



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 Network Management 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 Network Management 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. These 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

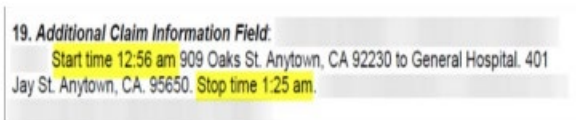
Note: Institutional based providers must report QM or QN

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. Mileage 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>.

1		2		3a PAT CNTL #		4 TYPE OF BILL	
				3b MED REC #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
9 PATIENT NAME a				9 PATIENT ADDRESS a			
b		b		c		d	

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 - <i>do not use punctuation or P.O. Box</i>	
		Line 3: Enter City, State and Zip-Code - <i>use 9 digits for Zip Code if known</i>	
		Line 4: Enter the 10-digit telephone Number XXXXXXXXXX - <i>no formatting</i>	
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.) - The first digit is a leading zero - The next 2 digits indicate the type of bill - 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. - <i>Cannot be blank or all zeros</i>	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	UNLABELED 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. 8b Enter Patient Last Name, First Name and Middle Name/Initial (if available), <i>in that specific order</i> - Use name as it appears on the Health Plan card - Use a comma or space to separate last and first names and do not use Titles - No spaces should be used in hyphenated or prefixed names (e.g., McKendrick, MacBeth Smith-Jones) - 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 9b Enter the Patient's City 9c Enter the Patient's State 9d Enter the patient's Zip Code (DO NOT use unless the Patient's address is outside of the US. - <i>This is for the Country Code for non-US addresses.</i>	Required

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES											29 ACOT	30
								18	19	20	21	22	23	24	25	26	27	28	STATE	

Field	Field Label	Instructions and Comments	Required or Conditional
10	BIRTHDATE	Enter the Patient's Date of Birth. MMDDYYYY (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: 1=Emergency 2=Urgent 3=Elective 5=Trauma 9=Information Not Available	Required

31-34 a,b	OCCURANCE CODE & DATE	Required when there is an Occurrence Code that applies to the claim. Occurrence Codes and Occurrence Spans are mutually exclusive. Occurrence Codes are 01-69 and A0-LZ. Occurrence Codes happen on a single day, and the associated date should be in MMDDYY format. 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. Occurrence Codes and Occurrence Spans are mutually exclusive. Occurrence Codes are 70-99 and M0-ZZ. Occurrence spans happen over a period of time and have an associated from and through date. 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	UNLABELED FIELD	NOT USED	N/A
38	UNLABELED 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

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HEDIS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
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11							11
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99							99
100							100

PAGE OF
CREATION DATE
TOTALS

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. For a drug, enter the NDC and associated information as follows with no spaces or delimiters: N4 11-digit NDC (no hyphens) Unit of Measure (F2, GR, ML, UN or ME) Quantity, using a decimal to represent any fractional units with no more than 3-digits to the right of the decimal (e.g. N412345678910ML3.025)	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. 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. Line 23 Enter the Date. This form is completed/printed.	Required
46	SERV UNITS	Enter the quantity (number of units) for this service line. 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. Note: For a HIPPS code line, this should always be zero. Line 23 Enter the total of all charges billed (the sum of the detail lines) on line 23 of the <u>final</u> page of the claim only.	Required

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

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A						57	A
B						OTHER	B
C						PRV ID	C

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) When the patient has other coverage, list the payers as indicated below: Line A (Required)=Primary Payer Line B =Secondary Payer Line C =Tertiary Payer	Line A Required 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 Lines B and C Conditional
52	REL. INFO	Required for each Payer listed in field 50. Release of Information Certification Indicator. This field shows whether the provider has a signed statement from the patient allowing the release of medical claim billing information to another organization. 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 Lines B and C Conditional
53	ASG. BEN.	Required for each Payer listed in field 50. Assignment of Benefits Certification Indicator. This field conveys that the provider has a signed form from the patient authorizing the payer to remit payment directly to the provider. Valid entries are Y (Yes) and N (NO).	Line A Required 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

58 INSURED'S NAME		59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A	
B				B	
C				C	

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 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: 01=Spouse 18=Self 19=Child 20=Employee 21=Unknown 39=Organ Donor 40=Cadaver Donor 53=Life Partner G8=Other	Line A Required 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 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 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. 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. 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. Note: All diagnosis codes should be coded to the highest level.	Conditional
68	UNLABELED 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. 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. Note: Refer to your contract with the payer to determine if the rates are based on APR-DRG =(Medicaid) 3-digits and severity digit 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. Note: All Diagnosis Codes should be coded to the highest level.	Conditional
73	UNLABELED FIELD	NOT USED	N/A
74 a-e	OTHER PROCEDURE CODE & DATE	Represents other procedures performed on inpatient claims.	Conditional
75	UNLABELED 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

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'. 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-form 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 manufacturer'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>.



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA CARRIER

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: 1st line - Payer Name 2nd line - Payer street address 3rd line - Second line of street address, if necessary/if not leave blank 4th line - City, State (2 characters), and ZIP code <i>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.</i>	Required

1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ OTHER ☐		2. INSURED'S I.D. NUMBER (For Program is Item 1)	
3. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐		8. RESERVED FOR NUCC USE	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	

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. 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. 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. 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. Enter an X in the correct box to indicate gender. 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. For Workers Comp claims, enter the name of the employer. For Other Property & Casualty claims, enter the name of the insured person or entity. 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. 1st line enter the street address 2nd line enter the City and State 3rd line enter the ZIP Code DO NOT enter a telephone number <i>Note: If the patient's address is the same as the insured's address, it is not necessary to report the patient's address.</i>	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. Self=indicates the insured is the patient Spouse=indicates the patient is the husband, wife, or qualified partner Child=indicates that the patient is the minor dependent 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. 1st line enter the street address 2nd line enter the City and State 3rd line enter the ZIP Code DO NOT enter a telephone number For Workers Comp claims, enter the address of the employer. For Other Property & Casualty claims enter the address of the insured noted in item number 4 <i>Note: Do not use punctuation (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.</i>	Conditional
8	UNLABELED FIELD	DO NOT USE	N/A

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) _____		b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? ☐ YES ☐ NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10a. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO <i>If yes, complete items 9, 9a, and 9d.</i>	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____		DATE _____		SIGNED _____	

PATIENT AND INSURED INFO

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. <i>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.</i>	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. <i>Note: Do not use a hyphen or space as a separator within the policy or group number.</i>	Conditional
9b.	UNLABELED FIELD	DO NOT USE	N/A
9c.	UNLABELED 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

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. Note: <i>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.</i>	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. Note: <i>see Appendix A for a partial list of claim codes.</i>	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. Note: <i>Do not use a hyphen or space as a separator within the policy or group number.</i>	Conditional
11a.	INSURED'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. Note: <i>if sex is unknown, leave blank.</i>	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. For Works Comp or Property & Casualty, enter the claim number assigned by the payer. Note: <i>Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.</i>	Conditional

11c.	PLAN/PROGRAM NAME	Enter the name of the insurance Plan or Program name of the insured. 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. 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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (JMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? ☐ YES ☐ NO	\$ CHARGES

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. 454=Initial Treatment 304=Latest Visit or Consultation 453=Acute Manifestation of a Chronic Condition 439=Accident 455=Last X-ray 471=Prescription 090=Report Start (Assumed Care Date) 091=Report End (Relinquished Care Date) 444=First Visit or Consultation <i>Note: Enter the qualifier between the left-hand set of vertical, dotted lines.</i>	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. <i>Note: An entry in this field may indicate employment - related insurance coverage.</i>	Conditional
17	REFERRING 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: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Enter the applicable qualifier to identify which provider is being reported DN=Referring provider DK=Ordering Provider DQ=Supervising Provider <i>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.</i>	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 OB=State license Number 1G=Provider UPIN Number G2=Provider Commercial Number LU=Location Number (Used for Supervising provider only). 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. <i>Note: This date is when a medical service is furnished because of, or subsequent, a related hospitalization.</i>	Conditional
19	ADDITIONAL CLAIM INFORMATION	Providers may enter a free-form narrative text that is relevant to the claim in this field. <i>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 Breakdown of modifier 99</i> 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". A "YES" mark indicates that the reported service was provided by an entity other than the billing provider. A "NO" mark or blank indicates that no purchased services are included in the claim. <i>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.</i>	Conditional

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. _____	B. _____	C. _____	D. _____			
E. _____	F. _____	G. _____	H. _____			
I. _____	J. _____	K. _____	L. _____		23. PRIOR AUTHORIZATION NUMBER	

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. 9=ICD-9-CM 0=ICD-10-CM Note: <i>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.</i>	Required
22	RESUBMISSION/ VOID	When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. 7=Replacement/Correction of a prior claim 8=Void/Cancel of prior claim Enter the original claim number in the ORIGINAL REF. NO. space. Note: <i>Do not add a leading "0" before frequency code 7 or 8. The original claim is required for processing.</i>	Conditional
23	PRIOR AUTHORIZATION	Enter the payer assigned prior authorization number for service(s). Note: <i>Do not enter hyphens or spaces within the number. For services that require prior authorization, the auth# <u>must</u> be submitted on the claim for processing.</i>	Conditional

	24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)			E. DIAGNOSIS PORTER	F. \$ CHARGES	G. DAYS OF SERVICE	H. SPST (New/Rel)	I. ID. QUAL	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From MM	YY	To MM	YY			OPT	HPCS	MODIFIER							
1																
2																
3																
4																
5																
6																

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. <i>Note: The number of days must correspond to the number of units in 24G.</i>	Required
24B	PLACE OF SERVICE	Enter the appropriate two-digit code in the unshaded area, to identify the location where the services were rendered. <i>Note: See Appendix B for a sample Place of Service listing</i>	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. <i>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.</i>	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. 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. 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. Note: No leading zeros should be reported. Units should be reported in whole units. Anesthesia services <u>must</u> be reported as minutes. Units may <u>only</u> 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. AV=Available - Nots Used (Patient refused referral) S2=Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem) 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) 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: OB=State License Number 1G=Provider UPIN Number G2=Provider Commercial Number LU=Location Number ZZ=Provider Taxonomy <i>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.</i>	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: Narrative description of unspecified codes National Drug (NDC) Device Identifier of the Unique Device Identifier for supplies Tooth numbers are areas of the oral cavity The following qualifiers are to be used when reporting these services: ZZ=Narrative description of unspecified code N4=National Drug Codes (NDC) DI=Device Identifier of the Unique Device Identifier (UDI) JP=Universal/National Tooth Designation System JO=ANSI/ADA/IOS Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity The following qualifiers are to be used when reporting NDC unit/basis of measurement: F2=International Unit ME=Milligram UN=Unit GR=Gram ML=Milliliter	Conditional
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25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (If yes, enter yes; if no, enter no)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rev'd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse so apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH# ()		
SIGNED _____ DATE _____		a. NPI b. _____		a. NPI b. _____		

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. 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. <i>Note: Do not enter hyphens with numbers.</i>	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. <i>Note: Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.</i>	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. <i>Note: Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.</i>	Conditional
30	UNLABELED 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 if different than the billing address. If the service is rendered at the same address as the billing provider the service address should not be sent, as it can cause rejections. 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 in the following format: 1st line- Name 2nd line - Address 3rd line - City, State and ZIP Code <i>Note: When more than one supplier is used, a separate 1500 claim form should be used to bill each supplier. Do not use punctuation</i>	Required

		<i>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.</i>	
32a	NPI	If a service facility location name & address is present in Box 32 when noted above as required, enter the NPI number of the service facility location in box 32A.	Conditional
32b	OTHER ID#	Enter the qualifier by identifying the non-NPI number followed by the ID number. The NUCC defines the following qualifiers: OB =State license Number G2 =Provider Commercial Number LU =Location Number <i>Note: Do not enter a space, hyphen, or other separator between the qualifier and number.</i>	Required
33	BILLING PROVIDER INFORMATION	Enter the provider's or supplier's billing name, address, and ZIP code in the following format: 1st line - Name 2nd line - Address 3rd line - City, State and ZIP code Do not use a hyphen or space as a separator with the telephone number. <i>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.</i>	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: OB =State license Number G2 =Provider Commercial Number LU =Location Number <i>Note: Do not enter a space, hyphen, or other separator between the qualifier and number.</i>	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	☐ EPSTD / 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. Statement of Actual Services if services have been performed Request for Predetermination/Preauthorization if there are no dates of service EPST if the claim is through the Early and Periodic Screening, Diagnosis and Treatment Program	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. 1st line – Payer Name 2nd line – Payer street address 3rd line – Second line of street address, if necessary/if not leave blank 4th line – City, State (2 characters) and ZIP code <i>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.</i>	Required
3a.	PAYER ID	Enter the Payer Identification Number for the Company/Plan specified in item 3 above. Leave it blank if not known. <i>Note: This identifier may be found on the patient's insurance card or in the provision of a provider contract.</i>	Conditional

Other Coverage

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		
4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F ☐ U	8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		
11a. Other Payer ID		

Field	Field Label	Instructions and Comments	Required or Conditional
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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. <i>Note: When either or both box(s) is marked, complete items 5 - 11</i>	Conditional
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. M =Male F =Female 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 1st line - Payer Name 2nd line - Payer street address 3rd line - Second line of street address, if necessary/if not leave blank 4th line - City, State (2 characters) and ZIP code <i>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.</i>	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: <i>This identifier may be found on the patient's insurance card or in the provision of a provider contract.</i>	Conditional
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Policyholder/Subscriber Information

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

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. M =Male F =Female 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. <i>Note: if the patient is also the primary insured, mark the box titled 'Self' and skip to item 23</i>	Required
19	UNLABELED 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-digits for the month and day and 4-digits for the year	Conditional
22	GENDER	Mark the gender of the patient M=Male F=Female 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.)						34. Diagnosis Code List Qualifier ☐ (ICD-10 = AB)				31a. Other Fee(s)											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)		A	C		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in 'A')		B	D		
35. Remarks																	32. Total Fee				

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: 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 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 - 1. Report each procedure, the tooth involved, and the fee on separate service lines, or 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: B=Buccal D=Distal F=Facial (or labial) I=Incisal L=Lingual M=Mesial O=Occlusal <i>Note: Do not leave any spaces between surface designations in multiple surface restorations (e.g., MOD)</i>	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. <i>Note: The default value is "01"</i>	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. <i>Note: Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.</i>	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. <i>Note: Do not use commas when reporting dollar amounts. Negative amounts and dollar signs are not allowed.</i>	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. <i>Note: Numbers marked are based on tooth morphology, not anatomic position</i>	Conditional
34	DIAGNOSIS CODE LIST QUALIFIER	Enter the appropriate code to identify the diagnosis code source: 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) 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
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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
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Ancillary Claim/Treatment Information

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)			
38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N)	
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)		39a. Date Last SRP	
42. Months of Treatment		41. Date Appliance Placed (MM/DD/CCYY)	
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)	
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident			
46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State	

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: 11=Office 21=Inpatient Hospital 22=Outpatient Hospital 31=Skilled Nursing Facility 32=Nursing Facility 02=Telehealth (aka Teledentistry) <i>Note: All current codes are available online from the Centers of Medicare and Medicaid Services in PDF format for download.</i>	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

40	TREATMENT FOR ORTHO	If no, skip to item 43, if yes, answer items 41 & 42 services are not related to Orthodontics	Conditional
41	DATE APPLIANCE PLACED	Enter the date an orthodontic appliance was placed in MM/DD/YYYY format. <i>Note: This information should also be reported in this section for subsequent orthodontic visits.</i>	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. a) If the claim does not involve a prosthetic restoration mark "NO" and proceed to item 45. b) If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to item 45. c) If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, 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. <i>Note: If the services you are providing are not the result of an accident, this item does not apply; skip to item 48.</i>	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

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

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. 1st line – Name 2nd line – Street address 3rd line – Second line of street address, if necessary/if not leave blank 4th line – City, State (2 characters) and ZIP code <i>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.</i>	Required
49	NPI	Enter the appropriate NPI type for the billing entity (Type 1 or Type 2). Type 1 Individual Provider – All individual dentists are eligible to apply for a Type 1 NPI 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. <i>Note: All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.</i>	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

51	SSN OR TIN	Report 1) SSN or TIN of the billing dentist is unincorporated; 2) corporation TIN of the billing dentist or dental entity if the practice is incorporated; 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. <i>Note: Do not use hyphens between the numbers.</i>	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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.	
X	
Signed (Treating Dentist)	Date
53a. Locum Tenens Treating Dentist?	☐
54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number () -	58. Additional Provider ID

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. <i>Note: This may vary from the billing dentist.</i>	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. 1st line – Street address 2nd line – Second line of street address, if necessary/if not leave blank 3rd line – City, State (2 characters) and ZIP code <i>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.</i>	Required
56a.	PROVIDER SPECIALTY CODE	Enter the code that indicates the type of dental professional who delivered treatment. 122300000X=Dentist 1223G0001X=General Practice 1223D0001X=Dental Public Health 1223E0200X=Orthodontics 1223P0300X=Periodontics 1223P0700X=Prosthodontics 1223P0106X=Oral & Maxillofacial Pathology 1223x0008X=Oral & Maxillofacial Radiology 1223S0112X=Oral & Maxillofacial Surgery	Required
57	PHONE NUMBER	Enter the business telephone number of the treating dentist. <i>Note: Do not use hyphens between the numbers.</i>	Conditional
58	UNLABELED FIELD	DO NOT USE	N/A