1. ADA Claim Form – Version 2019 Completion Aid for Dentists

Prior Authorization/Benefit Limit Exception Request

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the ADA claim form-Version 2019: for authorization and benefit limit exception requests of dental and orthodontia services.

Dentists – Provider Type 27

Document format

The document is divided into thirteen sections that correspond to the sections of the ADA claim form. They are:

- Header Information (Items 1-2)
- Insurance Co/Dental Benefit Plan Information (Item 3)
- Other Coverage (Items 4-11)
- Policy Holder/Subscriber Information (Items 12-17)
- Patient Information (Items 18-23)
- Record of Services Provided (Items 24-32)
- Missing Teeth Information (Item 33)
- Diagnosis Code Information (Items 29a, 34-34a)
- Remarks (Item 35)
- Authorizations (Items 36-37)
- Ancillary Claim/Treatment Information (Items 38-47)
- Billing Dentist or Dental Entity (Items 48-52A)
- Treating Dentist and Treatment Location Information (Items 53-58)

Each section contains a table with four columns. Each column provides a specific piece of information as explained below:

Item Number – Provides the item number as it appears on the claim form.

Item Name – Provides the item name as it appears on the claim form.

Item Code – Lists one of four codes that denote how the claim form item should be treated. They are:

- **M** – Indicates that the item **m**ust be completed.
- **A** – Indicates that the item must be completed, if **a**pplicable.
- **O** – Indicates that the item is **o**ptional.
- **LB** – Indicates that the item should be **l**eft **b**lank.

Notes – Provides important information specific to completing the item.

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Procedure for Submitting Benefit Limit Exception

When submitting the ADA Claim Form – Version 2019 for a Benefit Limit Exception (BLE), you must attach a completed BLE Request Form (MA549).

You must indicate "Dental BLE Attached": in Box 35 Remarks Section.

The request must include documentation supporting the need for the service, including but not limited to chart/record documentation, diagnostic study results, radiographs (if applicable), comprehensive medical and dental history.

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Item No.	Item Name	Item Code	Notes
Header Information			
1.	Type of Transaction	M	Check the **Request for Predetermination/Preauthorization** box if this is a **prior authorization; benefit limit exception** or post-operative review request.
2.	Predetermination/ Preauthorization Number	LB	Please leave this item blank.
Insurance Company/Dental Benefit Plan Information			
3.	Name, Address, City, State, Zip Code	O	MA does not require that you complete this item.
Other Coverage			
4.	Other Dental or Medical Coverage	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
5.	Name of Policyholder/ Subscriber in #4 Name (Last, First, Middle Initial, Suffix)	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
6.	Date of Birth (MM/DD/CCYY)	O	MA does not require that you complete this item.
7.	Gender	O	MA does not require that you complete this item.

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8.	Policyholder/ Subscriber ID # (SSN or ID#)	O	MA does not require that you complete this item.
9.	Plan/Group Number	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
10.	Patient's Relationship to Person Named in #5	O	MA does not require that you complete this item.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
Policyholder/ Subscriber Information			
12.	Policyholder/ Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	O	MA does not require that you complete this item.
13.	Date of Birth (MM/DD/CCYY)	O	MA does not require that you complete this item.
14.	Gender	O	MA does not require that you complete this item.
15.	Policyholder/ Subscriber ID# (SSN or ID#)	O	MA does not require that you complete this item.
16.	Plan/Group Number	O	MA does not require that you complete this item.
17.	Employer Name	O	MA does not require that you complete this item.

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Patient Information			
18.	Relationship to Policyholder/ Subscriber in #12 above	O	MA does not require that you complete this item.
19.	Student Status	O	MA does not require that you complete this item.
20.	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	M	Enter the beneficiary's last name, first name, and middle initial (if any).
21.	Date of Birth (MM/DD/CCYY)	M	Enter the beneficiary's birthdate in 2-digit month, 2-digit day and 4-digit year format.
22.	Gender	O	MA does not require that you complete this item.
23.	Patient ID/Account Number	M	Enter the beneficiary's 10-digit identification number as it appears on the beneficiary's ACCESS Card. If the beneficiary number is not available, access EVS by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to complete this item. **Eligibility of dental benefits must be verified at each visit.**
Record of Services Provided			
24.	Procedure Date (MM/DD/CCYY)	LB	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
25.	Area of Oral Cavity	A	Enter only one quadrant per claim line. When requesting periodontal services (**Procedure Codes D4210 and D4341**) or Alveoloplasty (**Procedure Codes D7310 and D7320**) enter the appropriate code to identify the quadrant on which the service was provided:

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			10 or UR – Upper Right Quadrant **20 or UL** – Upper Left Quadrant **30 or LL** – Lower Left Quadrant **40 or LR** – Lower Right Quadrant
26.	Tooth System	O	MA does not require that you complete this item.
27.	Tooth Number(s) or Letter(s)	A	**Do not enter quadrant in this block. Quadrant should be entered in Block 25 Area of Oral Cavity.** Enter only one tooth number or letter per line. This item must be completed whenever a particular tooth is involved. Use numerical identification **1 through 32** for permanent teeth; use capital letter identification **A through T** for primary teeth. For permanent supernumerary teeth, use numerical identification **51 through 82**. For primary supernumerary teeth; use capital letter identification **AS through TS.**
28.	Tooth Surface	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
29.	Procedure Code	M	Enter the code for the procedure to be performed. Only those codes listed in the MA Program Fee Schedule are covered by the MA Program. **Note**: **Authorization for Orthodontic Services** Procedure Code **D8080** is to be requested in conjunction with first quarter of treatment. Procedure Code **D8670** is to be requested for each quarter treatment. Only one treatment quarter may be entered/requested per line.
29a.	Diagnosis Pointer	A	Enter the letter(s) that identify the diagnosis code(s) applicable to the dental procedure in block 29 Procedure Code.

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			If the service was provided for the primary diagnosis (in Block 34a), enter A. If provided for the secondary diagnosis, enter B. If provided for the third diagnosis, enter C and for the fourth diagnosis, enter D. **Note: The primary diagnosis pointer must be entered first.** **If you complete Block 29a Diagnosis Pointer, you must also complete Block 34 Diagnosis Qualifier and Block 34a Diagnosis Code(s).**
29b.	Quantity	A	Enter the number of services provided.
30.	Description	O	MA does not require that you complete this item.
31	Fee	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
31a.	Other Fee(s)	O	MA does not require that you complete this item.
32.	Total Fee	O	MA does not require that you complete this item.
Missing Teeth Information			
33	(Place an 'X' on each missing tooth)	M	Indicate all missing teeth by marking an "X" on the chart. Use a slash (/) to indicate any teeth requiring extraction.
Diagnosis Code List Qualifier			
34.	Diagnosis Qualifier	A	Enter only one value in this Block. Enter AB when requesting services with ICD-10 codes. **Note: If you complete 34 Diagnosis Qualifier, you must also complete Block 29a Diagnosis Pointer and Block 34a Diagnosis Code(s).**

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34a	Diagnosis Code(s)	A	Enter one valid diagnosis codes after each letter (A – D). Enter the primary diagnosis code adjacent to the letter "A". Enter subsequent diagnosis codes adjacent to the letters "B", "C" and "D" in sequential order. **Note: If you complete Block 34a Diagnosis Code(s), you must also complete Block 29a Diagnosis Pointer and Block 34 Diagnosis Qualifier.**
Remarks			
35.	Remarks	M	This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is required, use another 8.5" by 11" sheet of paper and **attach** it to the prior authorization with a **paperclip**. Include the beneficiary's name and 10-digit beneficiary identification number in the upper right-hand corner of each additional sheet. **You must indicate "Dental BLE Attached".** Prior authorization of dental services must be performed as a part of a complete dental treatment program and must be accompanied by a detailed treatment plan. **Note:** For those Service Programs where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided. **If this is a resubmission of a previously denied prior authorization request, enter "Resubmission of a previously denied request" and the denied P.A. Reference Number in this item.**

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			Also, place the 7-digit number appearing on the left side of the X-ray envelope (ENV 98) and the words "X-Ray Envelope Number" in this item. Use the following procedure to submit X-rays with the ADA Claim Form, Version 2019: • Place your return address on the ENV 98 so the X-rays can be returned to you. • Place the X-rays in the ENV 98. The radiographs must be: o properly mounted; o clearly readable; o free from defects; o the clarity must be such that interpretation can be made without difficulty by using a conventional view box; o taken in a manner that all clinical crowns and roots are observable; and o labeled with the recipient's name, the recipient number, the provider's name, and the date the radiograph was taken. • Use one ENV 98 for each recipient. • Be sure that your (typed) return address is placed on the ENV 98 in the white block labeled "Provider Return Address". This envelope will be used by the Department when returning X-rays to you. DO NO USE TAPE OR STAPLES TO SEAL THE ENV 98. • Place the ENV 98 with completed ADA Claim Form – Version 2019, in an MA 320 envelope, or an envelope large enough to accommodate all documentation without folding, and mail to the Department.

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Authorizations			
36.	Patient/Guardian signature and Date	LB	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
37.	Subscriber signature and Date	LB	Do not complete this item.
Ancillary Claim/Treatment Information			
38.	Place of Treatment	O	Enter the 2-digit Place of Service Code to identify where the service was provided. 11 = Office 12 = Home 21 = Inpatient Hospital 22 = Outpatient Hospital 23 = Emergency Room 24 = Ambulatory Surgical Center/Short Procedure Unit 31 = Skilled Nursing Facility 32 = Nursing Facility 99 = Community **Note: All prior authorization lines must be provided in the same place of service.** .
39.	Number of Enclosures	O	MA does not require that you complete this item.
40.	Is Treatment for Orthodontics?	O	MA does not require that you complete this item.
41.	Date Appliance Placed (MM/DD/CCYY)	O	MA does not require that you complete this item.

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42.	Months of Treatment Remaining	O	MA does not require that you complete this item.
43.	Replacement of Prosthesis?	A	MA does not require that you complete this item.
44.	Date Prior Placement (MM/DD/CCYY)	O	MA does not require that you complete this item.
45.	Treatment Resulting from	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
46.	Date of Accident (MM/DD/CCYY)	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
47.	Auto Accident State	O	MA does not require that you complete this item for prior authorization; however, this may be necessary for claims submission.
Billing Dentist Or Dental Entity			
48.	Name, Address, City, State, Zip Code	O	Enter the name of the enrolled group, corporation, or organization **designated to receive payment.** This may be the same or a different provider than the provider rendering the service. The **payee** must be enrolled with the Department and must be listed as payee on the individual dentist's Provider Notice Information Form.
49.	NPI Number	M	Please enter the NPI number of the enrolled group, corporation, or organization **designated to receive payment.** This may be the same as or different from the provider rendering the service.
50.	License Number	O	MA does not require that you complete this item.
51.	SSN or TIN	O	MA does not require that you complete this item.

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52.	Phone Number	O	Enter the telephone number of the enrolled group, corporation, or organization other than the individual provider of the service, **designated to receive payment** for the service provided.
52A.	Additional Provider ID	M	**Enter the 9-digit PROMIS*e*™ ID number and the 4-digit service location code of the enrolled group, corporation, or organization designated to receive payment. This may be the same as or different from the provider rendering the service.** Do not use slashes, hyphens or spaces.***Payment will be made to the ID number appearing in this item**. **Note**: When submitting a Prior Authorization/BLE request, the 9-digit PROMIS*e*™ ID number and the 4-digit service location code entered in this Block must match the corresponding Block on the submitted ADA claim form for payment.
Treating Dentist and Treatment Location Information			
53.	Signature (Treating Dentist) and Date (MMDDYYYY)	M	The provider rendering the service **must sign and date** the request The signature certifies that the service has been provided in accordance with MA regulations. A signature stamp is acceptable if the provider authorizes its use and assumes responsibility for the information on the claim.
54.	NPI Provider ID	M	Please enter the NPI number of the treating dentist.
55.	License Number	M	Enter the complete alpha numeric license number of the dentist rendering the service. Example: **DS-012345L** **Do Not Enter the PROMIS*e*™ ID number.**
56.	Address, City, State, Zip Code	M	Enter the address (Street Address, City, State, and ZIP Code) where the service was performed.

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56A.	Provider Specialty Code	O	MA does not require that you complete this item.
57.	Phone Number	O	Enter the telephone number of the rendering/treating dentist that provided the service.
58.	Additional Provider ID	O	MA does not require that you complete this item.