CONDUENT

Claim Form Billing Instructions: Dental 2012 (ADA J430-434) Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE (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

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Item number	Required Field?	Description and Instructions
1	Required	Type of Transaction: Check "Statement of Actual Services" when billing for services rendered on a NM Medicaid claim. Check "EPSDT/Title XIX" if patient is covered by NM Medicaid Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21. Requests for Predetermination/Preauthorization should be sent directly to Qualis prior to submitting a claim for payment. Check "Request for Predetermination/ Preauthorization." If received by NM Medicaid, these will be returned to the provider.
2	Situational	Predetermination/Preauthorization Number: Enter the Prior Authorization number if a PA is required for services billed.
3	Not Required	Company/Plan Name, Address, City, State, and Zip Code: Enter Conduent claims mailing address: Conduent, PO Box 26500, Albuquerque NM 87125.
4	Required for Third Party Payer	Dental or Medical Coverage: Check the "Dental" box when the patient has third party dental coverage. If checked, a third party EOB is required with the claim. Medicare, Medicare Replacement, Medicaid, Conduent, IHS, and Centennial Care or Medicaid Managed Care Plans are not considered third party payers. Do not check the box for these plans. The "Medical" check box is not used.
5	Situational (Third Party insurance)	Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix): Enter Policyholder name.
6	Situational (Third Party insurance)	Date of Birth (MM/DD/CCYY): Enter Policyholder date of birth.
7	Situational (Third Party insurance)	Gender: Check Policyholder gender.
8	Situational (Third Party insurance)	Policyholder/Subscriber Identifier (SSN or ID #): Enter Policyholder identifier assigned by third party payer.
9	Situational (Third Party insurance)	Plan/Group Number: Enter Plan/Group number.
10	Situational (Third Party insurance)	Patient's Relationship to Person Named in Item #5: Check box according to Patient/Policyholder relationship.
11	Situational (Third Party insurance)	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code: Enter complete information for the third party payer or plan.

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

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. 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 | 23. Patient ID/Account # (Assigned by Dentist)

Item number	Required Field?	Description and Instructions.
12-17	Note	Policyholder/Subscriber Information: NM Medicaid clients are enrolled individually, so the patient is the policyholder.
12	Optional	Policyholder/Subscriber Name and Address: Enter the complete name, address, and zip code of the patient (required in Box 20).
13	Required	Date of Birth: Enter the patient’s date of birth in MM/DD/YYYY format.
14	Required	Gender: Check the patient’s gender.
15	Required	Policyholder/Subscriber ID: Enter the patient’s NM Medicaid ID number.
16	Reserved	Plan/Group Number: Reserved for NM Medicaid claims processing and must be left blank.
17	Not Required	Employer Name: Not used.
18	Not Required	Relationship to Policyholder/Subscriber in #12 Above: This is always Self, since NM Medicaid clients are enrolled individually. Not used.
19	Not Required	Student Status: Not used.
20	Required	Name, Address, City, State, Zip Code: Enter the complete name, address, and zip code for the patient.
21	Optional	Date of Birth: Date of birth must be entered in Box 13 or 21 – either box is valid.
22	Not Required	Gender: Not used.
23	Not Required	Patient ID/Account #: Enter internal patient account number if needed for your records.

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)

32. Total Fee

35. Remarks

Item number	Required Field?	Description and Instructions.
24–31	At least 1 charge line is required	Service Lines: Lines 1-10 are used to identify the services performed. Up to eighteen charge lines are allowed on one claim (using two pages). All codes entered must be valid codes from the ADA Current Dental Terminology Code Set (CDT)
24	Required	Procedure Date: Enter the date of service for the procedure in MMDDYYYY format. If no procedure dates are entered, the claim cannot be processed and will be returned to the provider. When this form is used to submit for prior authorization, leave blank.
25	Situational	Area of Oral Cavity: Identify the area of the oral cavity if required. Oral cavity codes are 2 digits.
26	Not Required	Tooth System: Not used.
27	Situational	Tooth Numbers or Letters: If the procedure code requires identification of teeth, enter the appropriate tooth number or letter. If the same code is done on more than one tooth, please bill each procedure code and the tooth involved on separate lines. If the procedure code involves range of teeth, report the range.
28	Situational	Tooth Surface: The identification of the surface(s) of the tooth that was treated is required for some services. Enter up to 5 codes for the surfaces treated.
29	Required	Procedure Code: Enter the 5-digit procedure code for the service performed.
29a	Not Required	Diagnosis Code Pointer: Enter the letter(s) from Item 34a that identifies the diagnosis code(s) related to the dental procedure.
29b	Not Required	Quantity: Enter the number of times (01-99) the procedure identified in Item 29 was performed on the date of service shown in Item 24. The default value is "01."
30	Situational	Description: Enter a brief description of the service provided. A description is required when submitting an "unspecified" procedure.
31	Required	Fee: Enter the charges for the service billed on the line. For-profit providers must include gross receipts tax in the line item charges. Do not bill a separate line for gross receipts tax.
31a	Required if box 4 is checked	Other Fees: The NM Medicaid program requires any prior payment made by a third party payer to be entered in this field. Leave blank if there is not a primary payer or if the primary payer did not make a payment on the claim. Do not enter previous amounts paid by Medicaid in this field.
32	Required	Total Fee: Enter total of all line item charges in this field. The total must be the exact sum of all line item charges. For a 2-page claim, enter total on the second page only. Do not subtract prior payments entered in Box 31a.

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33	Situational	Missing Teeth: Report missing teeth when pertinent. Example: Prosthodontic procedures.
34	Optional	Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source: **B** = ICD-9-CM **AB** = ICD-10-CM
34a	Not Required	Diagnosis Code(s): Enter applicable diagnosis codes after each letter (A – D). Enter the primary diagnosis code on the A line. ICD-10 codes are required for services with dates of service 10/01/2015 or later.
35 Left	Situational	Remarks: When resubmitting a previously denied claim or requesting an adjustment of a paid claim, enter the 17 digit Transaction Control Number (TCN) of the claim in the left side of the field. To meet timely filing guidelines, the resubmission must be received within 90 days of the RA date of the initial claim.
35 Right	Reserved	Reserved for NM Medicaid claims processing and must be left blank.

AUTHORIZATIONS

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

X Patient/Guardian Signature Date

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

X Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (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)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

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

Item number	Required Field?	Description and Instructions.
36 & 37	Not Required	Authorizations: This area is for the signature of the patient or guardian, and the signature of the "subscriber". The patient and the subscriber are same. NM Medicaid does not require these fields to be completed.
38	Required	Place of Treatment: Enter a valid Place of Service code.
39	Not Required	Number of Enclosures: This field is not used. Do not send x-rays, oral images or models to Conduent. They may be sent to the NM Medicaid Utilization Review Contractor when requesting prior authorization.
40-44	Not Required	Not used.
45	Situational	Treatment Resulting From: Check appropriate box if treatment resulted from accident or injury. Only one box may be checked.
46	Situational	Date of Accident: If a box in field 45 is checked, enter the date of accident in MMDDYYYY format.
47	Not Required	State of Accident: Not used.

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

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

Item number	Required Field?	Description and Instructions.
48	Required	Name, Address, City, State and Zip Code: Enter name, address, city, state and zip code of the billing (pay-to) provider, NOT the treating (rendering) provider unless they are the same. If the billing provider has more than one location in order to pay different gross receipts tax rates but has a single NPI, enter the zip code of the location where the service was rendered so the correct billing provider can be identified.
49	Required	NPI: Enter the billing provider's NPI.
50	Not Required	License Number: Not used.
51	Not Required	SSN or TIN: The billing (pay-to) provider's tax ID number can be entered here.
52	Not Required	Phone Number: Not used.
52a	Not Required	Additional Provider ID: The billing (pay-to) provider's NM Medicaid ID number can be entered here.
53	Required	Treating Dentist Signature and Date: A valid signature is required. It can be printed, stamped, typed or signed, but it must be the name of a person, not a facility. Claims without a valid signature will be denied. Enter the date in MMDDCCYY format.
54	Required	NPI: Enter the treating (rendering) provider's NPI in this field. If the NPI is unknown, the provider can be looked up on these websites in order to identify the NPI: NPPES - https://npiregistry.cms.hhs.gov/ or the NM Web Portal - https://nmmedicaid.portal.conduent.com/webportal/providerSearch
55	Optional	License Number: The treating (rendering) provider's license number can be entered here.
56	Optional	Address, City, State and Zip Code: The address, city, state and zip code of the location where the treatment occurred can be entered in this field.
56A	Situational	Provider Specialty Code: Enter treating (rendering) provider's taxonomy code if the NPI relates to multiple provider numbers.
57	Not Required	Phone Number: Not used.
58	Not Required	Additional Provider ID: The treating (rendering) provider's NM Medicaid ID can be entered here.

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Date	Revision History	Updated by
04/03/2015	Original document	PS
04/13/2015	All	DD
04/21/2015	All	HSD/DD
5/10/2017	Updated details all pages, updated logo to Conduent	PS
8/15/2017	Updated with State reviewer notes	PS
10/13/2017	Updated with instructions from the State	PS
02/07/2018	Updated with rebranded provider search URL	AH