

BUREAU FOR CHILDREN WITH MEDICAL HANDICAPS

BILLING INSTRUCTIONS FOR DENTAL SERVICES FOR AMERICAN DENTAL ASSOCIATION 1999 VERSION 2000 FORM

BILLING FORMS: J588, J589, J590

Item 1	DENTIST'S PRETREATMENT ESTIMATE OR STATEMENT OF ACTUAL SERVICES AND SPECIALTY	NOT REQUIRED
Item 2	MEDICAID CLAIM, EPSDT PRIOR AUTHORIZATION	NOT REQUIRED NOT REQUIRED
Item 3	CARRIER NAME	NOT REQUIRED
Item 4	CARRIER ADDRESS	NOT REQUIRED
Item 5	CITY	NOT REQUIRED
Item 6	STATE	NOT REQUIRED
Item 7	ZIP CODE	NOT REQUIRED
Item 8	PATIENT NAME (LAST, FIRST, MIDDLE)	Enter the patient's last name, first name and middle initial.
Item 9	ADDRESS	NOT REQUIRED
Item 10	CITY	NOT REQUIRED
Item 11	STATE	NOT REQUIRED
Item 12	DATE OF BIRTH	NOT REQUIRED
Item 13	PATIENT ID	NOT REQUIRED
Item 14	SEX	NOT REQUIRED
Item 15	PHONE NUMBER	NOT REQUIRED
Item 16	ZIP CODE	NOT REQUIRED
Item 17	RELATIONSHIP TO SUBSCRIBER/EMPLOYER	NOT REQUIRED
Item 18	EMPLOYER/SCHOOL NAME AND ADDRESS	NOT REQUIRED
Item 19	SUBSCRIBER/EMPLOYEE ID # OR SOCIAL SECURITY NUMBER	Enter the 12-digit BCMH Case Number.
Item 20	EMPLOYER NAME	NOT REQUIRED
Item 21	GROUP NUMBER	NOT REQUIRED
Item 22	SUBSCRIBER/EMPLOYEE NAME	NOT REQUIRED
Item 23	ADDRESS	NOT REQUIRED

Item 24	PHONE NUMBER	NOT REQUIRED
Item 25	CITY	NOT REQUIRED
Item 26	STATE	NOT REQUIRED
Item 27	ZIP CODE	NOT REQUIRED
Item 28	DATE OF BIRTH	NOT REQUIRED
Item 29	MARITAL STATUS	NOT REQUIRED
Item 30	SEX	NOT REQUIRED
Item 31	IS PATIENT COVERED BY ANOTHER DENTAL PLAN	NOT REQUIRED
Item 32	POLICY NUMBER	

If you have received payment for the service from a source other than Medicare, please enter the appropriate one-character source code as listed below:

- 1 = Self/Family*
- 2 = Blue Cross/Blue Shield*
- 3 = Private Carrier*
- 4 = Employer or Union*
- 5 = Public Agency*
- 6 = Other (enter the name and address of the source in the provider remarks section, Stock 61)*

*When numbers 1 thru 6 are entered in this block, the amount collected must be entered in the block labeled **PAYMENT BY OTHER PLAN**.*

If you have not received payment from a third-party insurer, but there are indications of private (non- Medicare) health insurance coverage in the case, please enter the appropriate one-character reason code as listed below:

E - Insurance Benefits Exhausted. Means the provider has confirmed there is private health insurance, but the policy benefits for the billed services have been exhausted.

F - No Coverage for All Billing Numbers. Means there is no private health insurance for any member of the medical assistance group. NOT APPLICABLE FOR BCMH CLIENTS.

L - Disputed or Contested Liability. Means the provider has confirmed that there is private health insurance, but the coverage for the billed service is disputed or contested by the insurance carrier due to a pre-existing condition or other policy limitation. Do not use this code when the insurance carrier is requesting additional information.

P - No Coverage for this BCMH Client. Means the

provider has confirmed there is private health insurance for some members of the client's family, but this particular client is not covered.

R - No Response From Carrier. Means no response from the insurance carrier within 90 days from submission of a claim to the insurance carrier. A claim with this code may not be submitted to BCMH until 91 days after the date of treatment.

S - Non-covered Services. Means the provider has confirmed there is health insurance, but the policy does not cover the services being billed. This code should also be used when the amount billed has been applied to the insurance deductible.

X - Non-cooperative Recipient. Means the provider has confirmed that there is private health insurance, but the patient refused to cooperate in collection effort.

Documentation to justify use of codes E, F, L, P, R, S and X must be retained for future audit purposes.

If you have not received payment from another source and there is no indication of health insurance coverage for the client, leave this item blank.

Item 33	OTHER SUBSCRIBER'S NAME	NOT REQUIRED
Item 34	DATE OF BIRTH	NOT REQUIRED
Item 35	SEX	NOT REQUIRED
Item 36	PLAN/PROGRAM NAME	NOT REQUIRED
Item 37	EMPLOYER/SCHOOL	NOT REQUIRED
Item 38	SUBSCRIBER/EMPLOYER STATUS	NOT REQUIRED
Item 39	PATIENT SIGNATURE BLOCK	NOT REQUIRED
Item 40	EMPLOYER/SCHOOL	NOT REQUIRED
Item 41	EMPLOYEE/SUBSCRIBER BLOCK	NOT REQUIRED
Item 42	NAME OF BILLING DENTIST OR BILLING ENTITY	Enter the provider's name.
Item 43	PHONE NUMBER	NOT REQUIRED
Item 44	PROVIDER ID	Enter the seven-digit Ohio Medicaid provider number of the dentist who performed the service. When the billing provider is in a group practice, the individual's provider number who performed the

		service must go in this space. If billing for a group practice, enter the group provider number in Block 45.
Item 45	DENTIST SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER	Enter the seven-digit Ohio Medicaid group provider number if applicable.
Item 46	ADDRESS	NOT REQUIRED
Item 47	DENTIST LICENSE #	NOT REQUIRED
Item 48	FIRST VISIT DATE OF CURRENT SERVICES	NOT REQUIRED
Item 49	PLACE OF TREATMENT	Check the appropriate block.
Item 50	CITY	NOT REQUIRED
Item 51	STATE	NOT REQUIRED
Item 52	ZIP CODE	NOT REQUIRED
Item 53	RADIOGRAPHS OR MODELS ENCLOSED	NOT REQUIRED
Item 54	IS TREATMENT FOR ORTHODONTICS?	NOT REQUIRED
Item 55	IF PROSTHESIS (CROWN, BRIDGE, DENTURE), IS THIS INITIAL PLACEMENT?	NOT REQUIRED
Item 56	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NOT REQUIRED
Item 57	IS TREATMENT RESULT OF AUTO ACCIDENT?	NOT REQUIRED
Item 58	DIAGNOSIS CODE INDEX	NOT REQUIRED
Item 59	EXAMINATION AND TREATMENT PLAN	NOT REQUIRED
	DATE	In chronological order, enter the first date of service to the last date of service in the eight digit format (MMDDCCYY). Enter all eight characters consecutively without dashes, slashes, or spaces. A separate line is required for each date of service.
	TOOTH	Enter the appropriate tooth number. Use tooth numbers on permanent teeth and tooth letters on primary teeth. Use CAPITAL LETTERS on primary teeth. Use two digit numbers for tooth number.
	SURFACE	Enter the surface(s) involved for all restorations. Use the following CAPITAL LETTER(S) ONLY FOR THE SURFACE(S):

M Mesial
 D Distal
 L Lingua
 I Incisal
 F Facial
 B Buccal
 O Occlusal

	DIAGNOSIS INDEX #	NOT REQUIRED
	PROCEDURE CODE	Enter the five character CPTIHPCS procedure code which corresponds to the service rendered.
	QUANTITY	NOT REQUIRED
	DESCRIPTION	NOT REQUIRED
	FEE	Enter your usual and customary fee for the line item.
	TOTAL FEE	Enter the total charge for all services on this invoice. This amount should be the sum of all fees entered for each line.
	PAYMENT BY OTHER PLAN	Enter the amount collected from all sources other than Medicaid. If the amount collected from all sources other than Medicaid exceeds the maximum payment that BCMH will make for the service or Medicaid has made a payment for the service, BCMH will not make any additional payment, and the payment will be considered paid in full. If this block is completed, then block 32 must also be completed.
	MAXIMUM ALLOWABLE	NOT REQUIRED
	DEDUCTIBLE	NOT REQUIRED
	CARRIER %	NOT REQUIRED
	CARRIER PAYS	NOT REQUIRED
	PATIENT PAYS	NOT REQUIRED
Item 60	IDENTIFY ALL MISSING TEETH WITH "X"	NOT REQUIRED
Item 61	REMARKS FOR UNUSUAL SERVICES	NOT RQUIRED
Item 62	DENTIST'S SIGNATURE BLOCK	The signature of the provider rendering the service billed on the invoice is required.

Item 63	ADDRESS WHERE TREATMENT WAS PERFORMED	NOT REQUIRED
Item 64	CITY	NOT REQUIRED
Item 65	STATE	NOT REQUIRED
Item 66	ZIP CODE	NOT REQUIRED

Mailing instructions:

Prepare one copy of the invoice to be retained in your file. Mail the original invoice when completed to:

Bureau for Children with Medical Handicaps
PO Box 1603
Columbus, OH 43126-1603