wisconsin Medicaid update
and BadgerCare
March 2004 ● No. 2004-19
Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dentists
HMOs and Other Managed Care Programs

Wisconsin Medicaid accepting ADA 2002 and 2000 claim forms

Effective immediately, Wisconsin Medicaid accepts the ADA 2002 and 2000 claim forms. Wisconsin Medicaid does not accept claims on the ADA 1994 claim form; claims submitted on this claim form are denied.

ADA 2002 and 2000 claim forms now accepted by Wisconsin Medicaid

Effective immediately, Wisconsin Medicaid accepts the American Dental Association's ADA 2002 and 2000 claim forms. Submit completed claims according to the instructions specific to the claim form. Refer to Attachments 1-4 of this *Wisconsin Medicaid and BadgerCare Update* for the ADA 2002 and 2000 claim form completion instructions and sample claims.

The ADA 2000 claim form instructions are included as a convenience for providers and do not replace the information in the July 2003 *Update* (2003-50), titled "Changes to local codes, paper claims, and prior authorization for dental services as a result of HIPAA." Providers should retain *Update* 2003-50 for their reference.

Wisconsin Medicaid's claim instructions vary from the ADA instructions. The variations are necessary for Wisconsin Medicaid to process claims. Providers are required to complete the elements in the Wisconsin Medicaid instructions found in Attachments 1 and 3 as appropriate. No other claim form elements are required. In addition, providers are not required to include attachments to the claim form unless instructed to do so in the Dental Services Handbook.

Mail completed paper claims to:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Note: As stated *Update* 2003-50, Wisconsin Medicaid does not accept the ADA 1994 claim form. Claims submitted on this claim form are denied.

Order ADA claim forms

Wisconsin Medicaid does not provide the ADA claim forms. To order the ADA 2002 or 2000 claim forms, do one of the following:

- Call the American Dental Association at (800) 947-4746.
- Order online at *www.adacatalog.org/*.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid or to recipients enrolled in Medicaid HMOs that do not provide dental coverage. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
ADA 2002 claim form completion instructions for dental services

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so in the Wisconsin Medicaid Dental Services Handbook.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for more information about the EVS.

HEADER INFORMATION

Element 1 — Type of Transaction (not required)

Element 2 — Predetermination/Preauthorization Number (required, if applicable)

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF), if applicable. Do not attach a copy of the PA/DRF to the claim. Services authorized under multiple PA requests must be submitted on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

PRIMARY PAYER INFORMATION

Element 3 — Name, Address, City, State, ZIP Code (not required)

OTHER COVERAGE

Element 4 — Other Dental or Medical Coverage? (not required)

Element 5 — Subscriber Name (Last, First, Middle Initial, Suffix) (not required)

Element 6 — Date of Birth (MM/DD/CCYY) (not required)

Element 7 — Gender (not required)

Element 8 — Subscriber Identifier (SSN or ID#) (not required)

Element 9 — Plan/Group Number (not required)

Element 10 — Relationship to Primary Subscriber (not required)

Element 11 — Other Carrier Name, Address, City, State, ZIP Code

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing Wisconsin Medicaid unless the service is not covered by commercial health insurance. Wisconsin Medicaid uses Element 11 to identify Medicare and commercial health insurance information, whether the recipient has commercial health insurance coverage, Medicare coverage, or both. Refer to the July 2003 *Wisconsin Medicaid and BadgerCare Update* (2003-50), titled "Changes to local codes, paper claims, and prior authorization for dental services as a result of HIPAA," (Attachments 6-13) for the following information:

- Wisconsin Medicaid commercial health or dental insurance explanation codes for use in Element 11 (Attachment 6).
- Medicare disclaimer codes (Attachment 7).
- A key to Wisconsin Medicaid's seven commercial health insurance indicators for use when a recipient's eligibility is confirmed in the EVS (Attachment 8).
- When the EVS indicates the code "DEN" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 9).
- When the EVS indicates the code "HMO" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 10).
- When the EVS indicates the code "VIS" for "Vision Only," providers are not required to bill private insurance.
- When the EVS indicates the codes "BLU," "WPS," "CHA," "HPP," or "OTH" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 12).
- When the EVS indicates the code "SUP" for "Medicare Supplement," providers must bill commercial insurance for Medicare-allowed services only (Attachment 11).
- Appropriate provider responses to special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid (Attachment 13).

Recipients with commercial health or dental insurance coverage

Commercial health or dental insurance coverage must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid. Commercial health insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When commercial dental or health insurance paid for some services

When commercial dental or health insurance paid only for some services and denied payment for the others, Wisconsin Medicaid recommends providers submit two separate Medicaid claim forms. To maximize Medicaid reimbursement, one claim should be submitted for the partially paid services and another for the services denied by commercial dental or health insurance.

Recipients with Medicare coverage

Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Do not enter a Medicare disclaimer code in Element 11 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.

- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. Refer to Attachment 7 of *Update* 2003-50 for a list of Medicare disclaimer codes.

Recipients with both Medicare and commercial dental or health insurance

Use both a Medicare disclaimer code (e.g., "M-5") and an other insurance explanation code (e.g., "OI-P") when applicable.

Note: The other carrier's address, city, state, and ZIP code are not required.

PRIMARY SUBSCRIBER INFORMATION

Element 12 — Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. The recipient's address, city, state, and ZIP code are not required.

Element 13 — Date of Birth (MM/DD/CCYY)

Enter the recipient's birth date in MM/DD/CCYY format (e.g., March 27, 1972, would be 03/27/1972).

Element 14 — Gender (not required)

Element 15 — Subscriber Identifier (SSN or ID#)

Enter the recipient's *10-digit* Medicaid identification number. Do not enter any other numbers or letters.

Element 16 — Plan/Group Number (not required)

Element 17 — Employer Name (not required)

PATIENT INFORMATION

Element 18 — Relationship to Primary Subscriber (not required)

Element 19 — Student Status (not required)

Element 20 — Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code (not required)

Element 21 — Date of Birth (MM/DD/CCYY) (not required)

Element 22 — Gender (not required)

Element 23 — Patient ID/Account # (Assigned by Dentist) (not required)

RECORD OF SERVICES PROVIDED

Element 24 — Procedure Date (MM/DD/CCYY)
Enter the date of service in MM/DD/CCYY format (e.g., November 1, 2003, would be 11/01/2003) for each detail.

Element 25 — Area of Oral Cavity
If the procedure applies to the repair of dentures or partials, the area of the oral cavity is entered here.

Element 26 — Tooth System (not required)

Element 27 — Tooth Number(s) or Letter(s)
If the procedure applies to only one tooth, the tooth number or tooth letter is entered here.

Element 28 — Tooth Surface
Enter the tooth surface(s) restored for each restoration.

Element 29 — Procedure Code
Enter the appropriate procedure code and modifier for the dental service provided.

Element 30 — Description
Write a brief description of each procedure.

Element 31 — Fee
Enter the usual and customary charge for each detail line of service.

Element 32 — Other Fee(s) (required for other insurance information, if applicable)
Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 32 is greater than zero, "OI-P" must be indicated in Element 11.) Do not include the Wisconsin Medicaid copayment amount. *If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement.* This allows Wisconsin Medicaid to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Element 33 — Total Fee
Enter the total of all detail charges. Do not subtract other insurance payments.

MISSING TEETH INFORMATION

Element 34 — Permanent and Primary (Place an 'X' on each missing tooth) (not required)

Element 35 — Remarks (required, if applicable)
List any unusual services, including reasons why limitations were exceeded. Providers should enter the word "Emergency" in this element for an emergency service.

AUTHORIZATIONS

Element 36 — Patient/Guardian Signature and Date (not required)

Element 37 — Subscriber Signature and Date (not required)

ANCILLARY CLAIM/TREATMENT INFORMATION

Element 38 — Place of Treatment (Check applicable box)
Check the appropriate box.

Element 39 — Number of Enclosures (00 to 99) (not required)

Element 40 — Is Treatment for Orthodontics? (not required)

Element 41 — Date Appliance Placed (MM/DD/CCYY) (not required)

Element 42 — Months of Treatment Remaining (not required)

Element 43 — Replacement of Prosthesis? (not required)

Element 44 — Date Prior Placement (MM/DD/CCYY) (not required)

Element 45 — Treatment Resulting from (Check applicable box) (required, if applicable)
Check appropriate box if the dental services were the result of an occupational illness/injury, auto accident, or other accident.

Element 46 — Date of Accident (MM/DD/CCYY) (required, if applicable)
If a box was checked in Element 45, enter the date the accident happened.

Element 47 — Auto Accident State (required, if applicable)
Enter the state where the auto accident occurred.

BILLING DENTIST OR DENTAL ENTITY

Element 48 — Name, Address, City, State, ZIP Code
Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and ZIP code. Enter the billing provider's complete city, state, and ZIP code as they appear on the Medicaid certification letter. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 48 must correspond with the provider identification number in Element 49.

If providers move or are at a different address, they should complete the Wisconsin Medicaid Provider Change of Address or Status form (HCF 1181) to notify Wisconsin Medicaid that an address change has occurred. The form is located on the provider forms section of the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Element 49 — Provider ID
Enter the billing provider's eight-digit Medicaid provider number. The provider number in this element must correspond with the provider name indicated in Element 48.

Element 50 — License Number (not required)

Element 51 — SSN or TIN (not required)

Element 52 — Phone Number (not required)

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Element 53 — Dentist's Signature Block

The provider or the authorized representative must sign in Element 53. The month, day, and year the form is signed must also be entered in MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with a date. However, claims with "signature on file" stamps are denied.

Element 54 — Provider ID

If Elements 48 and 49 indicate a clinic or group biller, indicate the Medicaid-certified treating provider's eight-digit Medicaid provider number in this element.

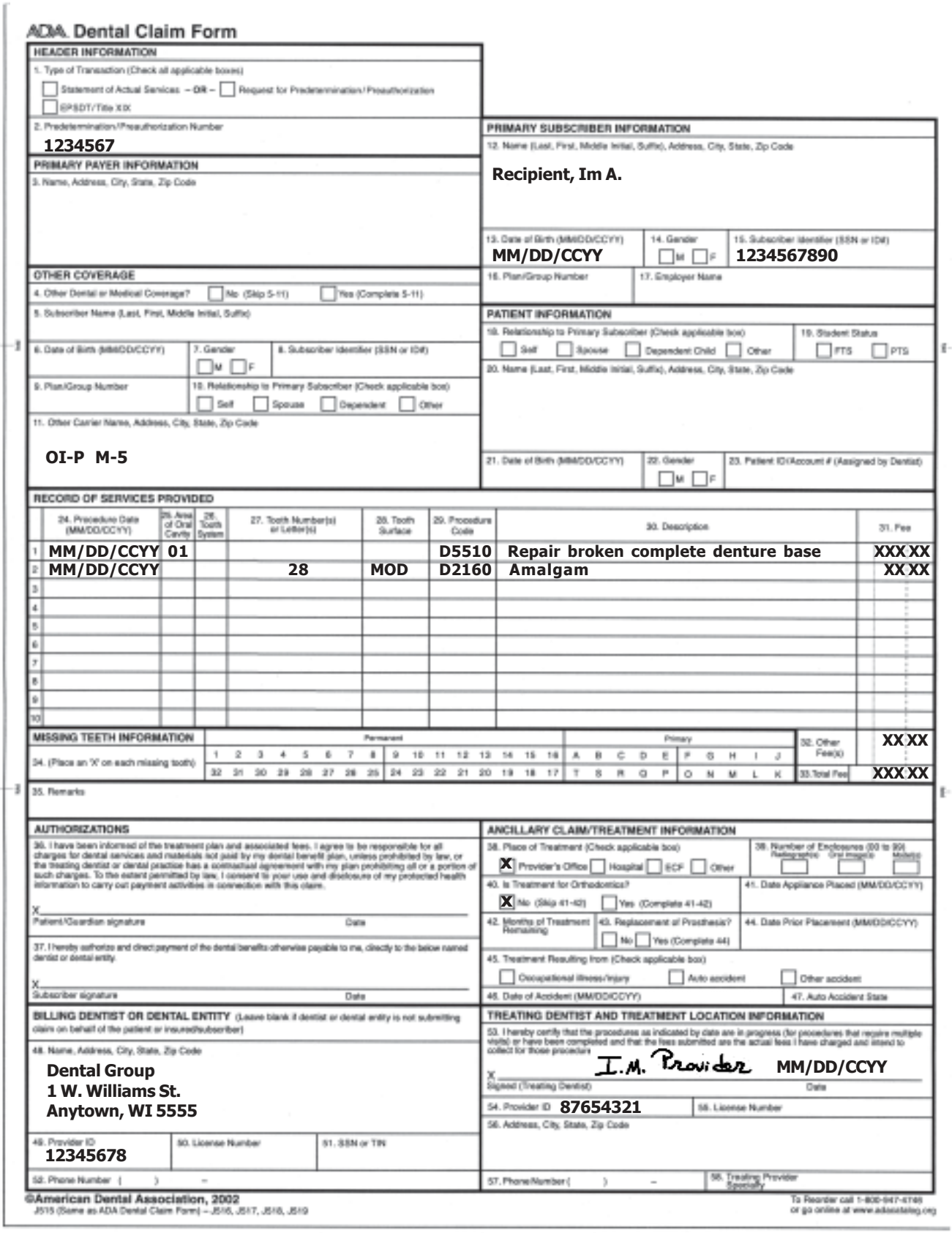
Element 55 — License Number (not required)

Element 56 — Address, City, State, ZIP Code (not required)

Element 57 — Phone Number (not required)

Element 58 — Treating Provider Specialty (not required)

ATTACHMENT 2
Sample ADA 2002 claim form for dental services



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination / Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number
1234567

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Recipient, Im A.

13. Date of Birth (MM/DD/CCYY) **MM/DD/CCYY** | 14. Gender ☐ M ☐ F | 15. Subscriber Identifier (SSN or ID#) **1234567890**

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE

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

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code
OI-P M-5

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ 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	**MM/DD/CCYY**	**01**				**D5510**	**Repair broken complete denture base**	**XXXXX**
2	**MM/DD/CCYY**			**28**	**MOD**	**D2160**	**Amalgam**	**XXXX**
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

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

Permanent																Primary										32. Other Fee(s)	XXXX
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	33. Total Fee	XXXXX
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		

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 (Check applicable box) ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Enclosures (00 to 99) Radiographs ☐ Oral Images ☐ Models ☐

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 (Check applicable box) ☐ 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
Dental Group
1 W. Williams St.
Anytown, WI 5555

49. Provider ID **12345678** | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X I.M. Provider **MM/DD/CCYY**
Signed (Treating Dentist) | Date

54. Provider ID **87654321** | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

©American Dental Association, 2002
J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-6745 or go online at www.adastore.org

ATTACHMENT 3
ADA 2000 claim form completion instructions for dental services

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so in the Wisconsin Medicaid Dental Services Handbook.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/* for more information about the EVS.

Element 1 — Dentist's Pre-Treatment Estimate, Dentist's Statement of Actual Services, Specialty (not required)

Element 2 — Medicaid Claim, EPSDT, Prior Authorization # (required, if applicable)

EPSDT (HealthCheck): HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). If the services were performed as a result of a HealthCheck EPSDT exam, check the EPSDT box.

Prior authorization #: Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Dental Request Form (PA/DRF), if applicable. Do not attach a copy of the PA/DRF to the claim. Services authorized under multiple PA requests must be submitted on separate claim forms with their respective PA numbers. Wisconsin Medicaid will only accept one PA number per claim.

Elements 3-7 — Carrier Name, Carrier Address, City, State, ZIP (not required)

PATIENT

Element 8 — Patient Name (Last, First, Middle)

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Elements 9-11 — Address, City, State (not required)

Element 12 — Date of Birth (MM/DD/YYYY)

Enter the recipient's birth date in MM/DD/YYYY format (e.g., March 27, 1972, would be 03/27/1972).

Element 13 — Patient ID

Enter the recipient's *10-digit* Medicaid identification number. Do not enter any other numbers or letters.

Elements 14-16 — Sex, Phone Number, ZIP Code (not required)

Element 17 — Relationship to Subscriber/Employee (not required)

Element 18 — Employer/School (not required)

SUBSCRIBER/EMPLOYEE AND OTHER POLICIES

Element 19 — Subs./Emp. ID#/SSN# (not required)

Element 20 — Employer Name (not required)

Element 21 — Group # (not required)

Elements 22-30 — Subscriber/Employee Name (Last, First, Middle), Address, Phone Number, City, State, ZIP Code, Date of Birth (MM/DD/YYYY), Marital Status, Sex (not required)

Element 31 — Is Patient Covered by Another Plan (not required)

Element 32 — Policy # (not required)

Element 33 — Other Subscriber's Name (required, if applicable)

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing Wisconsin Medicaid unless the service is not covered by commercial health insurance. Wisconsin Medicaid uses Element 33 to identify Medicare and commercial health insurance information, whether the recipient has commercial health insurance coverage, Medicare coverage, or both. Refer to the July 2003 *Wisconsin Medicaid and BadgerCare Update* (2003-50), titled "Changes to local codes, paper claims, and prior authorization for dental services as a result of HIPAA," (Attachments 6-13) for the following information:

- Wisconsin Medicaid commercial health or dental insurance explanation codes for use in Element 33 (Attachment 6).
- Medicare disclaimer codes (Attachment 7).
- A key to Wisconsin Medicaid's seven commercial health insurance indicators for use when a recipient's eligibility is confirmed in the EVS (Attachment 8).
- When the EVS indicates the code "DEN" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 9).
- When the EVS indicates the code "HMO" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 10).
- When the EVS indicates the code "VIS" for "Vision Only," providers are not required to bill private insurance.
- When the EVS indicates the codes "BLU," "WPS," "CHA," "HPP," or "OTH" for "Other Coverage," a list of procedure codes for claims for which commercial dental insurance must be billed prior to billing Wisconsin Medicaid (Attachment 12).
- When the EVS indicates the code "SUP" for "Medicare Supplement," providers must bill commercial insurance for Medicare-allowed services only (Attachment 11).
- Appropriate provider responses to special circumstances when billing commercial health or dental insurance prior to billing Wisconsin Medicaid (Attachment 13).

Recipients with commercial health or dental insurance coverage

Commercial health or dental insurance coverage must be billed prior to submitting claims to Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid. Commercial health insurance coverage is indicated by the EVS under "Other Commercial Health Insurance."

When commercial dental or health insurance paid for some services

When commercial dental or health insurance paid only for some services and denied payment for the others, Wisconsin Medicaid recommends providers submit two separate Medicaid claim forms. To maximize Medicaid reimbursement, one claim should be submitted for the partially paid services and another for the services denied by commercial dental or health insurance.

Recipients with Medicare coverage

Submit claims to Medicare before submitting claims to Wisconsin Medicaid.

Do not enter a Medicare disclaimer code in Element 33 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does not have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. Refer to Attachment 7 of *Update* 2003-50 for a list of Medicare disclaimer codes.

Recipients with both Medicare and commercial dental or health insurance

Use both a Medicare disclaimer code (e.g., "M-5") and an other insurance explanation code (e.g., "OI-P") when applicable.

Element 34 — Date of Birth (MM/DD/YYYY) (not required)

Element 35 — Sex (not required)

Element 36 — Plan/Program Name (not required)

Element 37 — Employer/School (not required)

Element 38 — Subscriber/Employee Status (not required)

Element 39 — Subscriber/Employee Signature and Date (not required)

Element 40 — Employer/School (not required)

Element 41 — Employee/Subscriber Signature and Date Authorizing Payment (not required)

BILLING DENTISTS

Element 42 — Name of Billing Dentist or Dental Entity

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, city, state, and ZIP code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 42 must correspond with the provider identification number in Element 44.

Element 43 — Phone Number (not required)

Element 44 — Provider ID

Enter the billing provider's eight-digit Medicaid provider number. The provider number in this element must correspond with the provider name indicated in Element 42.

Element 45 — Dentist Soc. Sec. or T.I.N. (not required)

Element 46 — Address

Enter the billing provider's complete street address. If providers move or are at a different address, they should complete the Wisconsin Medicaid Provider Change of Address or Status form (HCF 1181) to notify Wisconsin Medicaid that an address change has occurred. The form is located in the provider forms section of the Wisconsin Medicaid Web site at *dhfs.wisconsin.gov/medicaid/*. Providers without Internet access may request a copy by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Element 47 — Dentist License # (not required)

Element 48 — First Visit Date of Current Series (not required)

Element 49 — Place of Treatment

Check the appropriate box.

Elements 50-52 — City, State, ZIP Code

Enter the billing provider's complete city, state, and ZIP code as they appear on the Medicaid certification letter.

Element 53 — Radiographs or Models Enclosed? (not required)

Element 54 — Is Treatment for Orthodontics? (not required)

Element 55 — If Prosthesis (Crown, Bridge, Dentures), Is This Initial Placement? (not required)

Element 56 — Is Treatment Result of Occupational Illness or Injury? (required, if applicable)

Check yes or no to specify if the dental services were the result of an occupational illness or injury. If "yes" is indicated, write a brief explanation, including dates, in the space provided.

Element 57 — Is Treatment Result of: Auto Accident? Other Accident? Neither? (required, if applicable)

Specify if the dental services were the result of an auto accident or other accident. Write a brief description including dates if appropriate.

Element 58 — Diagnosis Code Index (not required)

Element 59 — Examination and Treatment Plans

Date (MM/DD/YYYY): Enter the date of service in MM/DD/YYYY format (e.g., November 1, 2003, would be 11/01/2003) for each detail.

Tooth: If the procedure applies to only one tooth, the tooth number or tooth letter is entered here. If the procedure applies to only one repair of dentures or partials, the area of the oral cavity is entered here.

Surface: Enter the tooth surface(s) restored for each restoration.

Diagnosis Index #: Not required by Wisconsin Medicaid.

Procedure Code: Enter the appropriate procedure code and modifier for the dental service provided.

Qty: Enter the exact quantity billed. When multiple quantities of a single type of service are provided on the same day, list the code only once with the appropriate quantity indicated at the end of the description. (This does not apply to codes that require modifiers.)

Description: Write a brief description of each procedure.

Fee: Enter the usual and customary charge for each detail line of service.

Total Fee: Enter the total of all detail charges.

Payment by Other Plan: Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 59 is greater than zero, "OI-P" must be indicated in Element 33.) Do not include the Wisconsin Medicaid copayment amount. *If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement.* This allows Wisconsin Medicaid to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do **not** enter Medicare-paid amounts in this field.

Max. Allowable: Not required by Wisconsin Medicaid.

Deductible: Not required by Wisconsin Medicaid.

Carrier %: Not required by Wisconsin Medicaid.

Carrier pays: Not required by Wisconsin Medicaid.

Patient Pays: Not required by Wisconsin Medicaid. Do not enter recipient copayment amounts.

Admin. Use Only: Enter an "E" in this element for an emergency service. Wisconsin Medicaid only accepts the letter "E" for indicating an emergency. No other letters are accepted in this element.

Element 60 — Identify All Missing Teeth with "X" (not required)

Element 61 — Remarks for Unusual Services (required, if applicable)

List any unusual services, including reasons why limitations were exceeded.

Element 62 — Dentist's Signature Block

The provider or the authorized representative must sign in Element 62. The month, day, and year the form is signed must also be entered in MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with a date. However, claims with "signature on file" stamps are denied.

If Elements 42 and 44 indicate a clinic or group biller, indicate the Medicaid-certified performing provider's name and eight-digit Medicaid provider number in this element.

Elements 63-66 — Address Where Treatment Was Performed, City, State, ZIP Code (not required)

ATTACHMENT 4
Sample ADA 2000 claim form for dental services

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 # **1234567**
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): **Recipient, Im A.**
9. Address
10. City
11. State
12. Date of Birth (MM/DD/YYYY): **MM / DD / YYYY**
13. Patient ID #: **1234567890**
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: **OI-P M-5**
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: **Dental Group**
43. Phone Number ( )
44. Provider ID #: **12345678**
45. Dentist Soc. Sec. or T.I.N.
46. Address: **1 W. Williams St.**
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☒Office ☐Hosp. ☐ECF ☐Other
50. City: **Anytown**
51. State: **WI**
52. Zip Code: **55555**
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
MM DD YYYY				D5110	1	Complete upper denture	XXX.XX
MM DD YYYY	28	MOD		D2160	1	Amalgam	XX.XX

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | T S R Q P | O N M L K

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

61. Remarks for unusual services

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 I.M. Provider 87654321 MM/DD/YYYY
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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J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746