Welbe Health

# Provider Billing Guide

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# Introduction

WelbeHealth is a Program of All-Inclusive Care for the Elderly (PACE) organization providing full-service healthcare and personalized support to assist our participants in aging well at home and staying in their community. WelbeHealth participants are supported by a dedicated team that coordinates all care needs with access to highly skilled doctors, dentists, home care, physical therapy, transportation, meals, social activities and much more.

WelbeHealth opened its doors to Stockton California seniors in the summer of 2019 and continues to grow throughout Northern and Southern California with additional centers coming soon to other states. For a full list of operating locations please visit our website
Locations - WelbeHealth

This guide is meant to assist you in properly billing WelbeHealth and will be revised periodically as needed. Additionally, providers may be notified of changes, reminders, and best practices via Provider Alerts and notices posted on the Provider Portal. These notifications can supersede information within this resource guide.

# Policies and Procedures

## Disclaimer

This manual is intended to help providers effectively do business with WelbeHealth. If there is any inconsistency between this manual and the terms of your network agreement, the terms of your agreement will control. It is not meant to replace the Medicare or Medi-Cal provider's billing guidelines and resources. If you have questions, please email WelbeHealth's provider partnership team at providers@welbehealth.com

## Participant/Balance Billing

WelbeHealth participants do not have out-of-pocket expenses for benefits covered under PACE. Share of Cost (SOC) responsibilities are cleared each month, and there are no deductibles, copays, or co-insurance amounts. All services provided to a WelbeHealth participant should be billed to WelbeHealth.
If the services provided are Covered Services, then WelbeHealth's reimbursement to the Provider constitutes full payment and the participant cannot be balanced billed for these services.

If a participant is willing to compensate the Provider for a non-covered service and the Provider is willing to accept a negotiated payment between the parties, that agreement must be provided to the participant in writing, making it clear the participant is financially responsible for the service, and be signed by the participant prior to services rendered. If you have questions, please contact WelbeHealth's provider partnership team at providers@welbehealth.com

Violation of the PACE and PACE governing agencies' rules could result in the immediate termination of the Provider's Agreement and potential actions from our governing agencies.

# Claims Submission and Processing

## Requirements for a complete claim

A Complete Claim is a complete and accurate claim form that includes all Provider and Participant information, as well as participants' records, information or documents needed to enable WelbeHealth to process the claim.

## Claim filing and payment timelines

Contracted providers must submit claims within the time limit indicated in the contract (agreement between WelbeHealth and the provider/organization). Non-contracted providers have three hundred and sixty-five (365) days from the date of service.

If the claim is not submitted within the appropriate time limit, the claim will be denied unless disputed and a good cause for delay can be presented.

Requests for claim adjustment, correction, or reconsideration of an adjudicated claim must also be received within one hundred and eighty (180) days of the date on the Remittance Advice (RA) or the time frame specified in the providers' agreement or three hundred and sixty-five days (365) for non-contracted providers following the date of payment or denial of the claim.
Extenuating circumstances causing delay would include but not limited to:

- A catastrophic event that substantially interferes with normal business operations of the Provider
- Administrative delays or errors by WelbeHealth, or WelbeHealth's governing agencies
- Other special circumstances review and approved by WelbeHealth

Consideration will be given to extenuating circumstances provided that complete documentation is submitted to WelbeHealth to justify the delay.

## Claims Submission Process

WelbeHealth requires claims to be submitted electronically through Electronic Data Interchange (EDI). Providers can submit EDI claims with no cost to them through our EDI partner Office Ally. Office Ally allows for attachments, if required. Claims requiring documentation are:

- Emergency Transports
- Services billed with an unlisted service code
- Services that require an invoice for pricing

If a claim has been denied requesting additional information or documentation, do not resubmit the claim, instead submit the requested information or documentation using the "Correspondence" process.

Office Ally
(866) 575-4120
info@officeally.com WelbeHealth Payer ID: WBHCA

Paper claims submission is not recommended, however if needed claims can be fax to
(626) 209-4367

*Note:* Effective September 1, 2025, the P.O. Box listed below is no longer available. Claims mailed to the P.O. Box will be returned to the provider.
P.O. Box 30760
Tampa, FL 33630-3760

## Medical Records

Medical records are required for all external partners (providers) providing services to WelbeHealth participants. Medical records should be sent to medrechub@welbehealth.com. Medical records are not required for claims processing and should not be submitted with the claim. All medical records, supporting documentation, and correspondence must comply with the HIPAA Privacy and Security Rules, including the minimum necessary standard.

## Corrected Claim Submission

Effective January 1, 2026, Corrected Claims must be submitted within 180 days from the date of service, unless the original claim was denied, then 180 days from the Remittance Advice (RA) date.

Prior to January 1, 2026, the submission timeframe was 30 days from the claim processing date.

WelbeHealth will treat corrected claims as replacement claims. When submitting a corrected claim, it is important that you follow corrected claim guidelines to avoid potential denial. When submitting a corrected claim the following is required:
UB-04 claim form – Field 4 (Bill Type) must have a "7" in the fourth digit placement and field 64 (Document Control Number) must list the original WelbeHealth claim number
CMS1500 claim form – Box 22 (Resubmission Code) must have a "7" followed by the original WelbeHealth claim number – do not add a leading 0
ADA claim form – Box 35 (Remarks) must state "Corrected Claim" and list the original WelbeHealth claim number

If you submit claims via our provider portal, please indicate "Corrected Claim" and the original claim number in the notes field to avoid delays and/or denial.

Note: Corrected claims should be sent with ALL line items originally filed for that claim, unless previously billed line(s) was submitted in error. Do not cross out any lines previously processed. You can add an additional line(s) not previously submitted and/or change unit values.

If your corrected claim is denied as a duplicate, do NOT submit a dispute if:

- Your corrected claim was not sent with the appropriate indicator and original claim number, instead
- Submit a new claim with the appropriate indicator and original claim number for processing.

If a dispute is received in this scenario, it will be returned to you to submit using the corrected claim steps listed above.

### Corrected Claim Submission Timeframe

Effective January 1, 2026, Corrected Claims must be submitted within 180 days from the date of service, unless the original claim was denied, then 180 days from the Remittance Advice (RA) date.

Prior to January 1, 2026, the submission timeframe was 30 days from the claim processing date.

## Orders

All external services except for urgent and emergent services require a WelbeHealth order. Orders are placed by internal WelbeHealth providers when care or services need to be provided by someone outside of a WelbeHealth center. The order, also known as a referral, starts the scheduling process for external care.

- If you have an order requesting services, please validate that the services you are performing are not listed on the Prior Authorization list; if so, you will need to request a prior authorization from WelbeHealth.
- If you have not received an order for services, please reach out at (650) 336-0300 to ensure the proper care has been reviewed and approved by our Interdisciplinary Team (IDT).

Note: An order does not replace an authorization

## Authorizations

WelbeHealth has a subset of services that require prior authorization. If the service being provided requires authorization, it must be obtained prior to services rendered and/or prior to billing. The prior authorization list can be found on our website https://welbehealth.com/partners and requests for prior authorization can be submitted through our provider portal (for contracted providers) or via fax to (209) 729-5854.

An order does not override or replace an authorization; please make sure you are checking services provided against the WelbeHealth prior authorization list to avoid delays in payment or denials.

The authorization must be listed on the claim to avoid denial. If your claim is denied due to missing or invalid authorization, do not submit a dispute. Submit a new claim following the corrected claim process.

Reminder:
WelbeHealth provides COVID-19 testing services directly. If a provider or organization chooses to provide COVID-19 testing at any of the following Place of Service (POS), prior authorization is required:

- POS 27 – Outreach Site/Street
- POS 81 – Independent Laboratory
- POS 82-98 – Unassigned
- POS 99 – Other

Note: Do not submit a claim with a hard copy of an authorization attached to a claim form.

## Scheduling External Participant Services

WelbeHealth schedules all external services including provider specialist appointments to ensure participant transportation needs are met. To schedule an appointment for our participants please call WelbeHealth's Advocate Hub at (650) 336-0300.

## Provider Dispute Resolutions (PDR) Submission

When submitting a PDR, Providers must be sure to completely and accurately fill out all requested information listed on the PDR form to process your PDR timely and accurately. This form can be located at https://welbehealth.com/partners/ .

WelbeHealth will resolve disputes and issue a written determination within thirty (30) working days of receipt of the dispute or amended dispute. In no case will WelbeHealth discriminate against or retaliate against a Provider because a dispute was filed.

- Contracted Providers must submit provider disputes online through the Provider Portal at https://welbehealth.quickcap.net/
- Non-Contracted Providers must file disputes with the appropriate PDR form and documentation via fax at (626) 498-2099 ATTN: PDR Dept.

Note: Failure to submit the provider dispute through the proper channels or without the PDR form will result in the return of the dispute and/or may delay the processing and potentially could fall outside of the dispute processing guidelines.
If the dispute is determined to be a Correspondence, it will be routed to the proper team for review and processing as a Correspondence claim.

PDR Reasons:

- Contract Dispute: Claim did not pay per contract rates/terms
- Appeal of Medical Necessity/Utilization Management Decision: Previously requested and denied authorization or partial authorization/different LOC
- Seeking Resolution of a Billing Determination: Do not agree with claim or claim line(s) processing/denial
- Recovery Dispute: A letter was received regarding an identified overpayment, and you do not agree with the determination
    - If the provider wishes to contest the notice of reimbursement of overpayment (Recovery Request Dispute), it must be within thirty (30) working days.

### PDR Submission Timeframe

PDRs must be submitted within the term listed in the agreement or, effective January 1, 2026, within 365 days from the Remittance Advice (RA).

Prior to January 1, 2026, the submission timeframe was 30 days from the claim processing date.

## Correspondence

If a claim has denied requesting additional information or if the provider feels additional information is warranted for a claim previously submitted to WelbeHealth a Correspondence form should be completed and submitted with the requested and/or additional documentation. The Correspondence form is located on the WelbeHealth website at https://welbehealth.com/partners/ . Some items that may require additional information are:

- W-9 requested
- Invoice required for pricing
- Documentation for unlisted code billed
- Proof of Timely Filing
- Authorization

All providers (contracted/non-contracted) should submit the Correspondence form and attachments via fax to **(626) 498-2099 ATTN: Corrs Unit**

**Note:** Do not submit a PDR or Corrected claim when additional documentation is needed/requested to process a claim already on file. This may cause a delay in processing, denial, or potential return of the information provided. The additional information received with the Correspondence form will be routed to the proper department for adjustment of the previously received claim.

### Correspondence Submission Timeframe

Effective January 1, 2026, Correspondence must be received within 180 days of the Remittance Advice (RA) date.

Prior to January 1, 2026, the Correspondence submission timeframe was 30 days from the claim processing date.

## Coordination of Benefits (COB)

As a PACE plan, most of our participants are solely covered by WelbeHealth for their Medicare and Medicaid benefits. However, there are times when a participant may have Other Health Coverage (OHC) that is primary. When submitting a claim to WelbeHealth for secondary payment/coordination of benefits the following are required:

- The claim must be identical to the claim submitted to the primary payer (e.g., codes, modifiers, and units billed), and
- Include the primary payer's processing information from the RA, EOB, or EOP (payments, remark/remark codes)

Note: If a participant is Medicare and/or Medi-Cal eligible and a WelbeHealth participant, do not bill Medicare or Medi-Cal directly. Claims should be directed to WelbeHealth for all Medicare/Medi-Cal processing.

## Fraud, Waste, and Abuse (FWA)

WelbeHealth cooperates with state and federal agencies to identify fraud, waste, abuse, and prevention. WelbeHealth works with analysts, compliance, and clinicians to perform audits and monitor compliance with standard billing requirements. Thes audits are used to identify the following activity:

- Inappropriate "unbundling" of codes
- Claims for services not provided
- Up-coding/Incorrect coding
- Potential over-utilization
- Coding (diagnostic or procedural) not consistent with referrals, medical records or participant's age/gender
- Improper use of benefits
- High number of units billed

When required, we report suspected fraud and/or abuse to our governing agencies and, if appropriate, the Department of Justice. Providers must cooperate in potential investigations by making office staff and subcontracted personnel available for interviews, consultation, hearings, and any other activities required in an investigation.

To report potential fraud, waste, and abuse, Providers can contact (844) 986-1440

## Billing and Coding Methodologies

As a state and federally funded program under Programs for All-Inclusive Care of the Elderly (PACE), WelbeHealth's reimbursement policies and guidelines are based on Medicare and/or Medi-Cal. Participating providers should reference their contract for terms related to payment. Non-contracted providers' reimbursement is based on Medicare guidelines and fee schedule in effect on the date services were performed. If services are not covered by Medicare, they will be processed under Medi-Cal rates. If the services provided are not covered by either, it is at WelbeHealth's discretion.

This section provides coding requirements to assist you in billing correctly for services rendered to WelbeHealth participants. Providers are responsible for the submission of accurate claims. The guidance below is intended to ensure that you are reimbursed based on the code or codes that correctly describe the services provided. References to CPT, HCPCS, Diagnosis, and other sources are for definitional purposes only and do not imply any right for reimbursement.

## Diagnosis

WelbeHealth uses ICD-10 (International Classification of Diseases, 10th Edition) as adopted by Medicare and Medi-Cal.

It is inappropriate to report a diagnosis just because it is on an approved list of diagnosis codes or on an order or a prior authorization. Reporting a diagnosis that the patient does not have or does not meet medical necessity based on the service or services provided solely for the purpose of obtaining reimbursement for a service is construed as fraud.

## Emergency Room Services

Emergency services do not require prior authorization. WelbeHealth does not deny clean claims for Emergency services including screening (triage) even when the condition does NOT meet the medical definition of "Emergency Services." Hospitals, Urgent Care Centers, and professional services (including labs, ancillary services, etc.) cannot bill, charge, or collect money from a WelbeHealth participant for any Emergency or Urgent Care Services covered under Medicare and/or Medi-Cal.

## Billing surgical procedures with modifiers

The use of modifiers is an integral part of billing for health care services by providing additional information for claims processing. This segment will provide information on the most commonly used modifiers; however, providers should refer to Medicare and Medi-Cal guidelines for the full list of modifiers and billing guidelines.

Primary Surgeon (Modifier AG): Per Medi-Cal, the primary surgeon or podiatrist is required to use modifier AG on the only, or highest valued, procedure code being billed for the date of service.

If AG modifier is not being utilized on the claim, surgical services billed should be in the highest to lowest value format to ensure proper processing and pricing.

Bilateral Procedures (Modifier 50): Modifier 50 is used when a bilateral procedure is performed.

Medi-Cal

| CPT | Modifier |
|---|---|
| 64490 | AG |
| 64490 | 50 |

Medicare

| CPT | Modifier |
|---|---|
| 64490 | 50 |

**Multiple Bilateral Procedures:** When billing multiple bilateral procedures performed by the same provider during the same operative session, modifiers 50, 51 or 99 may be required. If modifier 99 is used, you must use Box 19 of the 1500 claim form to denote the claim line and describe the modifier 99 breakdown.

Medi-Cal

| CPT | Modifier |
|---|---|
| 64490 | AG |
| 64490 | 50 |
| 64491 | 51 |
| 64491 | 50,51 |

| CPT | Modifier |
|---|---|
| 64490 | AG |
| 64490 | 50 |
| 64491 | 51 |
| 64491 | 99 |

Example: Box 19: LN4: 99=50,51

Medicar

| CPT | Modifier |
|---|---|
| 64490 | 50 |
| 64491 | 50 |

| CPT | Modifier |
|---|---|
| 64490 | 50 |
| 64490 | 50,51 |

**Multiple Procedures (Modifier 51):** The multiple procedures modifier identifies the second and subsequent lesser procedures performed by the same provider on the same day or at the same operative session. Modifier 51 reduction applies to all qualified second and subsequent procedures.

Medi-Cal

| CPT | Modifier |
|---|---|
| 64490 | AG |
| 64491 | 51 |
| 64492 | 51 |

Medicare

| CPT | Modifier |
|---|---|
| 64490 | |
| 64491 | 51 |
| 64492 | 51 |

**Billing Tip:** For bilateral procedures – Reimbursement is the total of:

- 150% of the fee schedule or contracted rate for the highest valued procedure
- 75% for the second through fifth bilateral procedures
- 50% for the sixth and additional bilateral procedures

Medi-Cal

| CPT/Modifier | Reimbursement Formula |
|---|---|
| 64490-AG | 100% of full rate |
| 64490-50 | 50% of full rate |
| 64491-51 | 50% of full rate |
| 64491-50,51 | 25% of full rate |
| 64492-51 | 50% of full rate |
| 64492-50,51 or 99 | 25% of full rate |

Medicare

| CPT/Modifier | Reimbursement Formula |
|---|---|
| 64490-50 | 150% of full rate |
| 64491-50 | 75% of full rate |
| 64492-50 | 75% of full rate |

Multiple Modifiers (Modifier 99): Modifier 99 is used when 2 or more modifiers apply to a single procedure. The use of this modifier may help avoid delays in processing and/or denials requesting additional information. If using modifier 99 a description of the line and breakdown of what modifiers 99 represents is required.

Assistant Surgeon (Modifier 80): Assistant surgeons must use modifier 80 as part of each procedure billed. The major surgical procedure is identified using modifier 80, and multiple surgical procedures can be identified using modifier 99 (ex.; 99=80,51).

*Note:* Not all surgical procedures are reimbursable to an assistant surgeon. To determine if a code may fall under this scenario, please refer to the Medicare/Medi-Cal guidelines.

## National Correct Coding Initiative Edits

The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. These mandatory national edits have been incorporated into our claims processing system and are effective for dates of services as specified by CMS.

## National Drug Codes

The National Drug Code (NDC) is required to be billed on claim forms for drugs administered by physicians, clinics, and hospitals. NDC codes must be reported on claims.

## Transportation

Medical transport is a transport that is medically necessary. Benefits include:

- Emergency transport – Ambulance transport to the nearest hospital is covered if the participant has reason to believe that the medical problem is an emergency, and that the problem calls for emergency transport. This includes ambulance transport services supplied through the "911" emergency response system
- Non-emergency medical transport – is covered when the member:
    - Moves to or from a hospital or skilled nursing facility
    - Needs to go to and from the participant's home to a scheduled medical appointment or the PACE center
    - Transports from ER/Hospital to home/resident

Requests for non-emergency medical transportation require prior authorization. Transportation should be arranged by a WelbeHealth PCP or Member Services and provided by an approved provider.

### Non-Emergency Medical Transportation Billing Requirements

The following information outlines the billing requirements for all Non-Emergency Medical Transportation (NEMT) providers.

1. Name of Referring Provider & NPI (Boxes 17a & 17b)
2. Pick up & Drop off Location with times (Box 19)
3. Prior Authorization Number (Box 23)
4. Origin and destination codes (Box 24D, Modifier field)

### Origin and destination codes

For ambulance service claims, providers and suppliers must report the origin and destination codes for each ambulance trip provided. The code is created by combining two alpha characters. Each alpha character, except for "X," represents an origin code or a designation code. The pair of alpha characters create one code to be reported in the modifier field. Origin and destination and their descriptions are as follows:

| Codes | Descriptions |
|---|---|
| D | Diagnostic or therapeutic site other than P or H when these are used as origin codes |
| E | Residential, domiciliary, custodial facility (other than 1819 facility) |
| G | Hospital based RSRD facility |
| H | Hospital |
| I | Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport |
| J | Freestanding ESRD facility |

| | |
|---|---|
| N | Skilled nursing facility |
| p | Physician's office |
| R | Residence |
| S | Scene of accident or acute event |
| X | Intermediate stop at physician's office on way to hospital (destination code only) |

Additional Modifiers:

| Modifier | Description |
|---|---|
| GM | Multiple patients on one ambulance Trip |
| QL | Patient pronounced dead after ambulance called |
| QM | Ambulance service provided under arrangement by a provider of services |
| QN | Ambulance service furnished directly by a provider of services |

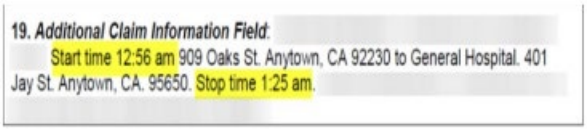
Note: Institutional based providers must report QM or QN

Night Calls (transportation between 7pm and 7am) may be reimbursed in any of the following scenarios:

1. Transport starts during the day and ends at night (after 7pm)
2. Entire transport occurs at night
3. Transport starts at night and ends during the day (after 7am)
4. Modifier UJ (Box 24D, Modifier field)

Night call Documentation must include:

- Appropriate HCPCS Code with Modifier UJ
- Indicate start and stop time Additional Claims Information Field (Box 19)




## Air Medical Transportation

Air ambulance for one-way recipient miles must be billed in statute miles, not nautical miles. Milage must be calculated with the Global Positioning System (GPS) coordinated from point of takeoff to point of landing.

Note: For electronic submission of transportation claims, we recommend providers contact their clearinghouse for proper transmission and configuration options to ensure proper claim submission.

## Services Requiring Documentation for Pricing

Procedure codes that require additional information for pricing must be submitted with the cost and/or description/documentation supporting the service. If this information is not submitted, the item will be denied. Services that generally require invoice and/or documentation for pricing are:

- Devices and Implants
- Unlisted Codes (codes ending in ***99)
- Covered Codes with no pricing (generally codes with $0.00, $0.01 or $0.03 on the Medicare and/or Medi-Cal fee schedule) – unless otherwise specified in a contract term

An invoice for pricing must contain the total invoice price plus shipping cost in Box 19 of the CMS-1500 claim form or its electronic equivalent for each line item submitted, or be submitted via paper with invoice to our dedicated claims submission fax number

Note: Total invoice price is the net amount a provider pays for an item/service, considering all discounts, rebates, refunds, or other adjustments. In addition, WelbeHealth will reimburse for shipping but no other additional fees (tax, handling fees, delivery fees, administrative fees).

## Skilled Nursing, Long Term/Custodial Care and Assisted Living


## Hearing Aids

Medi-Cal limits the total cost of hearing aid benefits to $1,510 per recipient per fiscal year.
The date that the hearing aid was ordered should be entered as the date of service (Box 24A).
Claims submitted for hearing aids and accessories must be billed with modifier NU (new equipment purchased), RB (repair) or RR (rental), as appropriate.
General reimbursement is as follows unless your contract states otherwise.

- Monaural/Monaural Contralateral hearing aid is the lesser of

    - $883.80, or
    - The billed amount
- Binaural/ Binaural Contralateral hearing aid is the lesser of
    - $1,480.32, or
    - The billed amount

Providers billing for loss and damage replacement of programmable or digital hearing aid systems must use code V5298, and state “replacement cost” in Box 19 to receive reimbursement for the replacement fee.

### Once in a Lifetime Procedures

The once in a Lifetime Procedures Policy identifies procedures that because of Current Procedural Terminology code description and/or human anatomy can be performed by a physician(s) or other health care professional(s) only once in a patient’s lifetime.
WelbeHealth will reimburse certain procedures only once during a patient lifetime based on Current Procedural Terminology codes descriptions and CMS and/or DHCS guidelines.

There may be situations that require the code(s) to be submitted more than once during a patient’s lifetime. In such cases, more than one Once in a Lifetime procedure, whether the same code or a different code from the same Code family, will be considered separately for reimbursement if reported with one of the following modifiers:

- Modifier 53 – Discontinued Procedure
- Modifier 55 – Postoperative Management Only
- Modifier 56 – Preoperative Management Only

Below is a list of Codes that are considered Once in a Lifetime Procedures

## Instructions on Filing out Claims Forms

### Facility Billing

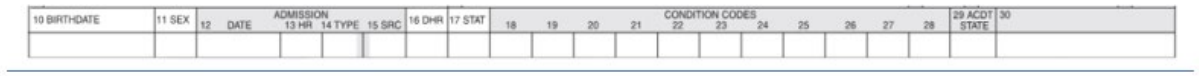
This segment provides an overview for completing a UB-04 claim form. This guide is designed to be used as a reference tool for our claim submitters to provide the expected content of each field on the UB-04, the standard paper claim form for facility claims. The UB-04 claim form must be completed for all facility claim submissions (including home health agency). All claims must be submitted within the required filing time limit.
This guide is not intended to replace the Official UB-04 Data Specifications published by the National Uniform Billing Committee (NUBC) and the American Hospital

Association. For more information on purchasing licenses for their complete specifications, please visit their website:

http://www.nubc.org/subscriber/index.dhtml.

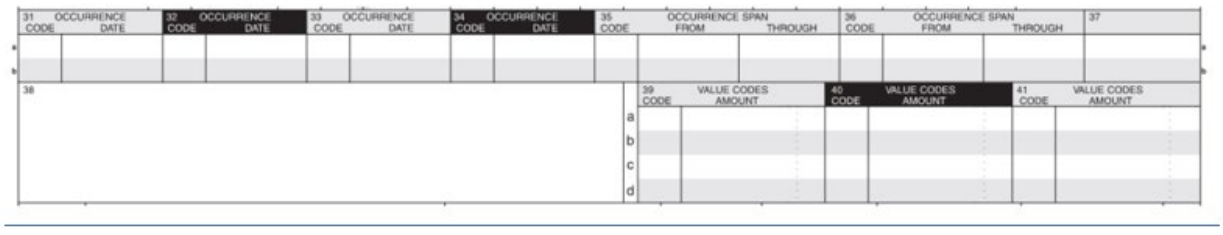

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 1 | UNLABELED FIELD | **Line 1:** Enter the Billing Provider/Organization Name | Required |
| | | **Line 2:** Enter complete Billing Street Address - *do not use punctuation or P.O. Box* | |
| | | **Line 3:** Enter City, State and Zip-Code - *use 9 digits for Zip Code if known* | |
| | | **Line 4:** Enter the 10-digit telephone Number XXXXXXXXXX - *no formatting* | |
| 2 | UNLABELED FIELD | **Lines 1 – 4:** Use if the Pay-to Address is different than information in Field 1 | Conditional |
| 3a | PAT CNTL # | Enter the Provider/Organization's Patient Account/Control Number | Required |
| 3b | MED REC # | Enter the Patient's Medical or Health Record Number | Conditional |
| 4 | TYPE OF BILL | Enter the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.)<br>- The first digit is a leading zero<br>- The next 2 digits indicate the type of bill<br>- The fourth digit indicates the frequency of the bill (7 for replacement, 8 for void) | Required |
| 5 | FED. TAX NO. | Enter the 10-character Billing Provider/Organization's Federal Tax ID Number (TIN) assigned by the federal government for tax reporting purposes, including the hyphen in the XX-XXXXXXX format. - *Cannot be blank or all zeros* | Required |
| 6 | STATEMENT COVERS PERIOD FROM/THROUGH | Enter <u>two</u> 6-digit dates (MMDDYY MMDDYY) for the beginning and ending services dates for the entire period invoiced on the claim | Required |
| 7 | UNLABLED FIELD | NOT USED | N/A |

| | | | |
|---|---|---|---|
| 8 a,b | PATIENT NAME | **8a** Enter the Patient's health plan ID, as it appears on the participants' WelbeHealth ID card.<br>**8b** Enter Patient Last Name, First Name and Middle Name/Initial (if available), *in that specific order*<br>- Use name as it appears on the Health Plan card<br>- Use a comma or space to separate last and first names and do not use Titles<br>- No spaces should be used in hyphenated or prefixed names (e.g., McKendrick, MacBeth Smith-Jones)<br>- A suffix such as Jr. or III should follow the last name (e.g., Johnson III, Johnson Jr.) | Required |
| 9 a-e | PATIENT ADDRESS | **9a** Enter the Patient's mailing street Address or P.O. Box<br>**9b** Enter the Patient's City<br>**9c** Enter the Patient's State<br>**9d** Enter the patient's Zip Code<br>(DO NOT use unless the Patient's address is outside of the US. - *This is for the Country Code for non-US addresses.* | Required |




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 10 | BIRTHDATE | Enter the Patient's Date of Birth. MMDDYYY (e.g., 09211965) | Required |
| 11 | SEX | Enter the Patient's Gender. M, F, and U (Unknown) are acceptable. | Required |
| 12 | ADMISSION DATE | Required for Inpatient, Home Health, and Hospice claims. For Home Health, this is the Start of Care Date. MMDDYY | Conditional |
| 13 | ADMISSION HR | Required for inpatient claim only, except Bill Type 021x. Enter the Admission Hour in military time (00-23). | Conditional |
| 14 | ADMISSION TYPE | Enter the Admission Type Code:<br>**1**=Emergency<br>**2**=Urgent<br>**3**=Elective<br>**5**=Trauma<br>**9**=Information Not Available | Required |

| | | | |
|---|---|---|---|
| 15 | ADMISSION SRC | Enter the Source of Admission Code:<br>1=Non-HealthCare Facility Point of Origin<br>2=Clinic or Physician's Office<br>4=Transfer from a Hospital (different facility)<br>5=Transfer from a SNF or ICF or ALF<br>6=Transfer from another HealthCare Facility - not defined elsewhere in this list<br>8=Court/Law Enforcement, Incarceration Facility<br>9=Information Not Available<br>B=Transfer from another Home Health Agency<br>D=Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer<br>E=Transfer from Ambulatory Surgery Center<br>F=Transfer from Hospice | Required |
| 16 | DHR | Enter the Discharge Hour in military time (00-23). Required on all final inpatient claims. | Conditional |
| 17 | STAT | Enter the Patient's 2-digit Status at the end of the period covered by the bill through discharge.<br>*See Appendix A for a partial list of the Patient's Discharge Status Codes.* | Required |
| 18-28 | CONDITION CODES | Enter Condition Codes if they are applicable. If more than one condition code applies, list it in numerical order.<br>*See Appendix B for a partial list of Condition Codes.* | Conditional |
| 29 | ACDT STA | Required when services reported on this claim are related to an auto accident.<br>Enter the 2-character state or providence code where the accident occurred. | Conditional |
| 30 | UNLABELED FIELD | NOT USED | N/A |




| Field | Field Label | Instructions and Comments | Required or Conditional |
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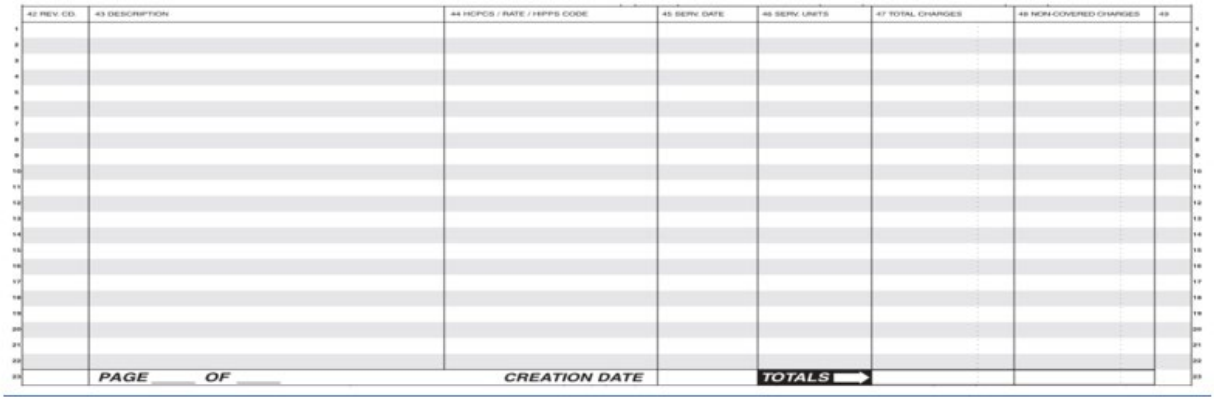
| | | | |
|---|---|---|---|
| 31-34 a,b | OCCURANCE CODE & DATE | Required when there is an Occurrence Code that applies to the claim.<br>Occurrence Codes and Occurrence Spans are mutually exclusive.<br>Occurrence Codes are 01-69 and A0-LZ.<br>Occurrence Codes happen on a single day, and the associated date should be in MMDDYY format.<br>Enter each code and corresponding date. List in alphanumeric order (numbers before letters), and use row A before moving to Row B. | Conditional |
| 35-36 a,b | OCCURRENCE SPAN CODE & FROM/THROUGH DATE | Required when there is an Occurrence Span that applies to the claim.<br>Occurrence Codes and Occurrence Spans are mutually exclusive.<br>Occurrence Codes are 70-99 and M0-ZZ.<br>Occurrence spans happen over a period of time and have an associated from and through date.<br>Enter each code and corresponding date range. list in alphanumeric order (numbers before letters), and use in row A before moving to row B. | Conditional |
| 37 | UNLABLED FIELD | NOT USED | N/A |
| 38 | UNLABLED FIELD | Name and Address of Claims Addressee - NOT USED | N/A |
| 39-41 | VALUE CODE & AMOUNT | Enter any Value Codes and Amounts. If more than one value code applies, list in alphanumeric order. | Conditional |




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|

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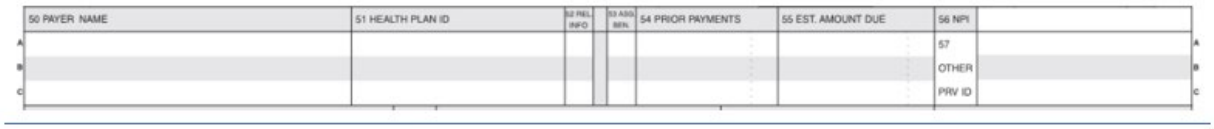
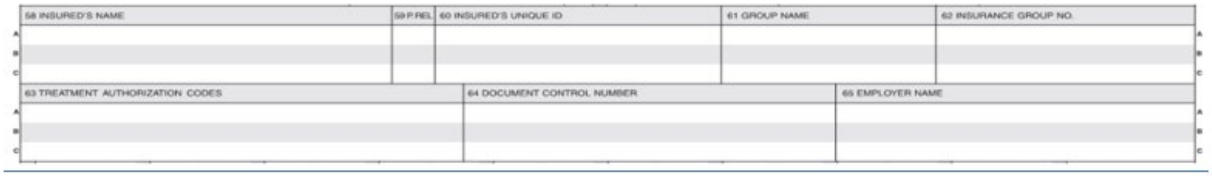
|---|---|---|---|
| 42 | REV CD | Enter the 4-digit revenue code that applies to the service line. See Appendix C for examples. **Note:** Must be 0022 (SNF HIPPS), 0023 (HHA HIPPS), or 0024 (IRF HIPPS) if the series line contains a HIPPS code. | Required |
| 43 | DESCRIPTION | Required ONLY when the service is a miscellaneous HCPCS or Drug. Otherwise, leave it blank.<br>For a drug, enter the NDC and associated information as follows with no spaces or delimiters:<br>N4 11-digit NDC (no hyphens)<br>Unit of Measure (F2, GR, ML, UN or ME)<br>Quantity, using a decimal to represent any fractional units with no more than 3-digits to the right of the decimal (e.g. N4123456789 10ML3.025) | Conditional |
| 44 | HCPCS/ RATES/ HIPPS CODE | Enter the applicable HCPCS code and up to 4 modifiers (as needed) or a HIPPS code with NO modifiers. The code submitted needs to be appropriate for the Revenue code entered in field 42.<br>**Note:** Home Health claims for patients covered under Medicare replacement plans (such as Advantage Plans or PACE Plans) are required to contain a HIPPS code. HIPPS codes must be submitted with the appropriate Revenue codes. Must be 0022 (SNF HIPPS), 0023 (HHA HIPPS), or 0024 (IRF HIPPS). | Required |
| 45 | SERV DATE | **Lines 1-22** Enter the Date of Service for each line item in the MMDDYY format. Use separate line items for different dates of service. The date should fall within the range entered in field 6.<br>**Line 23** Enter the Date. This form is completed/printed. | Required |
| 46 | SERV UNITS | Enter the quantity (number of units) for this service line.<br>**Note:** For HIPPS code lines, this should always be 1. | Required |
| 47 | TOTAL CHARGES | Lines 1-22 Enter the billed amount for each line item.<br>**Note:** For a HIPPS code line, this should always be zero.<br>Line 23 Enter the total of all charges billed (the sum of the detail lines) on line 23 of the final page of the claim only. | Required |

| | | | |
|---|---|---|---|
| 48 | NON-COVERED CHARGES | **Lines 1-22** Required if there are non-covered charges for this line.<br>**Line 23** Enter the total of all non-covered charges (the sum of the detail lines) on line 23 of the final page of the claim only. | Conditional |
| 49 | UNLABELED FIELD | NOT USED | N/A |



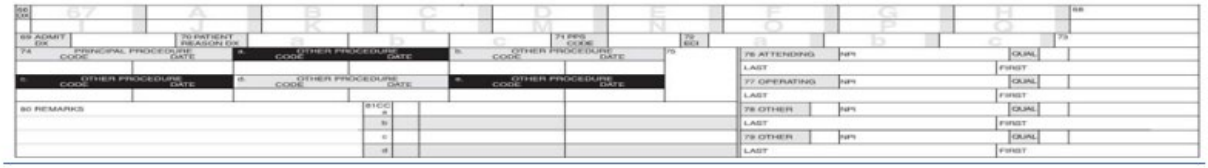

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 50 | PAYER NAME | Enter the name of each Payer (or health plan) being invoiced. (e.g., WELBEHEALTH)<br>When the patient has other coverage, list the payers as indicated below:<br>**Line A** (Required)=Primary Payer<br>**Line B**=Secondary Payer<br>**Line C**=Tertiary Payer | Line A Required<br>Lines B and C Conditional |
| 51 | HEALTH PLAN ID | Required for each Payer listed in field 50. Enter the Health Plan ID Number. | Line A Required<br>Lines B and C Conditional |
| 52 | REL. INFO | Required for each Payer listed in field 50.<br>Release of Information Certification Indicator.<br>This field shows whether the provider has a signed statement from the patient allowing the release of medical claim billing information to another organization.<br>**Note:** it is expected that the provider has all the necessary release information on file. It is expected that all released invoices contain a "Y." | Line A Required<br>Lines B and C Conditional |
| 53 | ASG. BEN. | Required for each Payer listed in field 50.<br>Assignment of Benefits Certification Indicator.<br>This field conveys that the provider has a signed form from the patient authorizing the payer to remit payment directly to the provider.<br>Valid entries are Y (Yes) and N (NO). | Line A Required<br>Lines B and C Conditional |

| | | | |
|---|---|---|---|
| 54 | PRIOR PAYMENTS | Required when the claim has already been adjudicated by the payer listed on this line. It is the amount that the health plan has paid towards this bill. 8-digits are allowed before the decimal point provided on the form and 2 after. (e.g., 10550208.50) | Conditional |
| 55 | EST. AMOUNT DUE | Amount provider estimates are due by the indicated provider (after prior payments are deducted) | Conditional |
| 56 | NPI | Enter the billing provider's 10-character National Provider ID number | Required |
| 57 | OTHER PRV ID | NOT USED | N/A |




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 58 | INSURED'S NAME | Enter the name of the individual under whose name the insurance is carried for the payers listed in field 50. LAST, FIRST MIDDLE (in this order). | Line A Required<br>Lines B and C Conditional |
| 59 | P REL | Enter the 2-digit code that represents the patient's relationship to the insured for each of the entries in field 58:<br>01=Spouse<br>18=Self<br>19=Child<br>20=Employee<br>21=Unknown<br>39=Organ Donor<br>40=Cadaver Donor<br>53=Life Partner<br>G8=Other | Line A Required<br>Lines B and C Conditional |
| 60 | INSURED'S UNIQUE ID | Enter the patient's Health Plan ID for each of the entries in field 58. Do not include the person code. | Line A Required<br>Lines B and C Conditional |
| 61 | GROUP NAME | Enter the patient's Group NAME for each of the entries in field 58, if no group NUMBER (in field 62) is available. | Conditional |

| | | | |
|---|---|---|---|
| 62 | GROUP NAME | Enter the patient's Group NUMBER (if on the ID card) for each of the entries in field 58. | Conditional |
| 63 | TREATMENT AUTHORIZATION CODES | Line A Enter the payer's authorization number, if applicable<br>Line B Enter a referral number, if applicable | Conditional |
| 64 | DOCUMENT CONTROL NUMBER | Enter the payer's original claim control number when submitting a replacement (correction) or void.<br>Note: Required when submitting a replacement or void to validate the original claim processed. | Conditional |
| 65 | EMPLOYER NAME | Enter Employer name of the insured | Conditional |



| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 66 | DX | Enter the ICD Code Qualifier to indicate the code revision in use (e.g., ICD-10) | Required |
| 67 | PRINCIPAL DX CODE | Enter the complete Principal Diagnosis Code. Include the 4th and 5th digits if applicable.<br>Note: All diagnosis codes should be coded to the highest level. | Required |
| 67 A-Q | OTHER DX CODE(S) | Enter any other relevant Diagnosis Code. Include the 4th and 5th digits if applicable.<br>Note: All diagnosis codes should be coded to the highest level. | Conditional |
| 68 | UNLABLED FIELD | NOT USED | N/A |
| 69 | ADMIT DX | Required when the claim involves inpatient admission. Enter the complete Admitting Diagnosis Code representing the reason for the visit at admission. Include the 4th and 5th digits if applicable.<br>Note: All diagnosis codes should be coded to the highest level. | Conditional |
| 70 a, b, c | PATIENT REASON DX | Required for Outpatient claims. Enter the Diagnosis Code that represents the patient's state/reason(s) for the outpatient visit at the time of registration. | Conditional |

| | | | |
|---|---|---|---|
| 71 | PPS CODE | Required when an inpatient hospital is under DRG contract with the payer. Enter the appropriate PPS Code.<br>Note: Refer to your contract with the payer to determine if the rates are based on<br>APR-DRG=(Medicaid) 3-digits and severity digit<br>MS-DRG=(Medicare) 3-digits | Conditional |
| 72 a, b, c | ECI | Required when an External Cause of Injury Code is needed to describe an injury, poisoning or adverse effect. Enter the appropriate Diagnosis Code.<br>Note: All Diagnosis Codes should be coded to the highest level. | Conditional |
| 73 | UNLABLED FIELD | NOT USED | N/A |
| 74 a-e | OTHER PROCEDURE CODE & DATE | Represents other procedures performed on inpatient claims. | Conditional |
| 75 | UNLABLED FIELD | NOT USED | N/A |
| 76 | ATTENDING | The ATTENDING provider is responsible for the patient's medical care and treatment reported on the claim. Enter the Attending Provider's information in the NPI, LAST, and FIRST boxes beside (and below) the box labeled 76 ATTENDING. | Required |
| 77 | OPERATING | The OPERATING physician information is only required when surgical procedure code(s) is listed on the claim. This is the individual with primary responsibility for performing the surgery. If this is relevant, enter the Operating provider's information in the NPI, LAST, and FIRST boxes beside (and below) the box labeled 77 OPERATING. | Conditional |

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|---|---|---|---|
| 78-79 | OTHER | If the REFERRING provider's information is different than the ATTENDING provider in field 76, enter the REFERRING provider's NPI, LAST, and FIRST in the boxes beside (and below) the box labeled 78 OTHER (or 79 OTHER) with a qualifier in the first box (in front of the NPI box) of 'DN'.<br>If the RENDERING provider's information is different than the ATTENDING provider in field 76, enter the RENDERING provider's NPI, LAST, and FIRST in the boxes besides (and below) 78 OTHER (or 79 OTHER) with a qualifier in the first box (in front of the NPI box) of '82'. | Conditional |
| 80 | REMARKS | Providers may enter free-from narrative text that is relevant to the claim in this field. | Conditional |
| 81a | CC | Enter qualifying code 'B3' for Taxonomy code and the Billing Provider's 10-digit taxonomy Code. | Conditional |

## DRG Reimbursement Information

Inpatient claims are processed using the Diagnosis Related Groups (DRG) model, Medicare Severity Diagnosis Related Group (MS-DRG) or All Patient Refined Diagnosis Related Group (APR-DRG). Please reference your contract term to ensure you understand which DRG WelbeHealth will use to determine proper payment. Non-contracted facilities will be reimbursed at MS-DRG.

Note: DRG's entered on the claim by the facility are not utilized by WelbeHealth to calculate rates and payments.

### High-Cost Drug Submission and Payment Rules

Certain provider agreements contain provision for the reimbursement of high-cost drugs. The claim must be billed with revenue code 0636, HCPCS code, and NDC code. If the agreement contains language requiring a manufacturer's invoice cost or manufacturers' invoice cost plus an additional %, the claim must be submitted with a manufacture's invoice.
If there is more than one item listed on the invoice, the item must be clearly identified by circling the item; do not highlight any information on the invoice. If more than one item on the invoice is listed on the claim, note the corresponding claim line to the item invoiced.

Claims missing the required information will be denied for lack of information.

WelbeHealth may perform periodic audits of high-cost drug billing practices to ensure compliance.

## Professional Billing

This segment provides an overview for completing a 1500 claim form. This guide is designed to be used as a reference tool for our claim submitters to provide the expected content of each field on the 1500 form, the standard paper claim form for professional claims. The 1500 claim form must be completed for all professional claim submissions. All claims must be submitted within the required filing time limit.

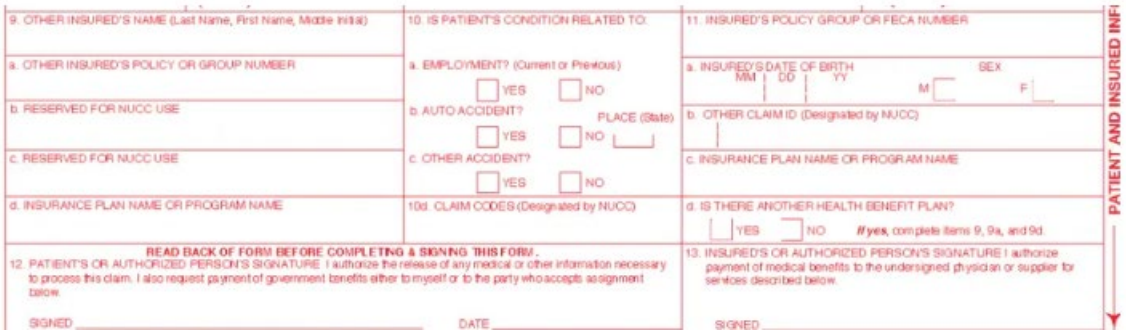
This guide is not intended to replace the Official 1500 Data Specifications published by the National Uniform Claim Committee (NUCC). For more information on purchasing licenses for their complete specification, please visit their website:

http://www.nucc.org/index/php/1500-claim-form-mainmenu-35.


| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| | CARRIER | Enter in the white, open CARRIER area the name and address of the payer in the following format:<br>**1st line** - Payer Name<br>**2nd line** - Payer street address<br>**3rd line** - Second line of street address, if necessary/if not leave blank<br>**4th line** - City, State (2 characters), and ZIP code<br>***Note:*** *Do not use punctuation (e.g., commas, periods) or other symbols in the address. Report a 5 or 9-digit ZIP code without the hyphen.* | Required |

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 1 | TYPE OF COVERAGE | Indicate the type of health insurance coverage applicable to the claim by placing an X in the appropriate box.<br>***Note:*** *Only one box can be marked. WelbeHealth participants are Medicare, Medicaid or dual covered. For dual covered participants, use "Medicare."* | Required |
| 1a. | INSURED'S ID NUMBER | Enter the insured's ID number as shown on the ID card.<br>***Note:*** *The member ID is located on the patient's WELBEHEALTH Identification card.* | Required |
| 2 | PATIENT'S NAME | Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (i.e., Jr., Sr), enter it after the last name and before the first name. Titles (i.e., Capt., Dr) and professional suffixes (i.e., PhD, MD, Esq) should not be included with the name.<br>***Note:*** *Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.* | Required |
| 3 | DATE OF BIRTH & SEX | Enter the patient's 8-digit birth date MM DD YYYY.<br>Enter an X in the correct box to indicate gender.<br>***Note:*** *Only one box can be marked. If sex is unknown, leave blank.* | Required |
| 4 | INSURED'S NAME | Enter the insured's full last name, first name and middle initial. If the patient uses a last name suffix (i.e., Jr., Sr), enter it after the last name and before the first name. Titles (i.e., Capt., Dr) and professional suffixes (i.e., PhD, MD, Esq) should not be included with the name.<br>For Workers Comp claims, enter the name of the employer.<br>For Other Property & Casualty claims, enter the name of the insured person or entity.<br>***Note:*** *Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.* | Conditional |

| | | | |
|---|---|---|---|
| 5 | PATIENT'S ADDRESS | Enter the patient's address.<br>1st line enter the street address<br>2nd line enter the City and State<br>3rd line enter the ZIP Code<br>DO NOT enter a telephone number<br>*Note: If the patient's address is the same as the insured's address, it is not necessary to report the patient's address.* | Conditional |
| 6 | RELATIONSHIP TO INSURED | Enter an X in the correct box to indicate the patient's relationship to insured when item number 4 is completed. Only one box can be marked.<br>Self-=indicates the insured is the patient<br>Spouse=indicates the patient is the husband, wife, or qualified partner<br>Child=indicates that the patient is the minor dependent<br>Other=indicates the patient is other than self, spouse or child which may include employee, ward, or dependent | Conditional |
| 7 | INSURED'S ADDRESS | Enter the insured address. If item number 4 is completed, this field should be completed.<br>1st line enter the street address<br>2nd line enter the City and State<br>3rd line enter the ZIP Code<br>DO NOT enter a telephone number<br>For Workers Comp claims, enter the address of the employer.<br>For Other Property & Casualty claims enter the address of the insured noted in item number 4<br>*Note: Do not use punction (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Report a 5 or 9-digit ZIP Code without the hyphen.* | Conditional |
| 8 | UNLABLED FIELD | DO NOT USE | N/A |




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 9 | OTHER INSURED'S NAME | If item number 11d is marked, complete this field, otherwise leave it blank. When additional health coverage exists, enter other insured's full last name, first name and middle initial of the enrollee in another health plan if different from that shown in item number 2.<br>***Note:*** *Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.* | Conditional |
| 9a. | OTHER INSURED'S POLICY OR GROUP NUMBER | If item number 11d is marked, complete this field, otherwise leave it blank. Enter the policy or group number of the other insured.<br>***Note:*** *Do not use a hyphen or space as a separator within the policy or group number.* | Conditional |
| 9b. | UNLABLED FIELD | DO NOT USE | N/A |
| 9c. | UNLABLED FIELD | DO NOT USE | N/A |
| 9d. | PLAN/PROGRAM NAME | If item number 9 is used, complete this field, otherwise leave it blank. Enter the other insurance plan or program name. | Conditional |

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| 10 a.-c. | PATIENT'S CONDITION | When appropriate, enter an X in the correct box to indicate whether one or more of the services described in item number 24 are for a condition or injury that occurred on the job or because of an auto or other accident. Only one box on each line can be marked.<br>***Note:*** *The State postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident". Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary. Primary insurance must then be shown in item number 11.* | Conditional |
| 10d. | CLAIM CODES | When applicable, use appropriate condition codes to report. When reporting more than one code, enter three blank spaces between each code.<br>***Note:*** *see Appendix A for a partial list of claim codes.* | Conditional |
| 11 | INSURED'S POLICY, GROUP OR FECA | Enter the insured policy or group number as it appears on the insured health care ID card. If item number 4 is completed, then this field should be completed.<br>***Note:*** *Do not use a hyphen or space as a separator within the policy or group number.* | Conditional |
| 11a. | INSURSED'S DOB, SEX | Enter the 8-digit date of birth MM DD YYYY of the insured (as indicated in item number 1a.) and an X to indicate the sex of the insured. Only one box can be marked.<br>***Note:*** *if sex is unknown, leave blank.* | Required |
| 11b. | OTHER CLAIM ID | Enter the "other Claim ID" and applicable claim identifier. If item number 10a-c is completed, then this field should be completed.<br>For Works Comp or Property & Casualty, enter the claim number assigned by the payer.<br>***Note:*** *Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.* | Conditional |

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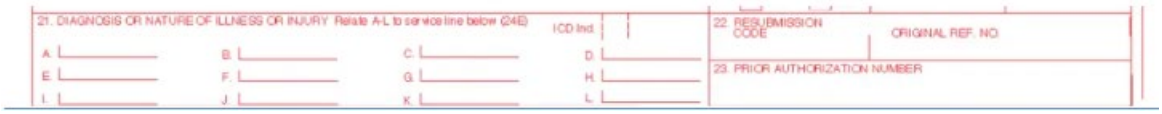
|---|---|---|---|
| 11c. | PLAN/PROGRAM NAME | Enter the name of the insurance Plan or Program name of the insured.<br>***Note:*** *The insurance Plan or Program name is the name of the plan or program of the insured as indicated in item number 1a.* | Required |
| 11d. | OTHER HEALTH BENEFIT PLAN | When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.<br>***Note:*** *This field should be used if the patient has insurance coverage other than the plan indicated in item number 1.* | Conditional |
| 12 | PATIENT'S AUTHORIZED SIGNATURE | Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". | Required |
| 13 | INSURED'S AUTHORIZED SIGNATURE | Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". | Required |

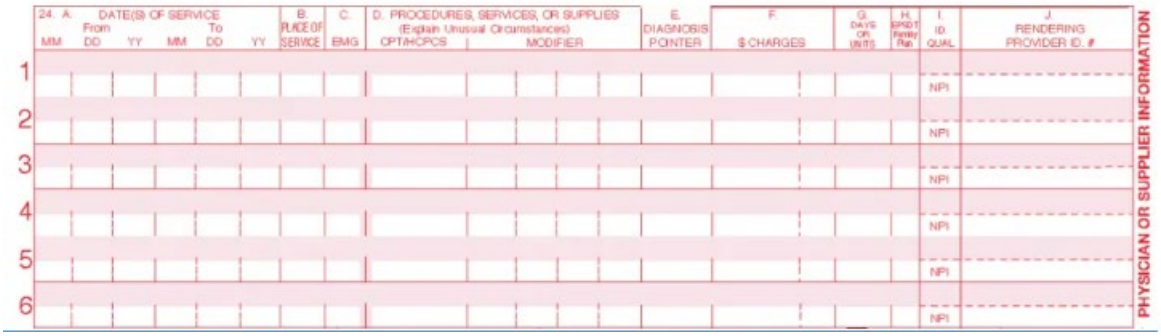

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 14 | DATE CURRENT ILLNESS, INJURY | Enter the 6-digit MM DD YY or 8-digit MM DD YYYY date of the first date of the present illness, injury, or pregnancy. Enter the applicable qualifier to identify which date is being reported. | Conditional |

| | | | |
|---|---|---|---|
| 15 | OTHER DATE | Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit MM DD YY or 8-digit MM DD YYYY format. Enter the applicable qualifier to identify which date is being reported.<br>**454=**Initial Treatment<br>**304=**Latest Visit or Consultation<br>**453=**Acute Manifestation of a Chronic Condition **439=**Accident<br>**455=**Last X-ray<br>**471=**Prescription<br>**090=**Report Start (Assumed Care Date)<br>**091=**Report End (Relinquished Care Date)<br>**444=**First Visit or Consultation<br>***Note:*** *Enter the qualifier between the left-hand set of vertical, dotted lines.* | Conditional |
| 16 | UNABLE TO WORK DATES | If the patient is employed and is unable to work in their current occupation, a 6-digit MM DD YY or 8-digit MM DD YYYY date must be shown from the "from-to" dates that the patient is unable to work.<br>***Note:*** *An entry in this field may indicate employment - related insurance coverage.* | Conditional |
| 17 | REFERRRING PROVIDER | Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:<br>**1**. Referring Provider<br>**2.** Ordering Provider<br>**3.** Supervising Provider<br>Enter the applicable qualifier to identify which provider is being reported<br>**DN=**Referring provider<br>**DK=**Ordering Provider<br>**DQ=**Supervising Provider<br>***Note:*** *Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the qualifier to the left of the vertical, dotted line.* | Required |

| | | | |
|---|---|---|---|
| 17a. &b. | OTHER ID# | 17a enter the qualifier indicator and Other ID number of the referring, ordering or supervising provider. The qualifiers used are<br>OB=State license Number<br>1G=Provider UPIN Number<br>G2=Provider Commercial Number<br>LU=Location Number (Used for Supervising provider only).<br>17b enter the 10-digit NPI# of the referring, ordering, or supervising provider | Required |
| 18 | DATES RELATED TO CURRENT SERVICES | Enter the inpatient 6-digit MM DD YY or 8-digit MM DD YYYY hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave the discharge date blank.<br>*Note: This date is when a medical service is furnished because of, or subsequent, a related hospitalization.* | Conditional |
| 19 | ADDITIONAL CLAIM INFORMATION | Providers may enter a free-from narrative text that is relevant to the claim in this field.<br>Note: *This field should not be used to indicate a "Corrected" or "Void" claim; please refer to item number 22 when submitting a corrected or void claim. Examples of when the field should be used is Transport* pickup/drop off locations<br>Breakdown of modifier 99<br>Notate when additional documentation is attached | Conditional |
| 20 | OUTSIDE LAB CHARGES | Complete this field when billing for purchased services by entering an X in "YES".<br>A "YES" mark indicates that the reported service was provided by an entity other than the billing provider.<br>A "NO" mark or blank indicates that no purchased services are included in the claim.<br>*Note: When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter the number right justified to the left of the vertical line. Enter 00 cents if the amount is a whole number. Do not use dollar signs, commas, or decimal points. Leave the right-hand field blank.* | Conditional |




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 21 | DIAGNOSIS | Enter the applicable diagnosis codes and ICD indicator to identify which version of ICD codes is being reported.<br>**9=**ICD-9-CM<br>**0=**ICD-10-CM<br>***Note:*** *Diagnosis codes should be coded to the highest level. Do not include the decimal point in the diagnosis code. List no more than 12 ICD codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field.* | Required |
| 22 | RESUBMISSION/ VOID | When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.<br>**7=**Replacement/Correction of a prior claim<br>**8=**Void/Cancel of prior claim<br>Enter the original claim number in the **ORIGINAL REF. NO.** space.<br>***Note:*** *Do not add a leading "0" before frequency code 7 or 8. The original claim is required for processing.* | Conditional |
| 23 | PRIOR AUTHORIZATION | Enter the payer assigned prior authorization number for service(s).<br>***Note:*** *Do not enter hyphens or spaces within the number. For services that require prior authorization, the auth# must be submitted on the claim for processing.* | Conditional |

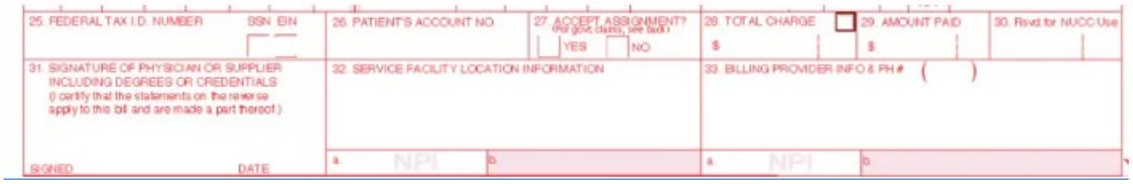



| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 24A | DATES OF SERVICE | Enter the date(s) of service, both the "From" and "To" dates. If there is only one date of service, enter that date under BOTH the "From" and "To" dates. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. ***Note:*** *The number of days must correspond to the number of units in 24G.* | Required |
| 24B | PLACE OF SERVICE | Enter the appropriate two-digit code in the unshaded area, to identify the location where the services were rendered. ***Note:*** *See Appendix B for a sample Place of Service listing* | Required |
| 24C | EMG | Enter Y for X in the unshaded area if the service line(s) where an emergency. Leave this field blank if the service line(s) is not related to an emergency. | Conditional |
| 24D | PROCEDURES, SERVICES, SUPPLIES | Enter the CPT or HCPCS code(s) and modifier(s) if applicable, from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-character modifiers. ***Note:*** *When additional narrative or description is required for the procedure code (e.g., unspecified code, NDC) use the shaded area of the line associated line in which the additional information applies to.* | Required |

| | | | |
|---|---|---|---|
| 24E | DIAGNOSIS POINTER | Enter the diagnosis code reference letter (pointer) as it relates to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) A–L or multiple letters as applicable.<br>***Note:*** *Do not use commas between the letters.* | Required |
| 24F | CHARGES | Enter the charge amount for each service line listed. Enter 00 in the right-hand area of the field if the amount is a whole number.<br>***Note:*** *Negative dollar amounts, or dollar signs are not allowed. Do not use commas when reporting dollar amounts.* | Required |
| 24G | DAYS OR UNITS | Enter the number of days or units. This field is commonly used for multiple visits, supplies, or anesthesia units or minutes. If only one service is performed, number 1 must be entered.<br>***Note:*** *No leading zeros should be reported. Units should be reported in whole units. Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period.* | Required |

| | | | |
|---|---|---|---|
| 24H | EPSDT/ FAMILY PLAN | For reporting of Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) and Family Planning Services. When reporting EPSDT on a claim, identify the status of the referral by entering one of the following reason codes, right justified in the shaded area of the field.<br>AV=Available - Nots Used (Patient refused referral)<br>S2=Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem)<br>ST=New Service Requested (Referral to another provider for diagnostic or corrective treatment/schedule for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals)<br>NU=Not Used (used when no EPSDT patient referral was given) | Conditional |
| 24I | ID QUALIFIER | Enter in the shaded area of 24I the qualifier if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. The NCCU defines the following qualifiers:<br>OB=State License Number<br>1G=Provider UPIN Number<br>G2=Provider Commercial Number<br>LU=Location Number<br>ZZ=Provider Taxonomy<br>*Note: Rendering provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider was used, enter that provider's information here. Report the Identification Number in items 24I and 24J only when different from the data recorded in items 33a and 33b.* | Conditional |
| 24J | RENDERING PROVIDER | The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. | Required |

| | | | |
|---|---|---|---|
| 24 | SHADED AREAS | The following are types of supplemental information that can be entered in the shaded areas of item 24:<br>Narrative description of unspecified codes<br>National Drug (NDC)<br>Device Identifier of the Unique Device Identifier for supplies<br>Tooth numbers are areas of the oral cavity<br>The following qualifiers are to used when reporting these services:<br>ZZ=Narrative description of unspecified code<br>N4=National Drug Codes (NDC)<br>DI=Device Identifier of the Unique Device Identifier (UDI)<br>JP=Universal/National Tooth Designation System<br>JO=ANSI/ADA/IOS Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity<br>The following qualifiers are to be used when reporting NDC unit/basis of measurement:<br>F2=International Unit<br>ME=Milligram<br>UN=Unit<br>GR=Gram<br>ML=Milliliter | Conditional |




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 25 | FEDERAL TAX ID NUMBER | Enter the federal Tax ID Number of the Billing Provider identified in item 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.<br>***Note:*** *Do not enter hyphens with numbers.* | Required |

| | | | |
|---|---|---|---|
| 26 | PATIENT'S ACCOUNT NO. | Enter the patient's account number assigned by the provider of service or supplier's accounting system.<br>***Note:*** *Do not enter hyphens with numbers.* | Conditional |
| 27 | ACCEPT ASSIGNMENT | Enter an X in the correct box. Only one box can be marked | Required |
| 28 | TOTAL CHARGES | Enter total charges for the services (i.e., total of all charges in 24F). If more than one claim form is required, enter the total billed charges on the last claim form. Enter 00 in the cents area if the amount is a whole number.<br>***Note:*** *Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.* | Required |
| 29 | AMOUNT PAID | Enter the total amount the patient and/or other payers paid on the covered services only. Enter 00 if the amount is a whole number.<br>***Note:*** *Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.* | Conditional |
| 30 | UNLABLED FIELD | DO NOT USE | N/A |
| 31 | SIGNATURE | Enter the legal signature of the practitioner, supplier, or representative, "Signature on File" or "SOF". Enter either the 6-digit date MM/DD/YY, 8-digit date MM/DD/YYYY, or alphanumeric date (i.e., January 1, 2003) the form was signed. | Required |
| 32 | SERVICE FACILITY LOCATION INFORMATION | Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. Enter the name and address information i the following format:<br>1st line- Name<br>2nd line - Address<br>3rd line - City, State and ZIP Code<br>***Note:*** *When more than one supplier is used, a separate 1500 claim form should be used to bill each supplier. Do not use punctuation or other symbols in the address. Enter a space between the name and state code; do not include a comma. Report a 9-digit ZIP code without the hyphen.* | Required |

| | | | |
|---|---|---|---|
| 32a | NPI | Enter the NPI number of the service facility location.<br>***Note:*** *Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.* | Required |
| 32b | OTHER ID# | Enter the qualifier by identifying the non-NPI number followed by the ID number. The NUCC defines the following qualifiers:<br>OB=State license Number<br>G2=Provider Commercial Number<br>LU=Location Number<br>***Note:*** *Do not enter a space, hyphen, or other separator between the qualifier and number.* | Required |
| 33 | BILLING PROVIDER INFORMATION | Enter the provider's or supplier's billing name, address, and ZIP code in the following format:<br>1st line - Name<br>2nd line - Address<br>3rd line - City, State and ZIP code<br>Do not use a hyphen or space as a separator with the telephone number.<br>***Note:*** *Do not use punctuation or other symbols in the address. Enter a space between the town name and state code; do not include a comma. Report a 9-digit ZIP code without the hyphen.* | Required |
| 33a | NPI | Enter the NPI number of the billing provider in item 33a. | Required |
| 33b | OTHER ID# | Enter the qualifier by identifying the non-NPI number followed by the ID number. The NUCC defines the following qualifiers:<br>OB=State license Number<br>G2=Provider Commercial Number<br>LU=Location Number<br>***Note:*** *Do not enter a space, hyphen, or other separator between the qualifier and number.* | Required |

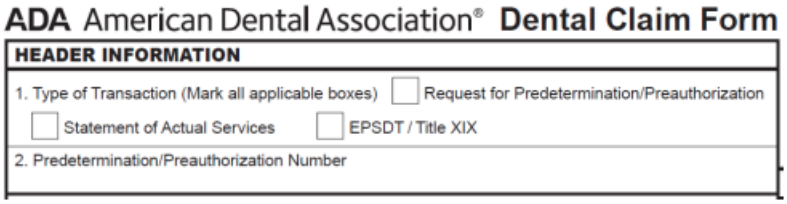
## ADA Form

This segment provides an overview for completing an ADA Dental claim form. This guide is designed to be used as a reference tool for our claim submitters to provide the expected content of each field on the ADA form, the standard paper claim form

for dental claims. The ADA claim form must be completed for all dental claim submissions. All claims must be submitted within the required filing time limit.

This guide is not intended to replace the Official ADA Data Specifications published by the American Dental Association.

## Header Information


ADA American Dental Association® Dental Claim Form

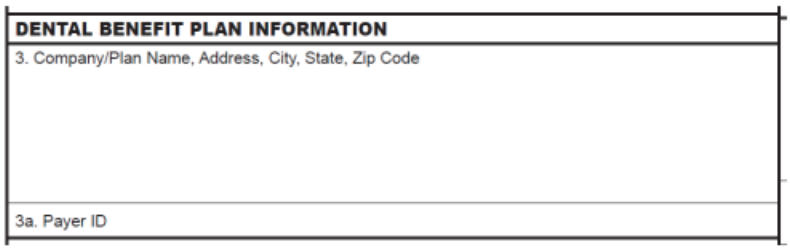
HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 1 | TYPE OF TRANSACTION | Mark an X in the box that applies to the submission.<br>**Statement of Actual Services** if services have been performed<br>**Request for Predetermination/ Preauthorization** if there are no dates of service<br>**EPST** if the claim is through the **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment **P**rogram | Required |
| 2 | PREDETERMINATION / PREAUTHORIZATION NUMBER | Enter the preauthorization number provided by the insurance company | Conditional |

## Insurance Company/Dental Benefit Plan Information


DENTAL BENEFIT PLAN INFORMATION

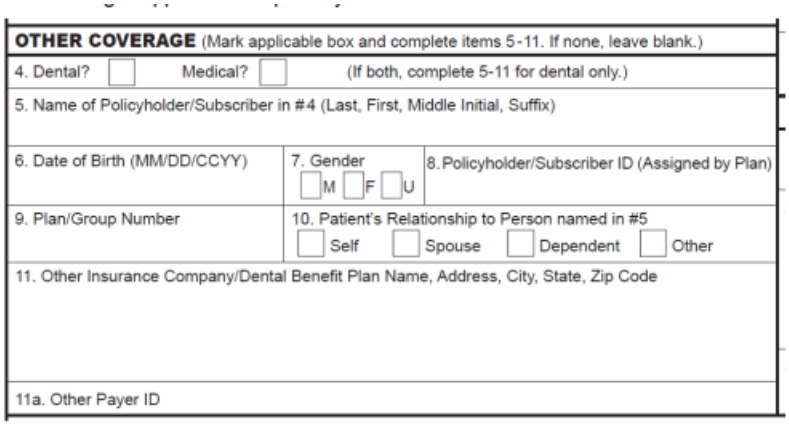
3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|

| | | | |
|---|---|---|---|
| 3 | PLAN INFORMATION | Enter the information for the insurance company or dental benefit plan that is receiving the claim.<br>1st line - Payer Name<br>2nd line - Payer street address<br>3rd line - Second line of street address, if necessary/if not leave blank<br>4th line - City, State (2 characters) and ZIP code<br>*Note: Do not use punctuation (e.g., commas, periods) or other symbols in the address. Report a 5 or 9-digit ZIP code without the hyphen.* | Required |
| 3a. | PAYER ID | Enter the Payer Identification Number for the Company/Plan specified in item 3 above. Leave it blank if not known.<br>*Note: This identifier may be found on the patient's insurance card or in the provision of a provider contract.* | Conditional |

## Other Coverage

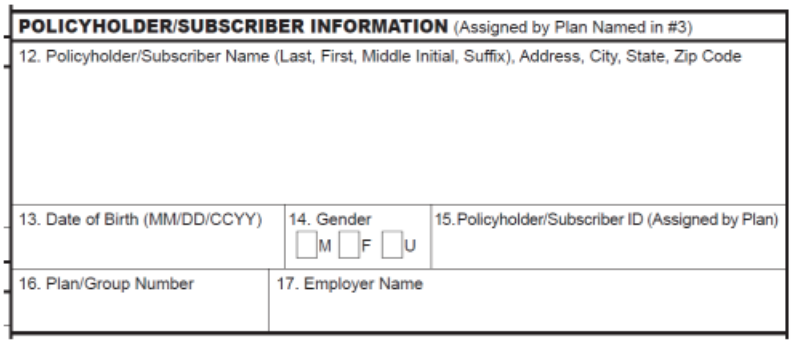



| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 4 | OTHER DENTAL OR MEDICAL COVERAGE | Mark the box after "Dental" or "Medical" if a patient has coverage under any other dental or medical plan, without regard to whether the dentist or patient will be submitting a claim to collect benefits under the other coverage. Leave blank if unknown. | Conditional |

| | | | |
|---|---|---|---|
| | | *Note: When either or both box(s) is marked, complete items 5 - 11* | |
| 5 | NAME OF POLICYHOLDER / SUBSCRIBER W/OTHER COVERAGE | If the patient has other coverage through a spouse, domestic partner; enter the name of the person who has the other coverage (Last, First, Middle Initial) | Conditional |
| 6 | DATE OF BIRTH | Enter the date of birth of the person listed in item 5. The date must be entered with 2-digits for the month and day and 4-digits for the year (MM/DD/YYYY) | Conditional |
| 7 | GENDER | Mark the gender of the person listed in item 5.<br>M=Male<br>F=Female<br>U=Unknown | Conditional |
| 8 | POLICYHOLDER / SUBSCRIBER IDENTIFIER | Enter the unique identifying number assigned by the plan to the person identified in item 5 | Conditional |
| 9 | PLAN / GROUP NUMBER | Enter the group plan or policy number of the person identified in item 5 | Conditional |
| 10 | PATIENT'S RELATIONSHIP | Mark the patient's relationship to the other insured named in item 5 | Conditional |
| 11 | OTHER INSURANCE / DENTAL INFORMATION | Enter the complete information of the additional payer, benefit plan or entity for the insured names in item 5<br>1st line - Payer Name<br>2nd line - Payer street address<br>3rd line - Second line of street address, if necessary/if not leave lank<br>4th line - City, State (2 characters) and ZIP code<br>*Note: Do not use punctuation (e.g., commas, periods) or other symbols in the address. Report a 5 or 9-digit ZIP code without the hyphen.* | Conditional |

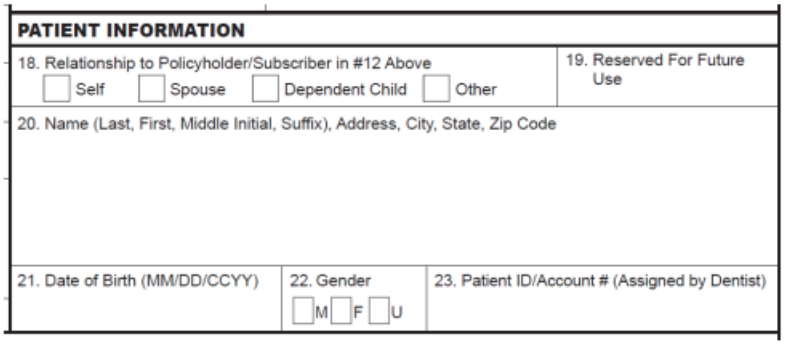
| | | | |
|---|---|---|---|
| 11a. | PAYER ID | Enter the Payer Identification Number for the Company/Plan specified in item 11 above. Leave it blank if not known. ***Note:*** *This identifier may be found on the patient's insurance card or in the provision of a provider contract.* | Conditional |

## Policyholder/Subscriber Information




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 12 | POLICYHOLDER / SUBSCRIBER INFORMATION | Enter the complete name, address, and ZIP code of the policyholder/subscriber with coverage from the company/plan in item 3 | Required |
| 13 | DATE OF BIRTH | Enter the policyholder/subscriber date of birth using 2-digits for the month and day and 4-digits for the year (MM/DD/YYYY) | Required |
| 14 | GENDER | Mark the gender of the person listed in item 5.<br>**M**=Male<br>**F**=Female<br>**U**=Unknown | Required |
| 15 | POLICYHOLDER / SUBSCRIBER IDENTIFIER | Enter the unique identifying number assigned by the payer to the person named in item 12 | Required |
| 16 | PLAN / GROUP NUMBER | Enter the policyholder/subscriber's group plan/policy number | Required |
| 17 | EMPLOYER NAME | If applicable, enter the name of the policyholder/subscriber's employer | Conditional |

## Patient Information



**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserved For Future Use

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

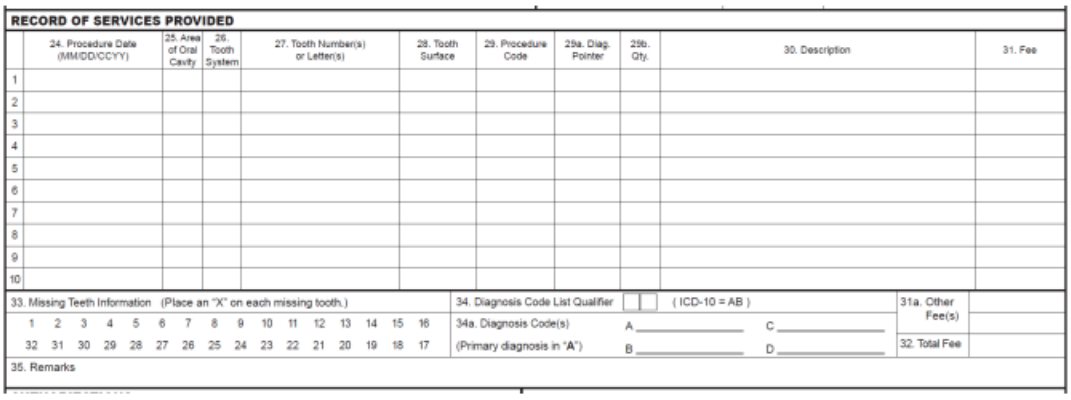
21. Date of Birth (MM/DD/CCYY)

22. Gender
☐ M ☐ F ☐ U

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

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 18 | RELATIONSHIP TO POLICYHOLDER / SUBSCRIBER | Mark the relationship of the patient to the person identified in item 12 who has the primary insurance coverage. ***Note:*** *if the patient is also the primary insured, mark the box titled* ***'Self'*** *and skip to item 23* | Required |
| 19 | UNLABLED FIELD | DO NOT USE | N/A |
| 20 | PATIENT INFORMATION | Enter the complete name, address, and ZIP code of the patient | Conditional |
| 21 | DATE OF BIRTH | Enter the patient's date of birth using 2-igits for the month and day and 4-digits for the year | Conditional |
| 22 | GENDER | Mark the gender of the patient<br>**M**=Male<br>**F**=Female<br>**U**=Unknown | Conditional |
| 23 | PATIENT ID / ACCOUNT # | Enter if the dentist's office has assigned a number to identify the patient | Conditional |

## Record of Services Provided



**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 | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)
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

34. Diagnosis Code List Qualifier ☐☐ ( ICD-10 = AB )
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee

35. Remarks

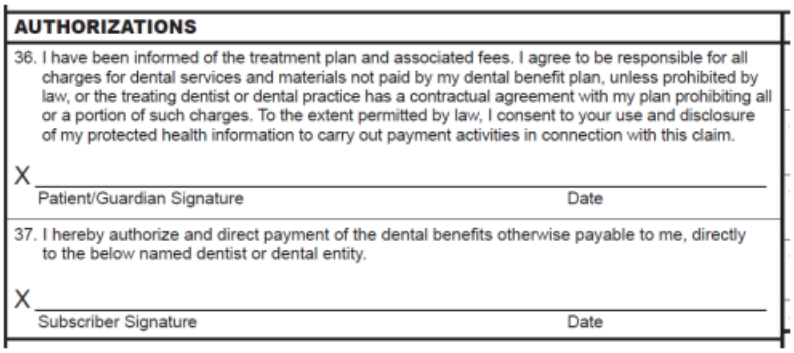
| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 24 | PROCEDURE DATE | Enter procedure date for actual services performed. The date must have 2-digits for the month and day and 4-digits for the year | Required |
| 25 | AREA OF ORAL CAVITY | Always report the area of the oral cavity when the procedure reported in item 29 refers to a quadrant or arch, and the area of the oral cavity is not uniquely defined by the procedure nomenclature. Example:<br>**Report** the applicable area of the oral cavity when the procedure nomenclature includes a general reference to an arch or quadrant, such as **D4263 bone replacement graft - first site in quadrant**<br>**Do not report** the applicable area of the oral cavity when the procedure either 1) incorporates a specific area of the oral cavity in its nomenclature, such as **D5110 complete denture-maxillary**; or 2) does not relate to any portion of the oral cavity, such as **D922 deep sedation/general anesthesia-first 15 minutes** | Conditional |
| 26 | TOOTH SYSTEM | Enter "JP" to indicate that teeth are being designated using the ADA's Universal/National Tooth Designation System (1-32 for permanent dentition and A-T for primary dentition) | Required |
| 27 | TOOTH NUMBER(S) OR LETTER(S) | Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth, otherwise leave blank. If the same procedure is performed on more than a single tooth on the same date of service, there are two options -<br>**1.** Report each procedure, the tooth involved, and the fee on separate service lines, or<br>**2.** Report the procedure on a single service line with the teeth involved in item 27, the number of times the procedure was delivered in item 29b | Conditional |

| | | | |
|---|---|---|---|
| | | (Quantity), and the total fee for all in item 31 (Fee) | |
| 28 | TOOTH SURFACE | This item is necessary when the procedure performed by the tooth involves one or more tooth surfaces. Otherwise, leave it blank. The following single letter codes are used to identify surfaces:<br>B=Buccal<br>D=Distal<br>F=Facial (or labial)<br>I=Incisal<br>L=Lingual<br>M=Mesial O=Occlusal<br>*Note: Do not leave any spaces between surface designations in multiple surface restorations (e.g.,* MOD*)* | Conditional |
| 29 | PROCEDURE CODE | Enter the appropriate procedure code in effect on the "procedure Date" (item 24) | Required |
| 29a | DIAGNOSIS CODE POINTER | Enter the letter(s) from item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first. | Required |
| 29b | QUANTITY | Enter the number of time (01-99) before the procedure identified in item 29 is delivered to the patient on the date of service shown in item 24.<br>*Note: The default value is "01"* | Required |
| 30 | DESCRIPTION | Provide a brief description of the services provided (e.g., abbreviation of the procedure code's nomenclature) | Conditional |

| | | | |
|---|---|---|---|
| 31 | FEE | Enter the full fee for each service line for the whole dollars. Enter 00 in the cents area if the amount is a whole number.<br>***Note:*** *Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.* | Required |
| 31a | OTHER FEE(S) | When other charges are applicable to dental services provided must be reported, enter the amount here. | Conditional |
| 32 | TOTAL FEE | Enter the sum of all fees from lines in item 31, plus any fee(s) entered in item 31a. Enter 00 in the cents area if the amount is a whole number.<br>***Note:*** *Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.* | Required |
| 33 | MISSING TEETH INFORMATION | Mark an X on the number of the missing tooth for identifying missing permanent dentition only. Report missing teeth when pertinent to Periodontal, Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim.<br>***Note:*** *Numbers marked are based on tooth morphology, not anatomic position* | Conditional |
| 34 | DIAGNOSIS CODE LIST QUALIFIER | Enter the appropriate code to identify the diagnosis code source:<br>AB=ICD-10-CM | Required |
| 34a | DIAGNOSIS CODE(S) | Enter up to four applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter. | Required |

| | | | |
|---|---|---|---|
| 35 | REMARKS | This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information you believe is necessary for the payer to process the claim. If submitting a corrected claim use this field (i.e., CORRECT CLAIM and original claim number)<br>***Note:*** *When the claim is for multi-unit implant supported prosthesis, the supporting implant body locations may not correlate to the anatomic location of a natural tooth. An appropriate notation in "Remarks" may avoid misunderstanding when the claim is submitted to the payer.* | Conditional |

## Authorizations



**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

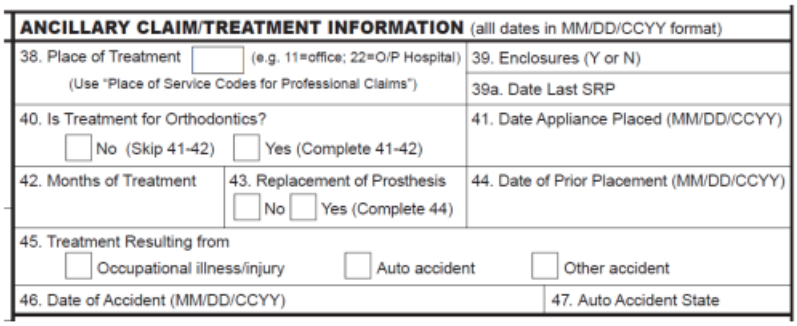
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 36 | PATIENT CONSENT | Enter "Signature on File " or "SOF" and the date in MM/DD/YY or MM/DD/YYYY to acknowledge the patient or patient's representative has agreed that he/she has been informed of the treatment plan and the release of any information necessary to carry out payment activities related to the claim | Required |

| | | | |
|---|---|---|---|
| 37 | AUTHORIZE DIRECT PAYMENT | Enter "Signature on File " or "SOF" and the date in MM/DD/YY or MM/DD/YYYY, this is required when the Policyholder/Subscriber named in item 12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. | Required |

## Ancillary Claim/Treatment Information




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 38 | PLACE OF TREATMENT | Enter the 2-digit Place of Service Code. Most frequently used codes are:<br>11=Office<br>21=Inpatient Hospital<br>22=Outpatient Hospital<br>31=Skilled Nursing Facility<br>32=Nursing Facility<br>02=Telehealth (aka Teledentistry)<br>***Note:*** *All current codes are available online from the Centers of Medicare and Medicaid Services in PDF format for download.* | Required |
| 39 | NUMBER OF ENCLOSURES | Enter a "Y" or "N" to indicate if there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models). | Conditional |
| 39a. | DATE LAST SRP | Enter the date of service for the last Scaling and Root Planning procedure (i.e. D4341) delivered to the patient in the space immediately to the right of this data element caption; date format is MM/DD/YYYY. Leave blank if not applicable to claim or unknown. | Conditional |

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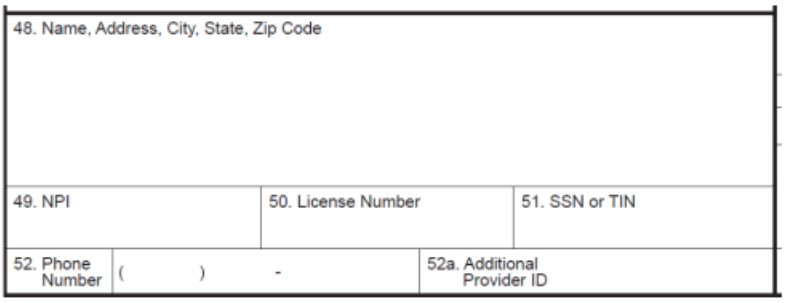
|---|---|---|---|
| 40 | TREATMENT FOR ORTHO | If no, skip to item 43, if yes, answer items 41 & 42services are not related to Orthodontics | Conditional |
| 41 | DATE APPLIANCE PLACED | Enter the date an orthodontic appliance was placed in MM/DD/YYYY format.<br>***Note:*** *This information should also be reported in this section for subsequent orthodontic visits.* | Conditional |
| 42 | MONTHS OF TREATMENT | Enter the total number of months required to complete the orthodontic treatment, from the beginning to the end of the treatment plan. | Conditional |
| 43 | REPLACEMENT OF PROSTHESIS | This item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures). Please review the following 3 situations to determine how to complete this item.<br>a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to item 45.<br>b) If the claim is for the initial placement of a crown, or a fixed or removable prothesis, mark "NO" and proceed to item 45.<br>c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prothesis, or the claim is to replace an existing crown, mark the "YES" field and complete section 44. | Conditional |
| 44 | DATE OF PRIOR PLACEMENT | Complete if the answer to item 43 was "YES". | Conditional |
| 45 | TREATMENT RESULTING FROM | If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to items 46 and 47.<br>***Note:*** *If the services you are providing are not the result of an accident, this item does not apply; skip to item 48.* | Conditional |
| 46 | DATE OF ACCIDENT | Enter the state in which the accident noted in item 45 occurred, otherwise leave it blank. | Conditional |
| 47 | AUTO ACCIDENT STATE | Enter the state in which the auto accident noted in item 45 occurred, otherwise leave blank. | Conditional |

Billing Dentist or Dental Entity




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 48 | BILLING DENTIST INFORMATION | Enter the name and complete address of a dentist or dental entity.<br>1st line - Name<br>2nd line – Street address<br>3rd line - Second line of street address, if necessary/if not leave blank<br>4th line - City, State (2 characters) and ZIP code<br>***Note:*** *Do not use punctuation (e.g., commas, periods) or other symbols in the address. Report a 5 or 9-digit ZIP code without the hyphen.* | Required |
| 49 | NPI | Enter the appropriate NPI type for the billing entity (Type 1 or Type 2).<br>Type 1 Individual Provider - All individual dentists are eligible to apply for a Type 1 NPI<br>Type 2 Organization Provider - A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as Type 1.<br>***Note:*** *All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.* | Required |
| 50 | LICENSE NUMBER | If billing the dentist is an individual, enter the dentist's license number. If the billing entity (e.g., corporation) is submitting the claim, leave it blank. | Conditional |

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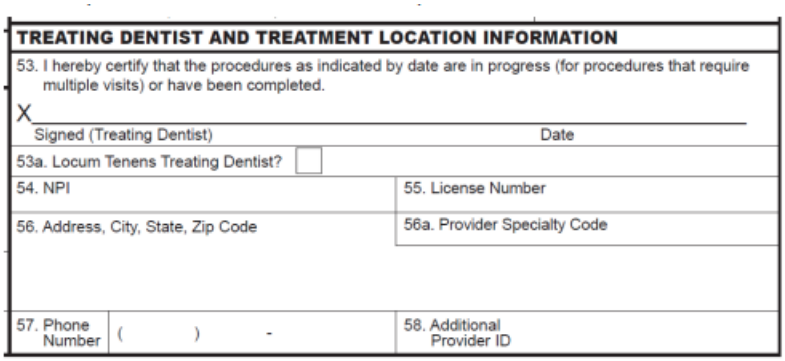
|---|---|---|---|
| 51 | SSN OR TIN | Report<br>1) SSN or TIN of the billing dentist is unincorporated;<br>2) corporation TIN of the billing dentist or dental entity if the practice is incorporated;<br>3) entity TIN when the billing entity is a group practice or clinic. | Required |
| 52 | PHONE NUMBER | Enter the business phone number of the billing dentist or dental entity.<br>***Note:*** *Do not use hyphens between the numbers.* | Conditional |
| 52a. | ADDITIONAL PROVIDER ID | This is an identifier assigned to the billing dentist or dental entity other than the SSN or TIN. It is not the provider's NPI | Conditional |

## Treating Dentist and Treatment Location Information




| Field | Field Label | Instructions and Comments | Required or Conditional |
|---|---|---|---|
| 53 | CERTIFICATION | Signature of the treating or rendering dentist and the date the form was signed (MM/DD/YY or MM/DD/YYYY) | Required |
| 53a. | LOCUM TENENS DENTIST | Mark box if the treating dentist is providing services in a locum tenens capacity, leave blank if not applicable. | Conditional |
| 54 | NPI | Enter the treating dentist Type 1 – Individual NPI. | Required |
| 55 | LICENSE NUMBER | Enter the license number of the treating dentist.<br>***Note:*** *This may vary from the billing dentist.* | Required |

| | | | |
|---|---|---|---|
| 56 | LOCATION OF TREATMENT | Enter the physical location where the treatment was rendered. There must be a street address, not a Post Office Box.<br>1st line – Street address<br>2nd line - Second line of street address, if necessary/if not leave blank<br>3rd line - City, State (2 characters) and ZIP code<br>*Note: Do not use punctuation (e.g., commas, periods) or other symbols in the address. Report a 5 or 9-digit ZIP code without the hyphen.* | Required |
| 56a. | PROVIDER SPECIALTY CODE | Enter the code that indicates the type of dental professional who delivered treatment. 122300000X=Dentist<br>1223G0001X=General Practice<br>1223D0001X=Dental Public Health<br>1223E0200X=Orthodontics<br>1223P0300X=Periodontics<br>1223P0700X=Prosthodontics<br>1223P0106X=Oral & Maxillofacial Pathology<br>1223x0008X=Oral & Maxillofacial Radiology<br>1223S0112X=Oral & Maxillofacial Surgery | Required |
| 57 | PHONE NUMBER | Enter the business telephone number of the treating dentist.<br>*Note: Do not use hyphens between the numbers.* | Conditional |
| 58 | UNLABLED FIELD | DO NOT USE | N/A |