Attention All Providers:

In order to report the National Provider Identifier (NPI), the American Dental Association (ADA) has revised the ADA Dental Claim Form (version J400). CareSource is now accepting this new ADA Dental Claim Form in order to be compliant with the Federal NPI initiative.

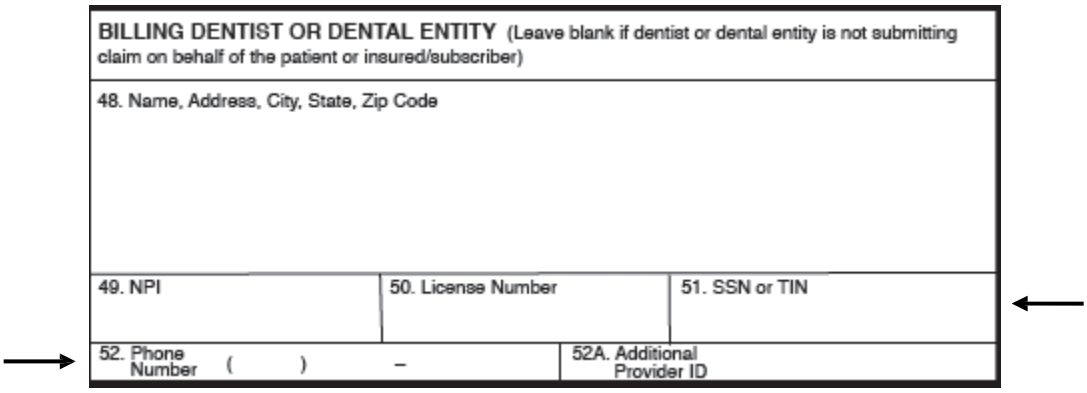
The ADA website http://www.ada.org/prof/resources/topics/claimform.asp contains instruction manuals for your reference.

We have provided some instruction below for key fields that are necessary to process your claims and ensure no interruption in payment. Please submit original forms so data entered is legible and not obscured.

Changes to the Form

Field Number 49: NPI number of the billing provider. This 10 digit number refers to the HIPAA National Provider Identifier Number.

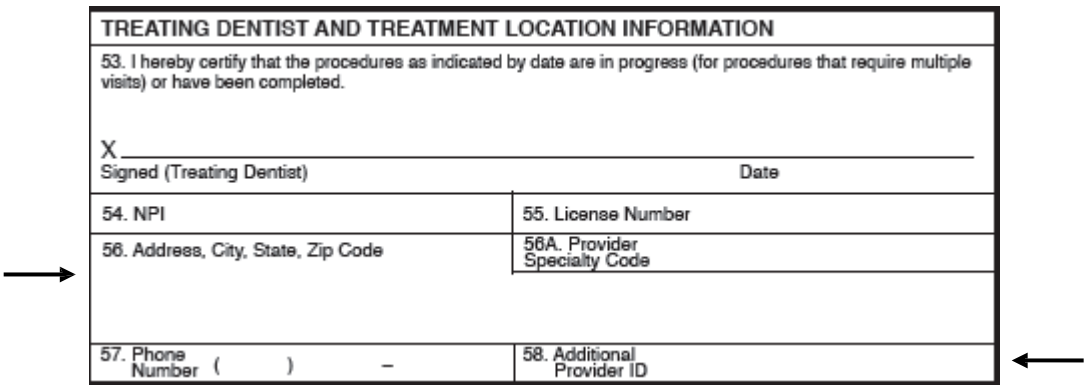
Field Number 51: SSN or TIN – Enter the 9 digit Tax ID #.



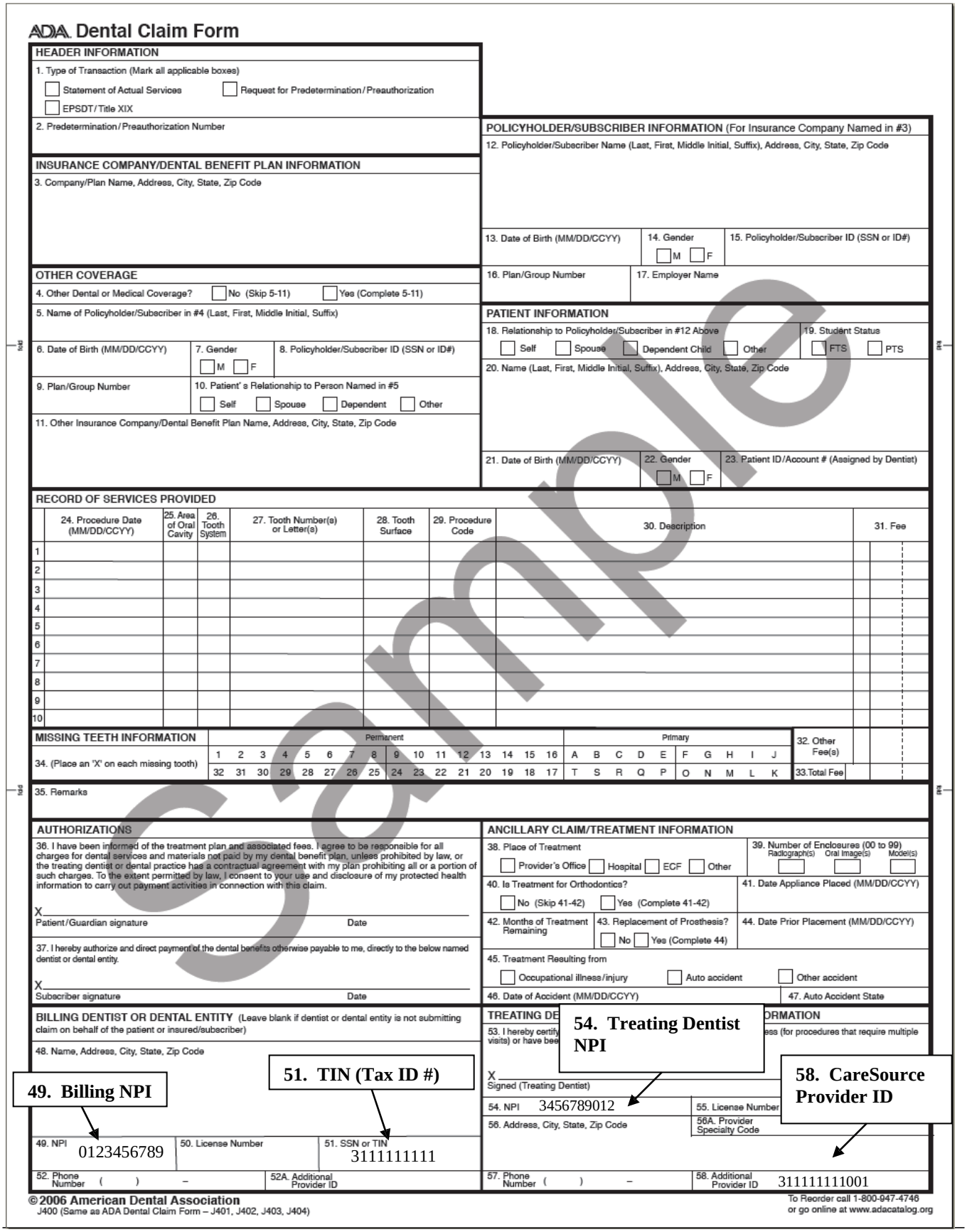
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)		
48. Name, Address, City, State, Zip Code		
49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) –	52A. Additional Provider ID	

Field Number 54: NPI number of the treating dentist performing or rendering the service.

Field Number 58: Additional Provider ID refers to the non-NPI number of the treating dentist. This is the CareSource 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



ADA Dental 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
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
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

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. Student Status ☐ FTS ☐ PTS
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)

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION
34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

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 ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
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 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

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 0123456789 | 50. License Number | 51. SSN or TIN 3111111111
52. Phone Number ( ) – | 52A. Additional Provider ID

TREATING DE…ORMATION
53. I hereby certify …ess (for procedures that require multiple visits) or have bee…
X _____ Signed (Treating Dentist)
54. NPI 3456789012 | 55. License Number
56. Address, City, State, Zip Code | 56A. Provider Specialty Code
57. Phone Number ( ) – | 58. Additional Provider ID 311111111001

49. Billing NPI
51. TIN (Tax ID #)
54. Treating Dentist NPI
58. CareSource Provider ID

Sample

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)
To Reorder call 1-800-947-4746 or go online at www.adacatalog.org