North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance
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Attention: All Providers

New Claim Form Instructions

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INTRODUCTION

This revised Special Bulletin replaces the December 2006 Special Bulletin

The CMS-1500 (12/90), the UB-92 and the American Dental Association (ADA) 2002 paper forms have been revised and will be replaced with the new CMS-1500 (08/05), the UB-04 and the ADA 2006 claim forms, respectively. Medicaid will begin accepting the claim forms effective with the dates shown below. Paper claims submitted on the old forms will not be processed after the date shown in the last column and will be returned to the provider. The intent of this bulletin is to address claim form changes only. **N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA.** For information related to claim filing requirements and billing guidelines refer to N.C.Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Claim form	Medicaid will accept the new paper form on:	Claims must be submitted on the new format no later than:
CMS-1500 (08/05)	Jan. 1, 2007	July 1, 2007
UB-04	March 1, 2007	Final date to be announced
ADA 2006	March 1, 2007	Final date to be announced

The revised paper claim forms are integral to the implementation of the National Provider Identifier (NPI) as the standard unique health identifier for providers (see http://www.ncdhhs.gov/dma/ for more information). N.C. Medicaid will allow a transition period to convert from the old paper claim forms to the new claim forms. Each form contains specific changes that will affect Medicaid claims processing, and specific time periods within which particular information must be submitted. Explanation of Benefits (EOB) verbiage will be changing to reflect the use of the revised paper claim formats. Please carefully review the Medicaid-related guidelines in this Bulletin.

DEFINITIONS

Atypical Provider: Provider who does not render health care services and is not eligible for an NPI. Example: a contractor who builds a wheelchair ramp on a recipient's home.

CA PCP: Carolina ACCESS Primary Care Provider

National Provider Identifier (NPI): New identifier issued through the National Plan and Provider Enumeration System (NPPES) developed by CMS. NPI will replace all Medicaid provider numbers currently used for billing purposes.

Qualifier: Identifies whether the number to the immediate right on the claim represents a Medicaid provider number (1D for CMS 1500 and G2 for UB04) or a taxonomy code (ZZ for CMS 1500 and B3 for UB04).

Taxonomy number: Code identifying a provider type and specialty

OVERVIEW OF CLAIM FORM CHANGES

Pending NPI implementation, continue to bill using your Medicaid Provider Number.

The following table provides a brief overview of changes for all claim forms. These changes will affect claims processing. Explanations of these changes and definitions of terms will be provided in the following pages.

UB-04	CMS-1500	ADA
Carolina ACCESS NPI or Medicaid Provider Number	Carolina ACCESS NPI or Medicaid Provider Number	NPI—Billing and Attending
No Signature field	NPI—Billing, Attending or Referring	Taxonomy—Billing and Attending
NPI—Billing, Attending and Referring	Qualifier 1D and ZZ	ZIP + 4 Code for Service Facility Location and Billing Location
Payer Code	Taxonomy—Billing, Attending	Medicaid Billing Provider Number for Prior Approval Purposes only.
Qualifier B3 and G2	ZIP + 4 Code for Service Facility Location and Billing Location	
Taxonomy—Billing		
Value Codes		
ZIP + 4 Code for Service Facility Location and Billing Location		

CLAIM FORM INSTRUCTIONS

Because providers are allowed to submit both Medicaid provider information *and* NPI information on claims during the transition period, there are two claim examples for each claim form: one for revised claim transition and one for NPI implementation. Refer to NPI publications for NPI implementation dates.

CMS-1500 (08/05) Changes Effective Jan. 1, 2007: Revised Claim Transition

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at *www.nucc.org*. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to N.C. Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

- Field 17a: If applicable, enter either the referring provider (the Medicaid provider number) or CA PCP provider number for claims requiring CA authorization (the Medicaid provider number) or the CA ACCESS override number assigned by EDS in the shaded field 17a. Qualifier 1D must precede either of these numbers in the delimited block immediately to the right of the field identifier "17a."

- Field 17b: The referring provider's NPI or CA PCP NPI for claims requiring CA authorization may be entered in this field. N.C. Medicaid requests that providers immediately start submitting the NPI in addition to the Medicaid provider number.

- Fields 24i and 24j, Attending Provider Number: If the procedure requires an attending provider number, the attending number must be entered.

    - Field 24j NPI (lower portion of the field): The attending provider's NPI may be entered in this field. N.C. Medicaid requests that providers immediately start submitting the NPI.

    - Fields 24i and 24j (upper shaded portion of the field): Enter qualifier 1D in field 24i and the attending provider's Medicaid number in 24j. After NPI implementation enter the taxonomy code in 24j with qualifier ZZ in 24i (During transition, taxonomy is not required).

- Field 32, Service Facility Location: Address where service was rendered, including ZIP + 4 Code.

- Field 33, Billing Provider Information: Provider address must include ZIP + 4 Code.

- Field 33a: Enter the Medicaid billing provider's NPI. N.C. Medicaid requests that providers immediately start submitting the NPI.

- Field 33b: Enter the Medicaid number, preceded by qualifier 1D. (This field is not specifically delimited.) It is not necessary to enter a space between qualifier 1D and the Medicaid number. After NPI implementation the taxonomy code with qualifier ZZ should be entered (During transition, taxonomy is not required).

CMS-1500 (08/05) Form Instructions for Field Changes Effective Jan. 1, 2007

Instructions for completing the standard CMS-1500 claim form as it relates to the claim form field changes are listed below. **Please note:** These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by NUCC. The NUCC instruction manual can be found at www.nucc.org. Refer to NPI publications for NPI implementation dates. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to N.C .Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Block	Block Name	Explanation
17.	Name of Referring Provider or Other Source	Use for referring provider's name.
17a.	Other ID Number	Use for CA override or Medicaid provider number (for CA authorization) with qualifier 1D, or taxonomy code with qualifier ZZ. During transition, taxonomy is not required.
17b.	NPI	Use for referring provider NPI or Carolina ACCESS PCP's NPI for CA authorization.
19.	Reserved for Local Use	Please be aware that Medicaid will no longer use block 19 for Carolina ACCESS.
24I. (upper shaded portion)	Qualifier	Enter qualifier 1D if entering Medicaid provider number or ZZ if entering taxonomy. During transition, taxonomy is not required.
24J. (upper shaded portion)	Rendering Provider ID Number	Enter Medicaid attending provider number or taxonomy. During transition, taxonomy is not required.
24J. (lower unshaded portion)	Rendering provider ID number	Enter attending provider NPI.
32.	Service Facility Location Information	Enter the ZIP + 4 Code.
33.	Billing Provider Info and Phone Number	Enter the billing provider's name, street address including ZIP + 4 Code and phone number.
33a.	NPI	Enter the billing provider's NPI.
33b.	Other ID Number	Enter the Medicaid provider number with 1D qualifier or taxonomy with ZZ qualifier. During transition, taxonomy is not required.

Note: Quick Reference Guides for Carolina ACCESS Provider on pages 17-21

CMS 1500 Example Effective January 1, 2007: Revised Claim through NPI Implementation Date (to be announced).

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHOR... to process this claim. I also ... below. ...HIS FORM. ...edical or other information necessary ...he party who accepts assignment

SIGNED ...TE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY

...S HAD SAME OR SIMILAR ILLNESS. ...ATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING P...

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE L... YES

...URY (Relate Item...

22. MEDICAID R... CODE

23. PRIOR AUT...

2. . 4. .

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI
2
3
4 NPI
5 NPI
6

25. FEDERAL TAX I.D. NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMO... $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

17a: Enter qualifier 1D and Medicaid CA PCP for CA authorizations, referring provider or CA override number (if applicable).

17b: NPI for CA PCP for CA authorizations or referring provider.

19: No longer used for Carolina ACCESS.

24I and J: Enter qualifier 1D and Medicaid attending provider number.

24J: Attending provider NPI.

32: Rendering location address. Must include ZIP + 4 Code.

33: Billing provider information. Must include ZIP + 4 Code.

33a: NPI for billing provider. 33b: Enter qualifier 1D and Medicaid provider number.

CMS-1500 Example: Effective with NPI Implementation Date (to be announced). Refer to future NPI publications for NPI

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous)
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M
(State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*
READ BACK OF FORM BEF
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATU to process this claim. I also request payment of govern below.
SIGNED
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

17a: Enter qualifier 1D and CA override number (if applicable) OR qualifier ZZ and referring provider's taxonomy number. Referring taxonomy code is not required.

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LA YES
URY (Relate Item
22. MEDICAID R CODE
23. PRIOR AUTH
4.

19: No longer used for Carolina ACCESS.

17b: NPI for CA PCP for CA authorization or referring provider.

24 I and J: Enter qualifier ZZ and attending taxonomy code.

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI
2
3
4
5 NPI
6

24J: Attending provider NPI. Required if billing with group NPI.

32: Rendering location address. Must include ZIP + 4 Code.

33: Billing provider information. Must include ZIP + 4 Code.

25. FEDERAL TAX I.D. NUMBER
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMO $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH #
a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

33a: NPI for billing provider. 33b: Enter qualifier ZZ and taxonomy.

UB-04 Changes Effective March 1, 2007: Revised Claim Transition

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Billing Committee (NUBC). The NUBC instruction manual can be found at *www.nubc.org*. Refer to NPI publications for NPI implementation dates. Changes to NC Medicaid programs and policies related to the implementation of the UB04 claim form will be addressed in separate bulletins. Information regarding NC Medicaid filing requirements and billing guidelines can be found at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

- Form locator 1: Name and service facility location (address must include ZIP + 4 Code) of the provider

- Form locator 2: Billing name and address (address must include ZIP + 4 Code) for the payment if different than that of the provider in FL1.

- Form locators 39–41 (Value Codes): Use value codes to identify covered days (80), non-covered days (81), co-insurance days (82) and lifetime days (83). Refer to the UB-04 manual for other value code definitions.

- Form locator 56 (NPI): Billing provider's NPI. Enter the billing provider NPI. N.C. Medicaid requests that providers immediately begin submitting the NPI with their Medicaid provider number.

- Form locator 57 (Other Payer ID): Enter the billing provider's Medicaid number on line A, B or C, to correspond with the Medicaid payer name.

- Form locator 76: (Attending provider): Enter the attending provider's NPI in the first space of this form locator, if applicable. Enter the attending provider's Medicaid provider number in the second space with qualifier G2, if applicable.

- Form locator 78 (Other): Enter qualifier DN for Referring Provider in the first space. The NPI of the CA PCP for claims requiring CA authorization or the referring provider may be entered in the second space identified as NPI. Enter either the CA PCP Medicaid provider number for claims requiring CA authorization, referring provider or the CA ACCESS override number assigned by EDS with qualifier G2 in the third and fourth space identified as QUAL field.

- Form locator 81 (Code-Code): Enter qualifier B3 and the billing provider taxonomy code. During transition, taxonomy is not required.

UB-04 Form Change Instructions

Instructions for completing the standard UB-04 claim form as it relates to the claim form field changes are listed below. These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by NUBC. The NUBC instruction manual can be found at www.nubc.org. Refer to NPI publications for NPI implementation dates. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guide lines refer to N.C. Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Form Locator/Description	Requirements	Explanation
1. Provider Name/Address/ City/State/Zip	Required	Enter the provider's name and the service facility location. The ZIP code must be in the ZIP + 4 format.
2. Pay-to Name/ Address/ City/State/Zip	Required	Enter the provider's name and address (address must include ZIP + 4 Code) for the payment if different than that of the provider in FL1.
39.–41., a–d Value Codes and Amounts	Required, where applicable	80 Covered Days 81 Non-covered Days 82 Co-insurance Days 83 Lifetime Reserve Days NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to NC Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.
50. Payer Name	Required	Enter the name of the insurance payer and the two-character payer code. **Payer Codes for NC Medicaid is -** Medicaid MC
56. NPI	Required	Enter your National Provider Identification number.
57. Other Provider ID	Required	Enter the Medicaid provider number without a qualifier
76. Attending Provider Information	Required, where applicable	Enter the attending provider's NPI or Medicaid provider number and G2 qualifier.
78. Carolina Access PCP/Referring Provider	Required, where applicable	Enter DN then the NPI for the CA PCP for claims requiring CA authorization or Referring provider if applicable. Enter the CA override or Medicaid provider number for claims requiring CA authorization or Referring provider with G2 qualifier, if applicable.
81. Code –Code Field	Required	Enter qualifier B3 and the Billing provider taxonomy code. During transition, taxonomy is not required.

Note: Quick Reference Guides for Carolina ACCESS Provider on pages 17-21

UB-04 Example Effective March 1, 2007 through NPI Implementation Date (to be announced).

FL1: Name and service facility location for provider (must include ZIP+4)

FL2: Name of billing location for provider (must include ZIP+4) if different from FL 1.

New value codes to report covered/non-covered days, co-insurance and lifetime reserve.

FL 50: New two-digit code identifying payer.

FL 56: Billing provider NPI.

FL 57: Medicaid provider number (required).

FL 76: Attending NPI.

FL 76: Attending Medicaid provider number. **Use qualifier G2**.

FL 81: Billing provider taxonomy. **Use qualifier B3**.

FL 78: **Use DN qualifier then the** CA PCP NPI for claims requiring CA authorization or Referring provider or referring provider's NPI.

FL 78: **Use qualifier G2** then the Medicaid CA number for claims requiring CA authorization or Referring provider number or CA override number.

UB-04 Example: Effective with NPI Implementation Date (to be announced). Refer to future NPI publications for NPI Implementation

FL1: Name and service facility location for provider (must include ZIP + 4

FL2: Name of billing location for provider (must include ZIP+4) if different from FL 1

New value codes to report covered/non-covered days, co-insurance and lifetime reserve.

FL 50: New two-digit code identifying payer.

FL 56: Billing provider NPI.

FL 76: Attending NPI.

FL 81: Billing provider taxonomy. **Use qualifier B3**.

FL 78: **Use DN qualifier** then the CA PCP NPI for claims requiring CA authorization or Referring provider or referring provider's NPI.

FL 78: **Use G2 qualifier** then the CA override number (if applicable).

Instructions for the 2006 ADA Claim Form

Please note: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the ADA. The ADA instruction manual can be found at www.ada.org. Refer to NPI publications for NPI implementation dates. NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to N.C. Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

ADA Changes Effective March 1, 2007: Revised Claim Transition

- Field 35 (Remarks): Enter the billing provider's taxonomy code.
- Field 48 (Address): Enter the provider address information which must include the ZIP + 4 Code.
- Field 49 (NPI): Enter the billing provider's NPI number.
- Field 52A (Additional Provider ID): Enter the Medicaid billing provider number. After NPI implementation, the Medicaid billing provider number is required for prior approval purposes only.
- Field 54 (NPI): Enter the attending provider's NPI number.
- Field 56 (Address): Enter the provider address information which must include the ZIP + 4 Code.
- Field 56A (Provider Specialty Code): Enter the attending provider's taxonomy code.
- Field 58 (Additional Provider ID): Enter the Medicaid attending provider number. After NPI implementation, the Medicaid attending provider number is no longer required and should not be entered on the request.

ADA Claim Form Instruction Changes

Instructions for the 2006 ADA Form as it relates to the claim form field changes are listed below. **Please note**: These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the ADA. The ADA instruction manual can be found at www.ada.org. Refer to NPI publications for NPI implementation dates. NC Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines refer to N.C. Medicaid program information and policies found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

Field Number	Field Name	Explanation
35	Remarks	Enter the billing provider's taxonomy code.
48	Billing Address, City, State, Zip Code	Enter the address, including ZIP + 4 Code.
49	NPI	Enter the billing provider's NPI.
52A	Additional Provider ID	Enter the Medicaid billing provider number. After NPI implementation, the Medicaid billing provider number is required for prior approval purposes only.
54	NPI	Enter the attending provider's NPI number for the individual dentist rendering the service. This number should correspond to the signature in field 53.
56	Address, City, State, Zip Code	Enter the address, including ZIP + 4 Code.
56A	Provider Specialty Code	Enter the attending provider's taxonomy code.
58	Additional Provider ID	Enter the Medicaid attending provider number. After NPI implementation, the Medicaid attending provider number is no longer required and should not be entered on the request.

ADA Example Effective March 1, 2007 through NPI Implementation Date (to be announced).

ADA Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender ☐M ☐F 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) 14. Gender ☐M ☐F 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other 19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) 22. Gender ☐M ☐F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION — 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; 32. Other Fee(s); 33. Total Fee

35. Remarks

35: Billing taxonomy.

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. NPI 50. License Number 51. SSN or TIN
52. Phone Number ( ) – 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Signed (Treating Dentist) Date
54. NPI 55. License Number
56. Address, City, State, Zip Code 56A. Provider Specialty Code
57. Phone Number ( ) – 58. Additional Provider ID

54: Attending NPI.

56A: Attending taxonomy.

58: Attending Medicaid provider number.

48 & 56: Address including ZIP + 4 Code.

52A: Billing Medicaid provider number.

49: Billing NPI.

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ADA Example: Effective with NPI Implementation Date (to be announced). Refer to future NPI publications for NPI Implementation Dates.

ADA Dental C...

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender ☐M ☐F 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) 14. Gender ☐M ☐F 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other 19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) 22. Gender ☐M ☐F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION — 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
34. (Place an 'X' on each missing tooth) 32. Other Fee(s) 33. Total Fee
35. Remarks

AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Patient/Guardian signature Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (... claim on behalf of the patient or insured/subscriber)
48. Name, Address, City, State, Zip Code
49. NPI 50. License Number 51. SSN or TIN
52. Phone Number ( ) – 52A. Additional Provider ID

...DENTIST AND TREATMENT LOCATION INFORMATION
...ify that the procedures ...een completed.
Signed (Treating Dentist) Date
54. NPI 55. License Number
56. Address, City, State, Zip Code 56A. Provider Specialty Code
57. Phone Number 58. Additional ...

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35: Billing taxonomy.

54: Attending NPI. Required if billing with group NPI.

56A: Attending taxonomy.

48 & 56: Address including ZIP + 4 Code.

49: Billing NPI.

52A: Billing Medicaid provider number, for prior approval purposes only.

QUICK REFERENCE GUIDES FOR CAROLINA ACCESS PROVIDERS

Significant changes regarding the placement of Carolina ACCESS information have occurred on both the CMS-1500 and the UB-04 claim forms. Outlined below are specific timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides and referring provider information on the claim. Please make note of these filing requirements.

CMS-1500 (08/05)
Claims Processed with CA PCP Authorization and/or CA Override
Transition Dates: Jan. 1, 2007, until NPI implementation

Effective July 1, 2007, providers must submit on the new CMS-1500 (08/05) claim form. Providers filing on the new CMS-1500 (08/05) claim form must follow the process below for claims received from Jan. 1, 2007, until NPI implementation.

Block	***Block Name***	***Required Field Yes / No***	***Value***	***Explanation***
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Yes	1D	Qualifier 1D represents Medicaid provider number.
17a (larger shaded box)	PCP Referral Number or CA Override Number	Yes	Medicaid Provider # or CA Override #	Enter the CA PCP referral number (Medicaid provider number) or the CA override number assigned by EDS.
17b	NPI (National Provider Identifier)	No	NPI Number	The CA referral information is processed from block 17a.

CMS-1500 (08/05)
Claims Processed with CA PCP Authorization
Effective with NPI implementation

Block	*Block Name*	*Required Field Yes / No*	*Value*	*Explanation*
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	No		
17a (larger shaded box)	Taxonomy Number of Referring Provider	No		
17b	NPI	Yes	CA referring provider's NPI number	This is a required field.

Note: If any value is entered in field 17a other than ZZ or blank, the claim will deny. If you enter a ZZ qualifier in field 17a you must enter the taxonomy number in field 17a or the claim will deny.

CMS-1500 (08/05)
Claims Processed with CA Override
Effective with NPI implementation

Block	*Block Name*	*Required Field Yes / No*	*Value*	*Explanation*
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Yes	1D	Qualifier 1D represents Medicaid provider number. If any other value is entered, the claim will be denied.
17a (larger shaded box)	CA Override Number	Yes	EDS-issued override number	
17b	NPI	No		Will not have NPI of referring provider.

UB-04
Claims Processed with CA PCP Authorization/Referral or CA Override
Transition Dates: March 1, 2007, through NPI implementation

Providers filing on the new UB-04 claim form must follow the process below for claims received from March 1 until NPI implementation.

Form Locator	*Description*	*Required Field Yes / No*	*Value*	*Explanation*
78 (blank field 1)	Provider Type Qualifier Code	Yes	DN	DN indicates referring provider.
78 (blank field 2)	NPI	No		
78 (blank field 3)	Qualifier	Yes	G2	Qualifier G2 represents Medicaid provider number. If any other value is entered, the claim will be denied.
78 (blank field 4)	PCP Referral Number or CA Override Number	Yes	Medicaid provider # or EDS-issued CA override #	Enter the current CA PCP number (Medicaid provider #) or the CA override number assigned by EDS.
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

UB-04
CA Claims Processed with PCP Authorization/Referral
Effective with NPI implementation

Form Locator	***Description***	***Required Field Yes / No***	***Value***	***Explanation***
78 (blank field 1)	Provider Type Qualifier Code	Yes	DN	DN indicates referring provider.
78 (blank field 2)	NPI	Yes	CA referring provider's NPI number	This is a required field.
78 (blank field 3)	Qualifier	No		
78 (blank field 4)	Other Provider Identifier of Referring Provider	No		
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

UB-04
CA Claims Processed with CA Override Number
Effective with NPI implementation

Form Locator	*Description*	*Required Field Yes / No*	*Value*	*Explanation*
78(blank field 1)	Provider Type Qualifier Code	Yes	DN	DN indicates referring provider.
78 (blank field 2)	NPI	No		
78 (blank field 3)	Qualifier	Yes	G2	Qualifier G2 represents CA override number. If any other value is entered, the claim will be denied.
78 (blank field 4)	CA Override Number	Yes	EDS-issued override number	
78 (blank field 5) Last	Last Name of Referring Provider	No		.
78 (blank field 6) First	First Name of Referring Provider	No		

Mark T. Benton, Director
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS