

March 2004 • No. 2004-19

Wisconsin Medicaid and BadgerCare Information for Providers

edica

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:

update

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.

2

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

6

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 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

EADER INFORMATION	im Forr									
Type of Transaction (Check a	I applicable to	and a								
_	-				. 1					
Statement of Actual Servi	ses - be - L	Hequest for Pred	eternination.	Proauthorizatio	°					
EPSDT/Title XIX										
2. Predetermination/Preauthorization Number						PRIMARY SUBSCRIBER INFORMATION				
1234567					1	12. Nome (Lost, First, Middle Initial, Suffix), Address, City, State, Zp Code				
PRIMARY PAYER INFORMATION						1				
Name, Address, City, State, 2	p Code				1	Recipient, Im A.				
					I					
					· 1					
					t	3. Date of Birth (MMOD/CCYY)	14. Gender	15. Subscriber identifier (SSN		
						MM/DD/CCYY		1234567890	1011240	
								1234507890		
THER COVERAGE			_			16. Plan/Group Humber	17. Employer Name			
. Other Dental or Medical Core	70g#?	No (Skip 5-11)	Yes (C	Complete 5-11)						
. Subscriber Name (Last, First,	Middle Initial, 5	Suffix)			F	PATIENT INFORMATION				
						18. Relationship to Primary Subsc	iber (Check applicable	box) 19. Stadent 5	Ratura	
. Date of Birth (MINIOD/CCYY)	7. Gend	ler 8. Subs	uniber identili	er (SSN or ID#)		Self 3pouse [Dependent Child	Other 0FTS	ET9	
		□ F				0. Name (Last, First, Middle Initia	Suffic), Address, City	State, Zp Cade		
. Plan/Group Number	10. Hole	dionship to Primary 5	Subscriber IC	heck applicable						
			Dece							
1. Other Carrier Name, Addres										
C Gronte Galerian marine, Adultes	V. malif. Second. 17	ft-0-908			I					
OI-P M-5					- H		1			
01-6 14-2					2	21. Date of Birth (MBMDD/CCYY)	22. Gender	23. Patient IO (Account # (Ass)	gned by Dentist	
							M F			
RECORD OF SERVICES P	ROVIDED									
24. Precedure Date	5 Ana 25	27. Tooth Num	rbertsi	28. Teofh	29. Procedure					
(MM/DD/DCYY)	of Oral Touth Cavity System	0.0100000	6	Surface	Code		30. Description		31. Pea	
MM/DD/CCYY	01				D5510	Repair broken	complete d	enture base	XXXX	
MM/DD/CCYY		28		MOD	D2160				XXX	
				TICE	DLIGG	Anargani			ЛЛЛ	
	_									
)								32. Other	XXX	
NISSING TEETH INFORM				Permanent			Primary	Cambrid Cambrid		
AISSING TEETH INFORM	a teofhú 1	2 3 4 5	6 7	8 9 10	11 12 13		D E P G	H I J Feeloo		
	a teofhú 1		6 7	8 9 10		1 14 15 18 A B C		H I J Fee(X) M L K 33.7btal Fee		
	a teofhú 1		6 7	8 9 10			DEFG			
4. (Place an V on each misain	a teofhú 1		6 7	8 9 10			DEFG			
4. (Place an W on each misain 5. Remarks	a teofhú 1		6 7	8 9 10	22 21 20	0 19 18 17 T 8 R	DEFON	M L K 33.Total Pee		
4. (Pisce an W on each missin 5. Remarks MUTHORIZATIONS	a tooth) 1 32	51 30 29 St	6 7 8 27 28	8 9 10 25 24 23	22 21 20	ANCILLARY CLAIM/TREAT	D E P O N	M L K 33.7cml Pee	XXX X	
 Place an W on each missin Remarks NUTHORIZATIONS Intrave brean informed of the harves for details services and 	g tooth) 1 32 treatment plan	SH SO 29 SH	6 7 8 37 28	8 9 10 25 24 23	22 21 20	ANCILLARY CLAIM/TREAT	D E P O N	M L K 33.7trial Pee	XXX X	
 Place an W on each mission Flemarks MUTHORIZATIONS I have been informed of the farges for dental services and the thesing dental or dental particles 	g tooth) 1 32 treatment plan materials no p	21 30 28 20 and associated less aid by my dontal ber	6 7 8 27 28 . I agree to b well plan, uni	9 10 20 24 23 presponsible for ersponsible for ersponsible all or	22 21 20 rall 2 y law, or a portion of	ANCILLARY CLAIM/TREAT	D E P O N	M L K 33.7trial Pee	XXXXX	
 Place an W on each missin Remarks NUTHORIZATIONS Intrave brean informed of the harves for details services and 	g tooth) 1 32 treatment plan reaterials not p chize has a con-	31 30 28 21 and associated less aid by my dental beer madiaal agreement v content to your use	6 7 8 27 28 with my plan, unit with my plan	9 10 20 24 23 presponsible for ersponsible for ersponsible all or	22 21 20 rall 2 y law, or a portion of	ANCILLARY CLAIM/TREAT	D E P O Q P O N	M L K 33.7trial Pee	XXXXX	
4. (Place an X on each missin 5. Remarks MUTHORIZATIONS 6. I have been informed of the harges for dental services and to thesing dental are cleant per such charges. To the estant per	g tooth) 1 32 treatment plan reaterials not p chize has a con-	31 30 28 21 and associated less aid by my dental beer madiaal agreement v content to your use	6 7 8 27 28 with my plan, unit with my plan	9 10 20 24 23 presponsible for ersponsible for ersponsible all or	22 21 20 rall y law, or a portion of cd health	ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hoag 40. Is Treatment for Orthodomica? No: (Skip 41-42) _ ye	D E P G G P O N MENT INFORMATION dicable bool and ECF OE b (Complete 41-42)	M L K 33.7oul Pee 2M 28. Number of Engloson National Control Control 41. Date Appliance Placed	XXXXX	
4. (Place an X on each missin 5. Remarks MUTHORIZATIONS 6. I have been informed of the harges for dental services and to thesing dental are cleant per such charges. To the estant per	g tooth) 1 32 treatment plan reaterials not p chize has a con-	31 30 28 21 and associated less aid by my dental beer madiaal agreement v content to your use	6 7 8 27 28 with my plan, unit with my plan	B 9 10 25 24 23 responsible for sis prohibited to prohibiting all or re of my protects	22 21 20 rall y law, or a portion of cd health	ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hoag 40. Is Treatment for Orthodomica? No: (Skip 41-42) _ ye	D E P G G P O N MENT INFORMATION dicable bool and ECF OE b (Complete 41-42)	M L K 33.7oul Pee 2M 28. Number of Engloson National Control Control 41. Date Appliance Placed	XXX X	
 Plece an W on each missin Plemarks MUTHORIZATIONS I have been informed of the harges for dental services and ne theories dental services and the theory out payment formation to carry out payment family Geardian signature 	g tooth) 1 32 treatmeent plan materials not p inited by law, 1 activities in so	Sri 30 29 21 and associated tees aid by my dental tee tractical agreement consent to your use smectice with this of	6 7 8 27 28 • I agree to b with my plan, uni with my plan, uni and disclosu are. Date	B 9 10 25 24 23 a responsible for miss prohibited gill or re of my protects	22 21 20 rall y law, or a portion of ed health 4	ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hosp 40. Is Treatment for Orthodomica? Mos (Skip 41-42) Ve 42. Months of Treatment 42. Rep	D E P G G P O N MENT INFORMATION dicable bool and ECF OE b (Complete 41-42)	M L K 33.7cm Pee 20 Number of Englosen National Control Control 41. Date Appliance Placed 17 44. Date Prior Placement (XXX X	
H. (Place an W on each misain 5. Remarks AUTHORIZATIONS 6. I have been informed of the harges for dental services and he treating dentist or clerital per solid-charges. To the estimate per enderhand services and person with marges.	g tooth) 1 32 treatmeent plan materials not p inited by law, 1 activities in so	Sri 30 29 21 and associated tees aid by my dental tee tractical agreement consent to your use smectice with this of	6 7 8 27 28 • I agree to b with my plan, uni with my plan, uni and disclosu are. Date	B 9 10 25 24 23 a responsible for miss prohibited gill or re of my protects	22 21 20	ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap C Provider's Office Hoap 40. Is Treatment for Orthodomica? Mostlay 41-401 Ve 42. Months of Treatment 43. Rep Remaining	D E P O Q P Q N MENT INFORMATIC ficable boti) Interference N Interference COmplete 41-42) O Interference Ves (Complete 41-42) O Interference Ves (Complete 41-42) O	M L K 33.7cm Pee 20 Number of Englosen National Control Control 41. Date Appliance Placed 17 44. Date Prior Placement (XXX X	
Place an W on each mission Pomarks UUTHOREZATIONS UUTHOREZATIONS If have been informed of the tharges for dental services and n theorem of control of the tharges for dental services and to carry our payment T Thereby sefronce and chectips and or dental service T. Thereby sefronce and chectips and on tail service	g tooth) 1 32 treatmeent plan materials not p inited by law, 1 activities in so	Sri 30 29 21 and associated tees aid by my dental tee tractical agreement consent to your use smectice with this of	6 7 8 27 28 • I agree to b with my plan, uni with my plan, uni and disclosu are. Date	B 9 10 25 24 23 a responsible for miss prohibited gill or re of my protects	22 21 20	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hoag 40. Is Treatment for Orthodomica? Mon (Skip 41-42) Ve 42. Months of Treatment 43. Reg Remaining Inon (Che	D E P O Q P Q N MENT INFORMATION dicable boxit Mail ECF Q Mail ECF Q Q Incomment of Prosthesia Q Ves (Complete 41-42) Lincomment of Prosthesia Ves (Complete box) Ves (Complete box) Ves (Complete box) Ves (Complete box)	M L K 33.7cm Pee 20 Number of Enclosen National Control Concernent 41. Date Appliance Placement (43. Date Prior Placement (
H. (Place an W on each mission Normarks NutrieOREZATIONS Howarks Howarks Howarks Constant and the second of the harpes for dential services constant and the resting dentiat or dential particle constant and the	g tooth) 1 32 treatmeent plan materials not p inited by law, 1 activities in so	Sri 30 29 21 and associated tees aid by my dental tee tractical agreement consent to your use smectice with this of	6 7 8 27 38 1 agree to to write plan, unit write plan, unit write plan, unit write plan and diselocul area Com paguible to me,	B 9 15 25 24 23 responsible to sis prohibited to sis prohibited at chiectly to the being	22 21 20 rall rall a portion of ad health a cos named a	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hoag 40. Is Treatment for Orthodomica? Mon (Skip 41-42) / Ye 42. Montas of Treatment 43. Reg Remaining from (Che Cocupational illness:/njary	D E P O Q P Q N MENT INFORMATION dicable boxit Mail ECF Q Mail ECF Q Q Incomment of Prosthesia Q Ves (Complete 4-42) Incomment of Prosthesia Q Ves (Complete 5-40) Q Ves (Complete 5-40) Anto according 1-40 accord	M L K 33.7cm Pee 20 Number of Enclosen National Control Concernent (41. Date Appliance Placement (43. Date Prior Placement (44. Date Prior Placement (MM/DD/CCYY	
H. (Place an W on each mission Remarks WITHOREZATIONS Howarks Howarks	g tooth) 1 32 weatwoord plane materials and p child be a con- mitted by lane, i activities in co- yment of the den	Sri 30 29 20 and associated hers ald by my dental be assessed to your use somedion with this of medion with this of	6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20 rational sectors of a sector of a	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hoag 40. Is Treatment for Orthodomica? Mon (Skip 41-42) / Ye 42. Montas of Treatment 43. Reg Remaining from (Che Cocopational illness/ngar) 45. Treatment Resulting from (Che	D E P O N G P O N N N MENT INFORMATIC dicable box) Interference N N N MENT INFORMATIC dicable box) Interference O N	M L K 33.7cm Pee 2M 28. Number of Enclosen National Control Control 41. Date Appliance Placed 41. Date Prior Placement (41. Date Prior Placement (41. Date Appliance Placement (42. Auto Accide		
(Place an X on each mission Place an X on each mission Place and X on each mission Inave been informed of the Inave been information of the Inave been informed of the Inave been information Inave been information of the Inave been information	g tooth) 1 32 treatment plan - materials not p close has a con- plant of the den yment of the den	Sri 30 29 20 and associated tees and by my dental ber machael agreement consert to por use smectice with this of mectice with this of tal benefits otherwise (6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20 and a second and a second and a second	ANCILLARY CLAIM/TREAT ANCILLARY ANCILLARY CLAIM/TREAT ANCILLARY ANCILARY ANCILLARY AN	D E P O MENT INFORMATIX Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment	M L K 33.7ctal Peel M L K 33.7ctal Peel M 39. Number of Enclosure er 41. Date Appliance Placed 41. Date Prior Placement (H H H H H H H H H H H H H H H H H H H	IN (00 to 20) (IN ADD/CCYY) IN State	
(Place an W on each mission Place an W on each mission Place and W on each mission Inave been informed of the Inave been informed of the Inave been information of the Inave been information to carry our payment Control of the each of the Inave of each of the each of the Inave of each of the each of the Inave of of th	g tooth) 1 32 treatment plan i materials not p clice has a corp plan in the set activities in co yment of the den wTAL ENTITY insure/Paulson	Sri 30 29 20 and associated tees and by my dental ber machael agreement consert to por use smectice with this of mectice with this of tal benefits otherwise (6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20 and a second and a second and a second	ANCILLARY CLAIM/TREAT ANCILLARY ANCILLARY CLAIM/TREAT ANCILLARY ANCILARY ANCILLARY AN	D E P O MENT INFORMATIX Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment	M L K 33.7ctal Peel M L K 33.7ctal Peel M 39. Number of Enclosure er 41. Date Appliance Placed 41. Date Prior Placement (H H H H H H H H H H H H H H H H H H H		
(Place an W on each mission Place an W on each mission Inava been informed of the marges for dental services and harges for dental services and harges for dental services and information to carry our payment control of the service of dental service for the service of dental service describer signature subscriber signature	g tooth) 1 32 treatment plan i materials not p clice has a corp plan in the set activities in co yment of the den wTAL ENTITY insure/Paulson	Sri 30 29 20 and associated tees and by my dental ber machael agreement consert to por use smectice with this of mectice with this of tal benefits otherwise (6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20 and a second and a second and a second	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hoag 40. Is Treatment for Orthodomical Mon (Skip 41-40) Ve 42. Months of Treatment 42. Reg Remaining Ve 43. Treatment Resulting from (Dis Cocopational illness-treat 44. Date of Accident (MMDDIGC) TREATING DEPITIAS AND TI 30. I Print Comparison of the proceeding 45. Treatment Resulting from 10 Mitting 10 Mit	D E P G Q P O N MENT INFORMATIX Matchie bool Independent of the site	M L K 33.7cm Pee 38. Number of Enclosure National Prior Placement (41. Date Prior Placement (44. Other accident 47. Auto Accident 10N INFORMATION	IN STATE	
(Place an W on each mission Place an W on each mission Place and W on each mission Inave been informed of the Inave been informed of the Inave been information of the Inave been information to carry our payment Control of the each of the Inave of each of the each of the Inave of each of the each of the Inave of of th	g tooth) 1 32 treatment plan i materials not p clice has a corp plan in the set activities in co yment of the den wTAL ENTITY insure/Paulson	Sri 30 29 20 and associated tees and by my dental ber machael agreement consert to por use smectice with this of mectice with this of tal benefits otherwise (6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20		D E P O MENT INFORMATIX Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment Ment	M L K 33.7cm Pee 20. Number of Enclosen National Control Placed 41. Date Appliance Placed 41. Date Prior Placement (44. Date Prior Placement (44. Date Prior Placement (44. Date Prior Placement (44. Date Prior Placement (45. Auto Accident 100 INFORMATION	IN STATE	
Place an X on each mission Place an X on each mission Place an X on each mission Place an information Place an information of the Inave been information of the Inave been information to carry our payment Place and a service and direct parent Place and the service and the service and Place and Place and the service and Place and the service and Place and P	g tooth) 1 32 treatment plan i materials not p close has a cost mitted by issue when of the den yment of the den tract ENTITY insuracity.been Zip Code	Sri 30 29 20 and associated tees and by my dental ber machael agreement consert to por use smectice with this of mectice with this of tal benefits otherwise (6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 38. Place of Treatment (Check ap Provider's Office Hoag 40. Is Treatment for Orthodomical Mon (Skip 41-40) Ve 42. Months of Treatment 42. Reg Remaining Ve 43. Treatment Resulting from (Dis Cocopational illness-treat 44. Date of Accident (MMDDIGC) TREATING DEPITIAS AND TI 30. I Print Comparison of the proceeding 45. Treatment Resulting from 10 Mitting 10 Mit	D E P G Q P O N MENT INFORMATIX Matchie bool Independent of the site	M L K 33.7cm Pee 38. Number of Enclosure National Prior Placement (41. Date Prior Placement (44. Other accident 47. Auto Accident 10N INFORMATION	In 100 to 201 In 100	
Place an % on each mission Place an % on each mission Place an % on each mission Place an information Invo been informed of the Invo been informed of the Invo been informed of the Invo been information to Control and annotate and Invo been information to Control and annotate T. Involve antiform algorithm T. Involve antiform algorithm Involve antiform Involve antiform	g tooth) 1 32 treatment plan - materials not p close has a cost prise has a cost mitted by insert activities in co yment of the den tract. ENTITY insure/Paulosci 20 Code St.	Sri 30 29 20 and associated tees and by my dental ber machael agreement consert to por use smectice with this of mectice with this of tal benefits otherwise (6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20 4 4 4 6 6 6 6 6 6 6 7 7 7 7 7 7 7 7 7 7		D E P O M MENT INFORMATIX dicable box) tail BCP C Complete 41-42) liccentral of Prochesic dic opplete 41-42) liccentral of Prochesic dicable box) Acto acc Y) REATMENT LOCAT sa indicable box data or the free mathematics Y. Process d Y. Y.	M L K 33.704 Pee M L K 33.704 Pee M 29. Newther of Englosure New 41. Date Appliance Placed 41. Date Prior Placement (H 4. Date Prior Placement (H 4. Date Prior Placement (H 7. Auto Accide 1001 INFORMATION Inter in program (by posederes the to in program (by posederes the))	In 100 to 201 In 100	
Place an X on each mission Place an X on each mission Place an X on each mission Place an information Place an information of the Inave been information of the Inave been information to carry our payment Place and a service and direct parent Place and the service and the service and Place and Place and the service and Place and the service and Place and P	g tooth) 1 32 treatment plan - materials not p close has a cost prise has a cost mitted by insert activities in co yment of the den tract. ENTITY insure/Paulosci 20 Code St.	Sri 30 29 20 and associated tees and by my dental ber machael agreement consert to por use smectice with this of mectice with this of tal benefits otherwise (6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible to reso prohibited to reso of my protects clinacity to the bala	22 21 20		D E P O M MENT INFORMATIX dicable box) tail BCP C Complete 41-42) liccentral of Prochesic dic opplete 41-42) liccentral of Prochesic dicable box) Acto acc Y) REATMENT LOCAT sa indicable box data or the free mathematics Y. Process d Y. Y.	M L K 33.7cm Pee M L K 33.7cm Pee M 28. Newsber of Endoom New 41. Date Applance Placed 41. Date Prior Placement (44. Date Prior Placement (44. Date Prior Placement (H Coher accident 47. Auto Accident 100 INFORMATION are in progress (br posederes the to the schall beer I have charged (82. MM/DD/C	In 100 to 201 In 100	
Place an % on each mission Place an % on each mission Place an % on each mission Place an information Invo been informed of the Invo been informed of the Invo been informed of the Invo been information to Control and annotate and Invo been information to Control and annotate T. Involve antiform algorithm T. Involve antiform algorithm Involve antiform Involve antiform	g tooth) 1 32 treatment plan in and plan in an operating the set of the set o	Sri 30 29 24 and associated fees aid by my dental ber martial agreement content by nor use servedion with this of the banefits otherwise (the ban	6 7 b 27 26 refit plan, to bread plan to bread the plan to be refit plan, to be plan to be refit plan to be plan to be refit plan to be plan to be refit plan to be plan to be payable to ma, the plan to be plan to be plan to be plan to be plan to be plan to be plan to be refit to be plan to be plan to be plan to be plan to be refit to be plan to be pl	B 9 15 25 24 23 responsible for res prohibiting all or res of my protects clinically to the balk antity is not suit	22 21 20	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 34. Place of Treatment (Check ap M Provider's Office Hoas 40. Is Treatment for Orthodomical M Provider's Office Ye Account of Treatment 42. Reg Hernaming 44. Mortis of Treatment 44. Reg Hernaming 45. Treatment Resulting from (Che Orthodomical likeses/rejury 46. Date of Accident (MMDDICC) TREATING DENTIST AND T 16. I have been completed and risolated and these providers 16. I have been completed and for Detail of Accident (MMDDICC) 16. I have been completed and for Detail of Accident (MMDDICC) 16. I have been completed and for Detail of Accident (MMDDICC) 16. Provider 10 8765432	D E P O M MENT INFORMATIX dicable box) tail BCP C Complete 41-42) liccentral of Prochesic dic opplete 41-42) liccentral of Prochesic dicable box) Acto acc Y) REATMENT LOCAT sa indicable box data or the free mathematics Y. Process d Y. Y.	M L K 33.7cm Pee M L K 33.7cm Pee M 28. Newsber of Endoom New 41. Date Applance Placed 41. Date Prior Placement (44. Date Prior Placement (44. Date Prior Placement (H Coher accident 47. Auto Accident 100 INFORMATION are in progress (br posederes the to the schall beer I have charged (82. MM/DD/C	IN STATE	
Place an % on each mission Place an % on each mission Place an % on each mission Place and a service and of the thrapes for dental services and thrapes for dental services and thrapes for dental services T. The ester parameter T. The setup satisfact signature T. The setup satisfact service theorements Links DENTIST OR DEI Sate, Address, Cry, State, Dental Group 1 W. Williams S Anytown, WI S	g tooth) 1 32 treatment plan - materials not p close has a cost prise has a cost mitted by insert activities in co yment of the den tract. ENTITY insure/Paulosci 20 Code St.	Sri 30 29 24 and associated fees aid by my dental ber martial agreement content by nor use servedion with this of the banefits otherwise (the ban	6 7 8 27 38 1 Agree to to weld plan, unit weld plan, unit weld plan and direction area Com pagable to ma, Date	B 9 15 25 24 23 responsible for res prohibiting all or res of my protects clinically to the balk antity is not suit	22 21 20	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 34. Place of Treatment (Check ap M Provider's Office Hoas 40. Is Treatment for Orthodomical M Provider's Office Ye Account of Treatment 42. Reg Hernaming 44. Mortis of Treatment 44. Reg Hernaming 45. Treatment Resulting from (Che Orthodomical likeses/rejury 46. Date of Accident (MMDDICC) TREATING DENTIST AND T 16. I have been completed and risolated and these providers 16. I have been completed and for Detail of Accident (MMDDICC) 16. I have been completed and for Detail of Accident (MMDDICC) 16. I have been completed and for Detail of Accident (MMDDICC) 16. Provider 10 8765432	D E P O M MENT INFORMATIX dicable box) tail BCP C Complete 41-42) liccentral of Prochesic	M L K 33.7cm Pee M L K 33.7cm Pee M 28. Newsber of Endoom New 41. Date Applance Placed 41. Date Prior Placement (44. Date Prior Placement (44. Date Prior Placement (H Coher accident 47. Auto Accident 100 INFORMATION are in progress (br posederes the to the schall beer I have charged (82. MM/DD/C	In 100 to 201 In 100	
Place an W on each mission Place an W on each mission Place an W on each mission Place and the marks MUTHORIZATIONS If have been informed of the harges for dental services and harges for dental services and harges for dental services and hardent Viceordian signature T. There is an one of the marks Intervention dental of the patient of Automotive services and direct patient Dental of the patient of Automotive Services Cry, State, Dental Group 1 W. Williams S Anytown, WI S	g tooth) 1 32 treatment plan in and plan in an operating the set of the set o	Sri 30 29 24 and associated fees aid by my dental ber martial agreement content by nor use servedion with this of the banefits otherwise (the ban	6 7 b 27 26 refit plan, to bread plan to bread the plan to be refit plan, to be plan to be refit plan to be plan to be refit plan to be plan to be refit plan to be plan to be payable to ma, the plan to be plan to be plan to be plan to be plan to be plan to be plan to be refit to be plan to be plan to be plan to be plan to be refit to be plan to be pl	B 9 15 25 24 23 responsible for res prohibiting all or res of my protects clinically to the balk antity is not suit	22 21 20	ANCILLARY CLAIM/TREAT ANCILLARY CLAIM/TREAT 34. Place of Treatment (Check ap M Provider's Office Hoas 40. Is Treatment for Orthodomical M Provider's Office Ye Account of Treatment 42. Reg Hernaming 44. Mortis of Treatment 44. Reg Hernaming 45. Treatment Resulting from (Che Orthodomical likeses/rejury 46. Date of Accident (MMDDICC) TREATING DENTIST AND T 16. I have been completed and risolated and these providers 16. I have been completed and for Detail of Accident (MMDDICC) 16. I have been completed and for Detail of Accident (MMDDICC) 16. I have been completed and for Detail of Accident (MMDDICC) 16. Provider 10 8765432	D E P 0 M MENT INFORMATIX dicable box) M M M Mail BCP C C C Mail BCP C C C Mail BCP C C C C Mail BCP C	M L K 33.7cm Pee M L K 33.7cm Pee M 28. Newsber of Endoom New 41. Date Applance Placed 41. Date Prior Placement (44. Date Prior Placement (44. Date Prior Placement (H Coher accident 47. Auto Accident 100 INFORMATION are in progress (br posederes the to the schall beer I have charged (82. MM/DD/C	IN STATE	

9

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.

14

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 eightdigit 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

	ntal Cla			version 2000								
©American Dental Association, 1999 version 2000 1. □Dentist's pre-treatment estimate Specialty (see backside) □Dentist's statement of actual services				3. Carrier Name								
				4. Carrier Address								
				5. City 6						7. Zip		
				9. Address							11. State	
	8. Patient Name (Last, First, Middle) Recipient, Im A.				9. Address			10. City				
PATIENT	12. Date of Birth (MMDD/YYY) 13. Patient ID # 12.34 12.34			14. Sex		15. Phone Nun ()	15. Phone Number ()		16. Zip Code			
PAT	17. Relationship to Subscriber/Employee:				567890 DM DF		18. Employer/School					
							Name		Address			
	19. Subs./Emp. ID#/SSN# 20. Employer Name				21. Group #			Is Patient covered by another plan 32. Policy # No (Skip 32–37) □Yes: □Dental or □ Medical				
	22. Subscriber/Employee Name (Last, First, Middle)					s						
					1	Dorrcies		OI-P M-5 ate of Birth (MM/DD/YYY) 35. Sex 36. Plan/Program Name				n Nama
YEE	23. Address			24. Phone Nur ()	nber g	/ 34. Date of Bin	/ (MM/DD/TTTT)		-			
MPLC	25. City	25. City 26. State			27. Zip Code	5	37. Employer/S Name	37. Employer/School Name Address				
ER / E	28 Date of Bi	28. Date of Birth (MW/DD/YYY) 29. Marital Status				30. Sex		38. Subscriber/Employee Status				
SUBSCRIBER / EMPLOYEE	1	1		Married Single			Employed Part-time Status Full-time Student Part-time Student					
subs	charges for de	intal services a	and materials no	n and associated fees. paid by my dental ben greement with my plan	efit blan, unless th	e treating	40. Employer/S Name	. Employer/School ameAddress				-
	charges. To the to this claim.	tal practice has ne extent perm	itted under appli	cable law, I authorize re	lease of any infor	mation relating		hereby authorize payment of the dental benefits otherwise payable to me directly to the v named dental entity.				
	X						×					
	Signed (Patie	nt/Guardian)		Date	(MM/DD/YYYY)		Signed (Emplo	e/subscriber)		Date (MM/DD/YYYY)		
	_		or Dental Entity			43. Phone Number 44. Provider ID # () 123456				45. Dentist Soc. Sec. or T.I.N.		
	46. Address	l Group)			47. Dentist License # 48. First visit date). Place of trea		
NTIST		1 W. Williams St. 50 City 51, State 52, Zip Code				53. Radiographs or models enclosed? 54. Is				Treatment for orthodontics? Use XNo		
G DE		50. City 51. State 52. Zip Code 51. State 52. Zip Code 52. Zip S5555				□Yes, How n	nany? 🗖 Ne	If service already commenced:				
BILLING DENTIST		55. If prosthesis (crown, bridge, dentures), is this If no, reason for replacement: initial placement? Yes No					ate of prior placeme	nt:	Date appliances placed Total mos. of treatment			
		56. Is treatment result of occupational illness or injury? XNo I Yes					57. Is treatment result of: auto accident? I other accident? I neither					
	Brief descript	on and dates_				Brief descripti	on and dates				-	
58. D	iagnosis Code	ndex (optional 2.)		4.	5.	6.	7.		8		
59. E	xamination and	_	s – List teeth in								Admin	n. Use Only
	B (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Coc D5110	le Qty		Description Complete upper denture		Fee		
	D YYYY 28 MOD		D3110 D2160	1	Amalgam			XX.XX				
							······································					
60. Identify all missing teeth with "X" Permanent Primary Total Fee XXX.XX												
					BCDE	FGHIJ	Payment by other p	lan	XX.XX			
					SRQP	ONMLK	Deductible					
61. Remarks for unusual services								Carrier %				
								Carrier pays				
								Patient pays				
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							ple visits) or 6 those	3. Address where treatm	ient was performe	ed		
procedures. T.M. Provider 87654321 MM/DD/YYYY								4. City		65.Sta	ate 6	6. Zip Code
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)												
©An	nerican Der	tal Assoc	ation, 1999	00 1501						101	veorger, ca	all 1-800-947-474