Completing a Paper ADA J400 Form

Information in this policy does not apply to members with the Choice or Choice Plus products offered through Passport Connect℠. For UnitedHealthcare's related policies/procedures, please go to *www.UnitedHealthcareOnline.com* or call 866-314-8166.

Overview

This supplement describes how to complete an ADA J400 claim form. The information outlines Harvard Pilgrim's standard policy for dental and oral surgery claim form submissions.

The "Type" column indicates whether a particular block is:
M = Mandatory **O** = Optional **N/A** = Not Applicable

Block Number	Name	Type	Instructions
1	Type of Transaction	M	Indicate whether the claim form is being used for pre-treatment approval or for actual services provided
2	Predetermination/Preauthorization Number	M	Enter predetermination/preauthorization number
3	Carrier name and address	M	The name and current address of the insurance carrier where the claim is being sent
4	Other Dental or Medical Insurance?	M	Check Yes or No to indicate whether patient is covered by another health or dental plan • Data in this field is used to determine if HPHC is the primary or secondary payer • If yes, complete 5–11 • If no, skip 5–11
5	Name of Policyholder/Subscriber	M	Enter the policyholder/subscriber's last name, first name and middle initial, if any, as shown on the policyholder/subscriber's HPHC ID card • Include any titles or both names, if hyphenated
6	Date of Birth	M	Enter the policyholder/subscriber's date of birth (MMDDCCYY) • Important for verification of eligibility
7	Gender	M	Check appropriate box to indicate patient's gender (M or F). Leave this field blank if unknown.
8	Policy/Subscriber ID	M	Enter the policyholder/subscriber's ID number from the other insurance carrier
9	Plan/Group Number	M	Enter the plan/group number of the policyholder/subscriber

Block Number	Name	Type	Instructions
10	Relationship to Policyholder/Subscriber	M	• Check the box for the relationship of patient to insured (self, spouse, child, etc.) • Policyholder/subscriber refers to insured person
11	Other Insurance Name and Address	M	The name and address of the other insurance
12	Policyholder/Subscriber's Name and Address	M	The policyholder or the subscriber • Used for identification purposes only (helpful if last names differ) • Enter the policyholder/subscriber's address and telephone number, except when the address is the same as the patient's; then enter the word "same"
13	Date of Birth	M	Enter the policyholder/subscriber's date of birth (MMDDCCYY) • Important for verification of eligibility
14	Gender	M	Check appropriate box to indicate policyholder/ subscriber's gender (M or F). Leave this field blank if unknown.
15	Policyholder/Subscriber ID	M	Enter the 11-character Harvard Pilgrim ID number, including the two-digit suffix (member Number), as shown on the policyholder/ subscriber's Harvard Pilgrim ID card
16	Plan/Group Number	M	Enter the plan/group number of the policyholder/subscriber
17	Employer Name	M	Enter the insured's employer name
18	Relationship to Policyholder/Subscriber	M	Enter relationship of patient to insured (self, spouse, child, etc.) • Policyholder/subscriber refers to insured person
19	Student Status	O	Check FTS (full time student) or PTS (part time student)
20	Patient's Name and Address	M	The patient's name and address • Used for identification purposes only (helpful if last names differ • Enter the patient's address and telephone number

Block Number	Name	Type	Instructions
21	Date of Birth	M	Enter the patient's date of birth (MMDDCCYY) • Important for verification of eligibility
22	Gender	M	Check appropriate box to indicate patient's gender (M, F, or U).
23	Patient ID/Account #	M	Enter the patient ID/account # assigned by dentist
24	Procedure Date	M	Enter the procedure date
25	Area of Oral Cavity	M	Enter the area of oral cavity
26	Tooth System	M	Enter the tooth system
27	Tooth Number(s) or Letter(s)	M	Enter the tooth number(s) or letter(s)
28	Tooth Surface	M	Enter the tooth surface
29	Procedure Code	M	Enter the appropriate ADA or CPT procedure code
30	Description	M	Enter the description for service rendered
31	Fee	M	Enter the service line charge for the service rendered
32	Other Fee(s)	M	Enter other fee(s) for the services rendered
33	Total Fee	M	Enter total charges for the services rendered
34	Missing Tooth	O	Mark missing teeth on diagram
35	Remarks	M	Indicate other information that may be helpful in determining benefits • HPHC requires a diagnosis code (including routine—Z0120) in order to process the claim; indicate diagnosis code here
36	Patient/Guardian Signature	M	Have the patient or authorized representative sign and date this block unless the signature is on file
37	Subscriber Signature	M	Have the subscriber sign and date this block unless the signature is on file

Block Number	Name	Type	Instructions
38	Place of Treatment	M	Enter place where treatment was rendered to patient
39	Number of Enclosures	M	Enter number of radiograph(s), oral images(s) or models(s)
40	Is Treatment for Orthodontics?	M	Check Yes or No • If yes, complete 41–-42 • If no, skip 41–42
41	Date Appliance Placed	M	Enter date appliance placed (MMDDCCYY)
42	Months of Treatment Remaining	M	Enter months of treatment remaining
43	Replacement of Prosthesis?	M	Check Yes or No • If yes, complete 44 • Data important to determine eligibility and liability • Most dental contracts have specific limitations on replacements
44	Date Prior Placement	M	Enter date of prior placement (MMDDCCYY)
45	Treatment Resulting From	M	Check off either occupational illness/injury, auto accident or other accident
46	Date of Accident	M	Enter date of accident (MMDDCCYY)
47	Auto Accident State	M	Enter auto accident state
48	Billing Dentist Name and Address	M	Enter the name and Harvard Pilgrim-assigned provider number of the individual dentist or the group practice responsible for billing • This is the name that should appear on any payments to the dental provider • This address is used by Harvard Pilgrim to return any rejected claims
49	NPI	M	Enter the dentist's National Provider Identifier (NPI number)
50	License Number	M	Enter the state license number of the dental provider
51	SSN or TIN	M	Enter dentist's federal tax ID (employer ID number) or Social Security number

Block Number	Name	Type	Instructions
52	Phone Number	M	Enter the phone number of the dental provider's billing phone number
52A	Additional Provider ID	O	
53	Treating Dentist Signature	M	Have the treating dentist sign and date this block
54	NPI	M	Enter the dentist's National Provider Identifier (NPI number) if different than box 49
55	License Number	M	Enter the state license number of the dental provider
56	Treating Dentist Address	M	Enter the address of the individual dentist or the group practice • This address is used by HPHC to return any rejected claims
56A	Provider Specialty Code	M	Enter the provider specialty code
57	Phone Number	M	Enter the phone number of the dental provider's treatment location
58	Additional Provider ID	O	

Claims Submission

Mail claims to:
Harvard Pilgrim Health Care
P. O. Box 699183
Quincy, MA 02269-9183

PUBLICATION HISTORY

01/01/12	removed First Seniority Freedom contact information
04/15/13	reviewed; removed outdated claim submission addresses
10/15/15	reviewed; ICD-10 coding update
12/01/21	annual review; administrative edits