# American Dental Association (ADA)
# Dental Claim Form Reference Guide

**Please fill out all required information on the proper claim form. Dental is required to use the ADA claim form 2012 version (previous versions are not permissible). Please type all information, handwritten claim forms will be denied. *Incorrect or incomplete claim forms may cause processing delays or rejection of claims.***

**California Correctional Health Care Services (CCHCS) reserves the right to request supporting documentation for any services provided. For assistance with completing the ADA claim form, please contact CCHCS, Healthcare Invoicing Section (HIS) Help Desk at (916) 691-0699 or via email m_HISProgramSupport@cdcr.ca.gov.**

***All items with an asterisk are required unless otherwise noted. Please ensure to complete these fields to avoid denial of the claim.***

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| **Header Information** | • Statement of Actual Services***** <br>  ○ Check this box when submitting a claim for services rendered. <br>• Request for Predetermination/Preauthorization***** <br>  ○ Requirement for only the Reentry Programs (REPS) population to request preauthorization prior to performing services. |
| **Insurance Company/Dental Benefit Plan Information** | *Dental claims shall all be sent to CorrectCare Integrated Health (CCIH) for processing.* <br>• For ADA claim form 2012 version, place CCIH's address in Box 3. <br><br>**CCIH** <br>**P.O. Box 349026** <br>**Sacramento, CA 95834-9026** |
| **Other Coverage** | *Optional fields – if completed, please provide the following:* <br>• Box 5 – The Incarcerated Persons name should be listed in Last Name, First Name format. <br>• Box 6 – Enter the Incarcerated Persons correct Date of Birth (DOB). <br>• Box 7 – Mark the Incarcerated Person Gender. <br>• Box 8 – Enter the Incarcerated Persons California Department of Corrections and Rehabilitation (CDCR) number. <br>  ○ CDCR numbers consist of six alphanumeric characters. <br>• Box 9 – Leave blank. <br>• Box 10 – Mark "Self" as the relationship to the information listed in box 5. <br>• Box 11 – Leave blank. <br>• Box 12 – The Incarcerated Persons name must be listed in Last Name, First Name format.***** <br>  ○ Place Institution/REPS Facility acronym/abbreviation in which the Incarcerated Person is housed followed by City, State, and Zip Code. <br>• Box 13 – Enter the Incarcerated Persons correct DOB.***** <br>• Box 14 – Mark the correct Gender for the Incarcerated Person.***** |

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| **Policy Holder/Subscriber Information and Incarcerated Person Information** | • Box 15 – Enter the Incarcerated Persons CDCR number.*<br>  ○ CDCR numbers consist of six alpha-numeric characters. ***Anything other than the six character CDCR number will result in a denial of the claim.***<br>  ▪ **Adult Identifications can be obtained at:** California Incarcerated Records & Information Search (CIRIS) - CDCR<br>• Box 16 – Leave blank.<br>• Box 17 – Leave blank.<br>• Box 18 – Mark "Self" as the relationship to the information listed in Box 12.*<br>• Box 19 – Leave Blank.<br>• Box 20 – List the Incarcerated Persons Name and Address as entered in Box 12.*<br>• Box 21 – List the Incarcerated Persons DOB.*<br>• Box 22 – Mark the correct Gender for the Incarcerated Person.*<br>• Box 23 – Enter the providers account or invoice number.* |
| **Record of Services Provided** | • Boxes 24, 26, 27, 29, 29a, 29b, 30, 31 & 32.*<br>• Box 33 – Should only be completed if there are missing teeth.*<br>• Box 34/34a – If applicable, enter the appropriate Medicare Diagnosis code(s).*<br>• Box 35 – Can be used for additional remarks necessary to describe treatment or to note that the claim is a Corrected Claim.* |
| **Authorizations** | • Box 36 – No Signature is required.<br>• Box 37 – Physician's must sign and date.* |
| **Ancillary Claim/Treatment Information** | • Box 38 – List the appropriate code for the treatment location using the Medicare recognized Place of Service (POS) code.*<br>Common POS codes are:<br>  ○ 09 – Prison Facility<br>  ○ 11 – Provider's Office<br>  ○ 21 – Inpatient Hospital<br>  ○ 22 – Outpatient Hospital<br>  ○ 24 – Ambulatory Surgical Center<br>• Box 39 – Mark Y or N for enclosures.*<br>• Box 40 – Mark if treatment is for Orthodontics, if not skip boxes 41 and 42.*<br>• Boxes 41 and 42 – Only fill out if treatment is for Orthodontics.*<br>• Ensure Box 41 lists the date of placement and Box 42 lists the number of treatment months remaining.*<br>• Box 43 – Mark whether or not there is a prosthetic replacement, if not skip box 44.*<br>• Box 44 – List the Prior Placement date of prosthetic.*<br>• Box 45 – Mark the appropriate box and complete boxes 46 and 47 if necessary.* |
| **Billing Dentist or Dental Entity** | • Box 48 – Enter the Name, City, State and Zip code for the billing providers remittance address.* |

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| | ○ Remittance address must match your submitted *STD204 Payee Data Record and Supplement Vendor Payee Data Record Forms*. If you need to update your remittance address, please contact the HIS Help Desk at (916) 691-0699 or via email m_HISProgramSupport@cdcr.ca.gov.<br>• Box 49 – Enter the Billing Provider's National Provider Identifier (NPI) number.*****<br>• Box 50 – Enter the dentists license number if the billing provider is an individual. Leave blank for a billing entity (e.g. corporation).*****<br>• Box 51 – Enter the billing Provider's Tax ID or SSN, whichever is appropriate.*****<br>• Box 52 – Enter a valid, current contact phone number. This will be used should CCHCS, HIS need to contact the Billing Provider.*****<br>• Box 52a – Enter any additional Provider NPI, should be the physician's NPI (if different from the Billing Provider NPI).***** |
| **Treating Dentist and Treatment Location Information** | • Box 53 – Enter the Treating Dentist's Name and the date of name entry.*****<br>• Box 54 – Enter the Treating Dentist's NPI number.*****<br>• Box 55 – Enter the Treating Dentist's License number.*****<br>• Box 56 – Enter the Service Facility Location address. If services were provided at an Institution/Facility, list the Abbreviation/Acronym with the City, State and Zip Code.*****<br>• Box 56a – Enter the Treating Dentist's Provider Specialty Code.*****<br>• Boxes 57 and 58 can be left blank. |