) how to examine the child using the lap position. Ask if the parent(s)/guardian(s) feel comfortable doing this once per month.

    - ➢ **Oral hygiene training:** Demonstrate how to position the child to clean the teeth. Record that this was demonstrated.

    - ➢ **Risk assessment for early childhood caries:** Assess the risk of dental disease for the child. Obtain a history of previous dental disease activity for this child and any siblings from the parent(s)/guardian(s). Also note the dental health of the parent(s)/guardian(s).

    - ➢ **Dietary counseling:** Talk with the parent(s)/guardian(s) about the need to use a cup, rather than a bottle, when giving the child anything sweet to drink. Note that dietary counseling was delivered.

- **Discussion of fluoride supplements:** Discuss fluoride supplements with the parent(s)/guardian(s). The dentist, physician, or ARNP must write a fluoride prescription for the child, if appropriate. Let the parent/guardian know fluoride supplements are covered under DSHS's Prescription Drug Program. Fluoride prescriptions written by the dentist, physician, or ARNP may be filled at any Medicaid-participating pharmacy. Ensure that the child is not already receiving fluoride supplements through a prescription written by the child's primary care medical provider.

- **Documentation** in the client's file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided.

Note: Bill DSHS under the Patient Identification Code (PIC) of the first child seen in the family. **Do not use the parent's PIC.** Family Oral Health Education **must be billed using ADA/HCPCS code D9999 with expedited prior authorization (EPA) number 870000997**. See page C.6.

- Application of fluoride gel or varnish
- Periodic oral evaluations, once every six months.

Coverage Table

ADA Code	Description	PA	Limitations	Maximum Allowable Fee
D0120	Periodic oral evaluation	No	One periodic evaluation is allowed every six months, per provider.	On-line Fee Schedules
D0150	Comprehensive oral evaluation	No	For DSHS purposes, this is to be considered an initial exam. One initial evaluation allowed per client, per provider or dental clinic. Normally used by a general dentist and/or a specialist when evaluating a patient comprehensively. *Six months must elapse before a periodic evaluation will be reimbursed.*	
D1203	Topical fluoride application	No	Allowed up to three times in a 12-month period per client, per provider or clinic. Document in the client's file which material (e.g., topical gel or fluoride varnish is used).	
D2140	Amalgam - one surface, primary or permanent.	No	Tooth and surface designations required. Allowance includes polishing.	

ADA Code	Description	PA	Limitations	Maximum Allowable Fee
D2150	Amalgam - two surfaces, primary or permanent.	No	Tooth and surface designations required. Allowance includes polishing.	On-line Fee Schedules
D2160	Amalgam - three surfaces, primary or permanent.	No	Tooth and surface designations required. **If billed on a primary first molar, DSHS will reimburse at the rate for a two-surface resin restoration.**	
D2330	Resin-based composite - 1 surface, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.	
D2331	Resin-based composite – 2 surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.	
D2332	Resin-based composite – 3 surfaces, anterior	No	Tooth and surface designations required. Allowed only on anterior teeth C through H and M through R.	
D2390	Resin-based composite crown, anterior – primary tooth	No	Tooth designation required.	

ADA Code	Description	PA	Limitations	Maximum Allowable Fee
D2391	Resin-based composite – one surface, posterior	No	Tooth and surface designations required. **Note:** Use this code when billing for a **glass ionomer** used for Immediate Restorative Treatment (IRT). This is allowed for children through age 5 when provided in the dental office or dental clinic.	
D2392	Resin-based composite – two surfaces, posterior	No	Tooth and surface designations required.	
D2393	Resin-based composite – three surfaces, posterior	No	Tooth designation required. **If billed on a primary first molar, DSHS will reimburse at the rate for a two surface resin restoration.**	On-line Fee Schedules
D2930	Prefabricated stainless steel crown - primary	No	Tooth designation required.	
D3220	Therapeutic pulpotomy	No	Covered only as complete procedure, once per tooth. Tooth designation required.	
D9920	Behavior management	No	Involves a patient whose documented behavior requires the assistance of at least **one additional dental professional staff** to protect the patient from self-injury while treatment is rendered.	
D9999	Family Oral Health Education	Use EPA # 870000997	**EPA Criteria:** Limited to one visit per day, per family, up to two visits **per child**, per 12-month period, per provider or clinic.	

Fee Schedule

You may view DSHS's Dental Schedule on-line at:

http://maa.dshs.wa.gov/RBRVS/Index.html

To obtain DSHS's provider numbered memoranda and billing instructions, go to DSHS's website at http://maa.dshs.wa.gov (click ***Billing Instructions/Numbered Memoranda***).

Completing the ADA Claim Form

DSHS accepts **ONLY** the 2006 American Dental Association (ADA) dental claim form.

Any other dental claim forms will not be processed and will be returned to the provider.

Remember: If you submit your claims electronically, DSHS will be able to process them faster.

General Information

- Include any required expedited prior authorization number.
- Send only one claim form for payment. If the number of services exceeds one claim form, a second form can be submitted. Please make sure that all necessary claim information (provider number, patient identification code, etc.) is repeated on the second form. Each claim form should show the total charges for the services listed.
- Use either blue or black ink only. **Do not use red ink, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers on claim form.
- Please refer to billing instructions for indication of when a tooth/arch/quadrant/tooth surface is required to be billed with a code. If the billing instructions indicate that a tooth number is required, please bill with the appropriate tooth number. If the billing instructions indicate that a tooth number is required, it would be an error to bill with a quadrant designation. If the billing instructions indicate that a quadrant is indicated, please bill with a quadrant, not a tooth number. Claims billed with inappropriate data will be denied.

Send your claims for payment to:

Claims Processing
PO Box 9253
Olympia WA 98507-9253

2006 ADA Claim Form Instructions

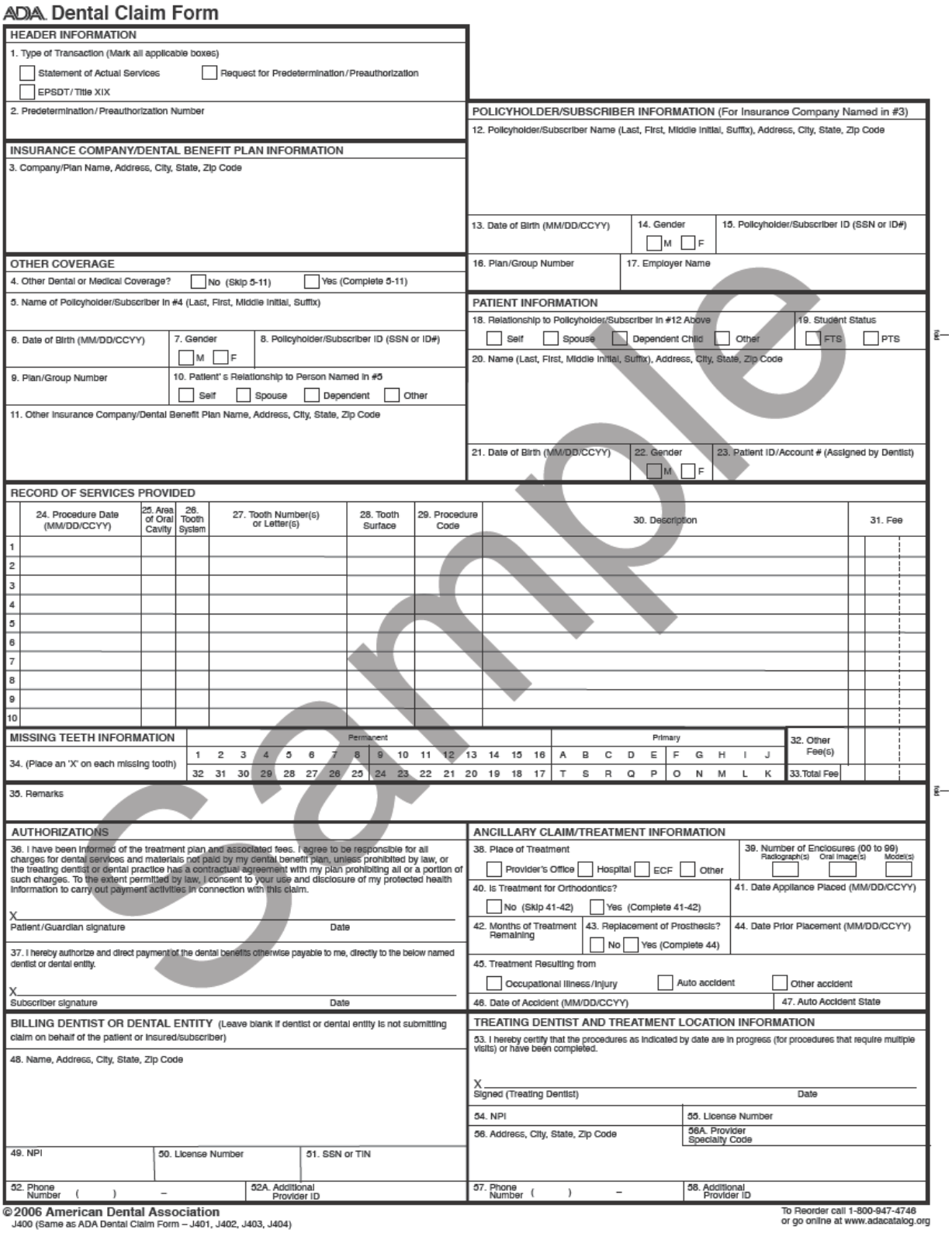
Field No.	Name	Entry
HEADER INFORMATION		
1.	Type of transaction	Mark the appropriate box if billing a claim (statement of actual services) or requesting authorization (request for predetermination)
2.	Predetermination/Preauthorization Number	Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		
3.	Company/Plan Name, Address, City, State, Zip Code	Enter the address for DSHS that is listed in the shaded box on page D.1.
OTHER COVERAGE		
4.	Other Dental or Medical Coverage	If client has other insurance primary to Medical Assistance, check the appropriate response.
5.	Name of Policyholder/Subscriber (Last, First, Middle Initial, Suffix)	If different from the patient, enter the name of the subscriber.
6.	Date of Birth (MM/DD/CCYY)	Enter the subscriber's date of birth.
8.	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the subscriber's SSN or other identifier assigned by the payer.
9.	Plan/Group Number	If the client has third party coverage, enter the dental plan # of the subscriber.
10.	Relationship to Primary Policyholder/Subscriber	Check the applicable box.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter any other applicable third party insurance.
POLICYHOLDER/SUBSCRIBER INFORMATION		
12.	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	If different from patient's (field 20), enter the legal name and address of the subscriber here.
13.	Date of Birth (MM/DD/CCYY)	If different from patient's, enter the subscriber's date of birth.
15.	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the SSN or other identifier assigned by the payer.
16.	Plan/Group Number	Enter the subscriber's group Plan or Policy Number.
17.	Employer Name	Enter the name of the subscriber's employer.
PATIENT INFORMATION		
18.	Relationship to Policyholder/Subscriber	Check the appropriate box.

Field No.	Name	Entry
PATIENT INFORMATION (cont.)		
20.	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Enter the client's legal name, address, and **Patient Identification Code (PIC)**.
21.	Date of Birth (MM/DD/CCYY)	Enter the client's date of birth.
23.	Patient ID/Account #	If you wish to use a medical record number, enter that number here.
RECORD OF SERVICES PROVIDED		
Each service performed must be listed as a separate, complete one-line entry. **Each extraction or restoration** must be listed as a separate line entry. If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.		
24.	Procedure Date (MM/DD/CCYY)	Enter the six-digit date of service, indicating month, day, and year (e.g., September 1, 2008 = 090108).
25.	Area of Oral Cavity	If the procedure code requires an arch or a quadrant designation, enter the appropriate arch or quadrant as follows: 01 Maxillary area 02 Mandibular area 10 Upper right quadrant 20 Upper left quadrant 30 Lower left quadrant 40 Lower right quadrant
26.	Tooth system	Not used.
27.	Tooth Number(s) or Letter(s)	If the procedure code requires a tooth designation, enter the appropriate tooth number or letter (only one tooth may be billed per line). • 01 through 32 for permanent teeth • A through T for primary teeth • 51 through 82 or AS through TS for supernumerary teeth
28.	Tooth Surface	If the procedure code requires a tooth surface, enter the appropriate letter(s) from the list below to indicate the tooth surface. Up to five surfaces may be listed in this column: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal

Field No.	Name	Entry
RECORD OF SERVICES PROVIDED (cont.)		
29.	Procedure Code	Enter the appropriate (2007 CDT) procedure code that represents the procedure or service performed. **The use of any other procedure code(s) will result in denial of payment.**
30.	Description	Give a brief written description of the services rendered. When billing for general anesthesia or IV sedation, enter the actual beginning and ending time.
31.	Fee	Enter **your usual and customary fee** (not DSHS's maximum allowable rate) for each service rendered. If fee schedule indicates to bill Acquisition Cost (AC), please bill your acquisition cost.
33.	Total Fee	Total of all charges.
34.	Missing Teeth Information	Place an "X" on the appropriate missing teeth.
35.	Remarks	Enter the provider number assigned by DSHS when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the DSHS Remittance and Status Report in the ***Provider Number*** area at the top of the page. If performing provider is different than that listed in field 49, enter the rendering provider's Medicaid provider number here.
		To indicate a payment by another plan, enter "insurance payment" and the amount. Attach the insurance EOB to the claim.

Field No.	Name	Entry
ANCILLARY CLAIM/TREATMENT INFORMATION		
38.	Place of Treatment	DSHS defines the following places of service for paper claims when a place of treatment box is checked but no two-digit place of service is indicated: **Box checked** — **Place of Service (POS)** Office — Dental office (POS 11) Hospital — Outpatient hospital (POS 22) ECF — Skilled nursing facility (POS 31) Other — DSHS will not allow place of service "other" without a two digit place of service indicated. If the services rendered are not in one of the places of service as indicated above, then the two-digit POS **must** be indicated in field 38. DSHS considers the following places of service for dental claims (not all services are covered in all places of service) **Office** **11** dental office **Hosp** **21** inpatient hospital **22** outpatient hospital **23** hospital emergency room **ECF** **31** skilled nursing facility **32** nursing facility **54** intermediate care facility/mentally retarded **Other** **03** school-based services **12** client's residence **24** professional services in an ambulatory surgery center **50** federally qualified health center **71** state or public health clinic (department) DSHS requires that a valid two-digit place of service be indicated that accurately reflects the place of service. Inaccurate place of service designations will be denied.

Field No.	Name	Entry
ANCILLARY CLAIM/TREATMENT INFORMATION (cont.)		
39.	Number of Enclosures (00 to 99)	Check the appropriate box. **Note:** Do not send X-rays when billing for services.
40.	Is Treatment for Orthodontics?	Check appropriate box.
41.	Date Appliance Placed (MM/DD/CCYY)	This field ***must be completed*** for orthodontic treatment.
43.	Replacement of Prosthesis?	Check appropriate box. If "yes," enter reason for replacement in field 35 (Remarks).
44.	Date Prior Placement (MM/DD/CCYY)	Enter appropriate date if "yes" is check for field 43.
45.	Treatment Resulting from	Check appropriate box.
46.	Date of Accident (MM/DD/CCYY)	Enter date of accident.
BILLING DENTIST OR DENTAL ENTITY		
48.	Name, Address, City, State, Zip Code	Enter the dentist's name and address as recorded with DSHS.
49.	NPI	Enter your National Provider Identifier (NPI). It is this code by which providers are identified, not by provider name. **Without this number your claim will be denied.**
52.	Phone Number	Enter the billing dentist's phone number.
52a.	Additional provider ID	Medical Assistance billing ID number.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
54.	NPI	Enter the performing provider's NPI if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique NPI and/or name.
56.	Address, City, State, Zip Code	If different than field 48, enter the treating dentist's information here.
57.	Phone Number	If different from field 52, enter the treating dentist's phone number here.
58.	Additional provider ID	Medical Assistance rendering provider ID number.



ADA 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

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)

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

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

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

Completing the CMS-1500 Claim Form

General Instructions

Note: DSHS encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section.

Refer to **DSHS's** current **General Information Booklet** (http://maa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf) for instructions on completing the CMS-1500 Claim Form.

Instructions Specific to Participating Providers (e.g., RNs, ARNPs, and Physicians) Approved by DSHS to Furnish ABCD Program Services

The following CMS-1500 Claim Form instructions relate to the ABCD Program:

Field No.	Name	Entry
23	Authorization Number	Enter EPA #870000997 here when billing procedure code D9999, Family Oral Health Evaluation.