ODJFS Instructions for Completing the ADA 2006 Paper Claim Form

Revised 2011.12.14

DISCLAIMER: This document is intended to be a helpful guide, but users should not rely on any part of it as a definitive statement about claims submission. The Ohio Department of Job and Family Services has taken great care to ensure that the information in this document is accurate, but there may be inadvertent errors of typography or fact, and the content may have been superseded. Therefore, no warranty, either express or implied, is made for its usability with a particular claim.

HEADER INFORMATION

Item 1 Type of Transaction (Mark all applicable boxes)

Mark 'Statement of Actual Services'.

In addition, mark 'EPSDT / Title XIX' if the patient either (1) has coverage under Medicaid and is younger than 21 or (2) has coverage under Healthy Start and is younger than 19.

Do not mark 'Request for Predetermination / Preauthorization'. Requests for prior authorization (PA) of dental services must be submitted through the Web Portal.

Item 2 Predetermination/Preauthorization Number

Complete this field only if prior authorization (PA) has been granted for the services reported on the claim. Use the PA number assigned by the Ohio Department of Job and Family Services (ODJFS) that is shown on the Prior Authorization notification. PA numbers generated by MITS have ten digits; MMIS-generated PA numbers have six digits.

Note: For information about prior authorization, please refer to the Dental Services Handbook, which can be found in the 'Ohio Health Plans - Provider' folder on the ODJFS Electronic Manuals (eManuals) website, http://emanuals.odjfs.state.oh.us/emanuals.

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

Item 3 Company/Plan Name, Address, City, State, Zip Code

No entry is required.

OTHER COVERAGE

Item 4 Other Dental or Medical Coverage?

No entry is required.

Item 5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

No entry is required.

Item 6 Date of Birth (MM/DD/CCYY)

No entry is required.

Item 7 Gender

No entry is required.

Item 8 Policyholder/Subscriber ID (SSN or ID#)

No entry is required.

Item 9 Plan/Group Number

No entry is required.

Item 10 Patient's Relationship to Person Named in #5

No entry is required.

Item 11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

No entry is required.

POLICYHOLDER/SUBSCRIBER INFORMATION

Item 12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Enter the patient's last name, first name, and middle initial exactly as printed on the Ohio Medicaid card.

Item 13 Date of Birth (MM/DD/CCYY)

Enter the patient's date of birth.

Item 14 Gender

No entry is required.

Item 15 Policyholder/Subscriber ID (SSN OR ID#)

Enter the 12-digit Billing Number from the patient's medical card. Do not use any other number.

Item 16 Plan/Group Number

No entry is required. As of August 2, 2011, paper claims involving third-party payment (payment from another source) will not be accepted. Any claim involving third-party payment must be submitted by EDI (in an 837D transaction) or through the Web Portal.

Item 17 Employer Name

No entry is required.

PATIENT INFORMATION

Item 18 Relationship to Policyholder/Subscriber in #12 Above

No entry is required.

Item 19 Student Status

No entry is required.

Item 20 Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

No entry is required.

Item 21 Date of Birth (MM/DD/CCYY)

No entry is required.

Item 22 Gender

No entry is required.

Item 23 Patient ID/Account # (Assigned by Dentist)

No entry is required.

RECORD OF SERVICES PROVIDED

Item 24 Procedure Date (MM/DD/CCYY)

In chronological order, enter the first date of service to last date of service in the eight-digit format MMDDCCYY. Enter all eight characters consecutively (including leading zeroes) without dashes, slashes, or spaces. A separate line is required for each date of service.

Item 25 Area of Oral Cavity

No entry is required.

Item 26 Tooth System

No entry is required.

Item 27 Tooth Number(s) or Letter(s)

Enter the appropriate tooth number. Use two-digit tooth numbers for permanent teeth and tooth letters (CAPITALIZED) for primary teeth.

Item 28 Tooth Surface

For all restorations, enter the CAPITAL letter(s) corresponding to the surface(s) involved:

M – Mesial
D – Distal
L – Lingual
I – Incisal
F – Facial
B – Buccal
O – Occlusal

Item 29 Procedure Code

Enter the five-character CDT/HCPCS procedure code corresponding to the service rendered.

Note: For information about covered services and codes, please refer to the Dental Services Handbook, which can be found in the 'Ohio Health Plans - Provider' folder on the ODJFS Electronic Manuals (eManuals) website, http://emanuals.odjfs.state.oh.us/emanuals.

Item 30 Description

No entry is required.

Item 31 Fee

Enter your usual and customary fee for the line item procedure.

Item 32 Other Fee(s)

No entry is required. Leave this field blank.

Item 33 Total Fee

Enter the total charge for all services on this invoice.

MISSING TEETH INFORMATION

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

No entry is required.

Item 35 Remarks

No entry is required unless an exclusion from co-payment applies.

Note: This space may be used to enter remarks or clarifying information. Whenever a provider is instructed to enter information in the remarks space on the invoice, the information should be entered here.

If a service for which you are submitting a claim is subject to a Medicaid co-payment (as described in rule 5101:3-1-09 of the Ohio Administrative Code) but an exclusion from co-payment applies (also as described in that rule), then no co-payment should be charged or collected. The exclusion must be noted here on the claim form with the appropriate ten-character exclusion code:

Exclusion	Exclusion Code
The patient is pregnant, or the pregnancy ended within the past 60 to 90 days.	COPAY PREG
The patient is receiving hospice services.	COPAY HSPC
The patient received emergency services that are subject to a co-payment.	COPAY EMER

Note: There is a single space after the qualifier 'COPAY'. This space must be entered to ensure correct adjudication of the claim.

AUTHORIZATIONS

Item 36 [Patient/Guardian Signature Block]

No entry is required.

Item 37 [Subscriber Signature Block]

No entry is required.

ANCILLARY CLAIM/TREATMENT INFORMATION

Item 38 Place of Treatment

Check the appropriate block.

Item 39 Number of Enclosures (00 to 99)

No entry is required. Do not send radiographs or models with the claim form.

Item 40 Is Treatment for Orthodontics?

No entry is required.

Item 41 Date Appliance Placed (MM/DD/CCYY)

No entry is required.

Item 42 Months of Treatment Remaining

No entry is required.

Item 43 Replacement of Prosthesis?

No entry is required.

Item 44 Date Prior Placement (MM/DD/CCYY)

No entry is required.

Item 45 Treatment Resulting from

No entry is required.

Item 46 Date of Accident (MM/DD/CCYY)

No entry is required.

Item 47 Auto Accident State

No entry is required.

BILLING DENTIST OR DENTAL ENTITY

Item 48 Name, Address, City, State, Zip Code

Enter the provider's name and mailing address.

Item 49 NPI

If the treating dentist is affiliated with a dental group and payment is to be made to the dental group, enter the dental group's Type 2 National Provider Identifier (NPI). If the treating dentist is submitting a claim for services as an individual dentist, enter that person's Type 1 NPI to ensure that payment is made to the individual.

Item 50 License Number

No entry is required.

Item 51 SSN or TIN

Enter the provider's Social Security Number or Taxpayer Identification Number.

Item 52 Phone Number

No entry is required.

Item 52A Additional Provider ID

No entry is required.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Item 53 [Treating Dentist's Signature Block]

The signature of the provider rendering the service is required.

Item 54 NPI

Enter the NPI of the treating dentist.

Item 55 License Number

No entry is required.

Item 56 Address, City, State, Zip Code

No entry is required.

Item 56A Provider Specialty Code

No entry is required.

Item 57 Phone Number

No entry is required.

Item 58 Additional Provider ID

No entry is required.

MAIL THIS CLAIM TO:
Ohio Department of Job and Family Services
P.O. Box 7965
Akron, OH 44306

TIPS FOR SUBMITTING PAPER CLAIMS

Keep the claim form clean, undamaged, and free from debris.

- Use an original, preprinted form. Photocopies and faxes are not acceptable. The CMS-1500 and UB-04 forms are printed with distinctive red "drop-out" ink.
- Be sure that the paper is thick enough (20- or 22-lb.) to keep any printing on the back from showing through and the form from jamming the scanner. But do not use card stock.
- Do not fold or crease the claim form. Mail it in an envelope that is at least 9" x 12".
- Do not mar the paper with correction fluid, staples, sticky notes, or food stains.

Complete the form with a view toward scanning.

- Use a computer printer or a typewriter. Do not fill in information by hand.
- Enter information only in applicable fields.
- CAPITALIZE ALL LETTERS.
- Do not add descriptions of procedure codes, modifiers, or diagnosis codes.
- Left-justify the entry in a field. Keep the entry within the field; make sure that no content touches or runs beyond the boundaries of the field.
- Do not add notations, circles, scribbles, overstrikes, or cross-outs. Do not apply correction fluid, labels, stickers, or rubber stamp impressions.
- Omit honorifics (Ms., Dr., etc.) from names.
- Omit punctuation marks, symbols, and special characters (e.g., hyphens, periods, parentheses, dollar signs, and ditto marks).
- Print or type with a standard font. Do not use italic, script, or artistic fonts.
    - Use black toner or ink (even on forms printed in red). Laser printers turn out pages with more consistent color density (darkness). If an inkjet printer or a typewriter is used, check the cartridge or ribbon frequently and change it as necessary.
    - Select a legible typeface. Some sources suggest that a sans serif font (such as Arial or Lucida Console) may produce better scanning results than a serif font (such as Times New Roman or Courier).*
    - Choose a standard size (from 10 to 12 points in height) or pitch (10 or 12 characters per inch in width). Do not use small or condensed fonts.
    - Make sure that the lines and curves of printed or typed characters are continuous and smooth, not broken up like stenciling or early dot-matrix printing.

Keep a few additional details in mind.

- A paper attachment should be no smaller than 8.5" x 11".
- Attachments must be received no later than 14 days after the claim has been submitted. An attachment must be either uploaded through the Web Portal or mailed with a cover page generated in the Web Portal.
- A claim form that cannot be processed will be returned with a letter indicating the reason for its return.

Remember, the form you submit will be read by a machine. If you can't read it, the machine probably can't either.

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* Serifs are little flourishes at the ends of strokes that make up a letter. The letter m printed in Times New Roman has serifs; the letter m printed in Arial does not.