Minnesota Standards for the Use of the ADA Dental Claim Form (2006)

February 28, 2007

As defined by the Commissioner of Health

ADA Dental Claim Form Manual

Third Edition

Administrative Uniformity Committee

MINNESOTA MDH DEPARTMENT OF HEALTH

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MINNESOTA MDH DEPARTMENT OF HEALTH

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Protecting, maintaining and improving the health of all Minnesotans

Minnesota Department of Health
Division of Health Policy

Notice of Adoption of the "Minnesota Standards for the Use of the ADA Dental Claim Form (2006) as Defined by the Commissioner of Health"; Per *Minnesota Statutes*, section 62J.52, Subdivision 3.

Adoption: Notice is hereby given that the "Minnesota Standards for the Use of the ADA Dental Claim Form (2006)" as proposed at State Register, Volume 31, Number 24, page 752, December 11, 2006, is adopted without any changes.

Manual Available: The "Minnesota Standards for the Use of the ADA Dental Claim Form (2006), as defined by the Commissioner of Health", is available for use for paper claims submitted on the ADA Dental Claim Form (2006). The manual is available on the internet at www.mmaonline.net/auc and in Minnesota's Bookstore at (651) 297-3000 or (800) 657-3757.

Description and Statutory Reference: The manual is a description of the conventions of use for the ADA Dental Claim Form (2006) paper claim form published by the American Dental Association (ADA). The manual has been developed per *Minnesota Statutes*, section 62J.52, subdivision 3. The statute reads in relevant part: "(a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American Dental Association uniform dental billing form. (b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the Administrative Uniformity Committee dated February 1994, and as amended or further defined by the commissioner." The updated edition of this manual, in this announcement, is the further definition mentioned.

Development: The Administrative Uniformity Committee (AUC) and the Dental Claim Form subcommittee developed and revised the manual. This manual has been submitted for public comment; the most recent (third) edition was announced in the *State Register* on December 11, 2006. The public comment period for the second edition was from December 11, 2006 to January 10, 2007. The Minnesota Department of Health at (651) 201-3573 collected the public comments. Only one comment in support of the manual was received.

Date of Implementation: The Manual "Minnesota Standards for the Use of the ADA Dental Claim Form (2006) is to be used by providers and non-government payers in Minnesota as of February 28, 2007.

Dianne M. Mandernach, Commissioner
Dated: January 29, 2007

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Administrative
Uniformity
Committee

February 28, 2007

Effective January 1, 1996, Minnesota providers are required to use uniform billing formats for medical, allied health, hospital and dental bills. Payers are required to accept these forms for claim payment purposes.

Minnesota Statutes section 62J.52, part of the Health Care Administrative Uniformity Act of MinnesotaCare legislation, requires providers to use the American Dental Association (ADA) Dental Claim Form to submit their bills to payers. *Minnesota Statutes* section 62J.535 requires payers to accept these forms for billing.

To help providers and payers complete the ADA Dental Claim Form (2006), the Administrative Uniformity Committee (AUC), a committee consisting of public and private payers and providers, has developed a user manual. Using the criteria outlined in the manual will improve consistency in data and will help reduce health care costs.

The Standards for the Use of the ADA Dental Claim Form (2006) Manual is available from Minnesota's Bookstore at (651) 297-3000 or 1-800-657-3757 or it may be downloaded from the AUC Web site www.mmaonline.net/auc/. Updates will be available as often as required by changes in the claim form or billing practices and will seek to reduce variation in billing practices over time. The AUC will continue to work to improve the clarity and usefulness of the manual.

Questions?

- Questions about specific patients and their insurance claims should be directed to the payer of the claim.
- Questions, comments and recommendations for clarification or updates to the manual may be directed in writing to:

Administrative Uniformity Committee
c/o Minnesota Department of Health
Division of Health Policy
P.O. Box 64882, St. Paul, MN 55164-0882

Allina Hospitals and Clinics ◊ American Association of Healthcare Administrative Management ◊ Blue Cross Blue Shield of MN ◊ CentraCare Health System ◊ Children's Hospitals and Clinics ◊ Delta Dental Plan of MN ◊ Fairview Hospital and Health Care Services ◊ HCPCS Committee ◊ Health Care Payer and Provider Advisory Council ◊ HealthEast ◊ HealthPartners ◊ Hennepin County Medical Center ◊ Hennepin Faculty Associates ◊ Mayo Clinic ◊ Medica Health Plan ◊ Metropolitan Health Plan ◊ MN Dental Association ◊ MN Department of Health ◊ MN Department of Human Services ◊ MN Department of Labor and Industry ◊ MN Hospital Association ◊ MN Medical Association ◊ MN Medical Group Management Association ◊ MN Pharmacists Association ◊ MN Uniform Billing Committee ◊ Noridian Administrative Services, L.L.C. - Medicare Part A ◊ Park Nicollet Health Services ◊ PreferredOne ◊ St. Mary's/Duluth Clinic Health System ◊ UCare MN ◊ University of Minnesota Physicians ◊ Wisconsin Physician Services – Medicare Part B

Visit our Web site at: www.mmaonline.net/auc/

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Foreword

February 2007

History:

This manual for completing the ADA Dental Claim Form (2006) is the third edition. The manual is part of the Administrative Simplification Act (ASA) of 1994, *Minnesota Statutes* 62J.52, Subdivision 3, which requires:

"(a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American Dental Association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the administrative uniformity committee dated February 1994, and as amended or further defined by the commissioner. "

The updated editions of this manual are the further definition mentioned.

The Administrative Uniformity Committee (AUC) and the Dental Claim Technical Advisory Group revised this manual. This manual has been developed by the AUC to help reduce administrative burden on providers and payers, associated with varied billing practices. The AUC also seeks to improve the consistency of claims data. The AUC and the Dental Claim TAG consist of providers, payers, professional associations and government agencies. Public comment from any interested parties was solicited during the development and before publication of this manual.

Intent:

The intent of this manual, and indeed the entire ASA, is to promote uniformity among payers and providers in completing billing formats. One payer must not require a field to be completed while another payer refuses to accept claims in which that field has been completed. This manual provides Minnesota norms. The AUC anticipates that Minnesota payers will standardize themselves to these norms, and promote this uniformity to the extent possible.

Note: Submissions for government programs, such as Medicare and Medicaid (Medical Assistance) must conform to federal and state regulations that sometimes require variations from usual practice. See Appendix 3 for resource information.

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Electronic Concordance

The concordance with electronic claims has been included in this edition of the ADA Dental Claim Form (2006) Manual. We offer the electronic concordance for ANSI ASC X12-837D version 004050X0142 (HIPAA compliant). The reference to the NSF format has been removed from this manual.

The AUC believes that electronic submission of claims is more cost and time effective; and expects most providers will move to electronic claims. The electronic concordance in this manual is informational, and intended to help providers become accustomed to the interaction between the paper and electronic formats. They are not intended for implementation of electronic claims.

Further information on HIPAA and Electronic Data Interchange (EDI) in dentistry is available from the American Dental Association at 1-800-947-4746 or go online at www.ada.org.

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Administrative
Uniformity
Committee

How to Use this Manual

To remain in compliance with Minnesota State Law, payers and providers are required to adopt all conventions in this manual. Each page of the manual refers to a specific item or "box" on the ADA Dental Claim Form (2006). The title of each box is listed on the claim form followed by the requirements for the data. The electronic concordance for ANSI is also listed for each box for reference.

Instructions: How to complete the box for commercial payers. When billing directly to government programs such as Medicare or Medicaid (Medical Assistance) information must conform to state and federal regulations, which sometimes require variations from usual practice. Please see Appendix 3 for resource information.

Example: A simple example of the data to be entered. Examples given are for illustrative purposes, and may not describe every claim situation. Some boxes may have multiple examples.

Definitions: Explanations of the words used in the titles or instructions. Definitions given are for illustrative purposes, and may not describe every claim situation.

Format: Describes whether the data is alpha, alphanumeric, numeric or other conventions, as needed.

Used for: Describes how the data element is used.

Required: Describes the level of need for the data element. See Designation of Data Elements page for definition.

Electronic concordance: Describes how the data element fits into two common electronic formats. Electronic commerce is preferred by many payers and has financial and time advantages for payers and providers. This information is provided for informational purposes.

Designation of Data Elements

Each data element on the ADA Dental Claim Form (2006) is designated as: required, may be required by contract, recommended, or not required.

Required:	Required means that the data element is needed and used by the payer to process and/or adjudicate the claim. Claims sent to the payer without a required data element may be pended for further information, denied and/or returned to the provider.
May be required by contract:	May be required by contract means that some payers need the data element to process and/or adjudicate the claim. When a contractual agreement or requirement in a published manual exists that requires such a data element, the payer may pend or deny claims sent without it. A mission of the AUC is to minimize the number of data elements which have this designation, however, it is recognized that some payers do not currently have the information systems to process claims without these elements.
Recommended:	Recommended means that the data element may assist the payer but is not required to process and/or adjudicate the claim. Recommended data elements: • expand on the required data identifying the patient, insured, or insurance program • allow more efficient coordination of benefits • allow payers to be aware that another insurance exists
Not required:	Not required means that the data element is not used by payers to process and/or adjudicate the claim.

This manual does not attempt to include information on government programs such as Medicare or Medicaid (Medical Assistance) claims. Please refer to the manuals for these programs when needed. See Appendix 3 for resource information.

Acronyms

ADA	American Dental Association
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI ASC Committee	American National Standards Institute Administrative Simplification
ASA	American Society of Anesthesiologists
ASC	Ambulatory Surgical Center
AUC	Administrative Uniformity Committee
CHAMPUS	Civilian Health & Medical Program of Uniformed Service. CHAMPUS is also known as TRICARE
CHAMPVA	The Department of Veteran's Affairs Civilian Health & Medical Program
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CPT	Common Procedural Terminology
C&TC	Child and Teen Checkup
DHS	Department of Human Services
DLI	Department of Labor and Industry
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EPSDT	Early Periodic Screening Development Tool
FECA	Federal Employees' Compensation Act, 5 USC 8101 et seq.
HCFA	Health Care Financing Administration (see CMS)
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
ICD-9-CM	International Classification of Disease, 9th Revision, Clinical Modification
MDH	Minnesota Department of Health
MHCP	Minnesota Health Care Programs (also referred to as DHS)
NPI	National Provider Identification
NSF	National Standard Format
PGAMC	Prepaid General Assistance Medical Care
PIN	Personal Identification Number
PMAP	Prepaid Medical Assistance Program
POS	Place of Service
TPA	Third Party Administrator
UPIN	Unique Personal Identification Number
WC	Workers' Compensation

Errors and Comments

The Minnesota AUC and the Dental Claim Technical Advisory Group developed this guide.

However, you may find errors, or business needs that the guide does not address. We encourage you to report these issues to the AUC using the format below. When possible, members of the AUC will take substantive issues forward to the appropriate state or national claims-related committee.

Date of manual: _____

Page number (in manual): _____

Box Number: _____

Narrative description of error or comment:

Report errors to:

Administrative Uniformity Committee
c/o Minnesota Department of Health
Division of Health Policy
Center for Data Initiatives
P.O. Box 64882
St. Paul, MN 55164-0882
www.mmaonline.net/auc/

Thank you for bringing these issues to our attention.

Minnesota Standards for the Use of the ADA Dental Claim Form (2006)

February 28, 2007

Third Edition

Administrative Uniformity Committee

MINNESOTA MDH DEPARTMENT OF HEALTH

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HEADER INFORMATION

Box Number 1

Title: TYPE OF TRANSACTION (Mark all applicable boxes)

Instructions: Enter an X in the correct box. Check either Statement of Actual Services OR Request for Predetermination/Preauthorization. In addition, check EPSDT/Title XIX if applicable.

Example: X

Definitions: Statement of Actual Services means that the procedures indicated have been completed and payment is being requested.

Request for Predetermination /Preauthorization means that the procedures indicated are in progress and payment is not being requested.

EPSDT/Title XIX means patient is covered by state Medicaid's **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment program for persons under age 21.

Format: Alpha. Use one capital X.

Used for: Identification of transaction type for payer.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 1** **Request for Predetermination/ Preauthorization** 2300 | CLM19 | 1383 / PB **ADA Form Locator 1** **Statement of actual services** 2300 | CLM19 | 1383 / (empty) **ADA Form Locator 1** **EPSDT / Title XIX** 2300| CLM12

HEADER INFORMATION

Box Number 2

Title: PREDETERMINATION/PREAUTHORIZATION NUMBER

Instructions: Enter the predetermination or preauthorization number as assigned by the payer when submitting a claim for services that have been predetermined or preauthorized.

Example: 468001234

Definitions: The number issued by a payer when a predetermination or preauthorization of services has been requested.

Format: Alphanumeric.

Used for: Determine eligibility of predetermined or preauthorized services.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 2 Predetermination/Preauthorization Number** 2300 | REF02 | 127 (REF01 = 'G1')

PRIMARY PAYER INFORMATION

Box Number 3

Title: COMPANY/PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE

Instructions: Enter the Primary Payer name, address, city, state and zip code. Do not use punctuation except ”#” and “-“.

Example: MAJOR DENTAL PLAN
ATTN GEORGE JETSON - CLAIMS
56789 ALTA VISTA DRIVE #100
ANYWHERE MN 55440-1234

Definitions: Primary Payer is the insurance plan, Third Party Administrator or other payer who will handle the claim.

Format: Use two-digit state code and, if available, nine-digit zip code. Avoid punctuation except “#” and “-”. Scanning technology may read punctuation as delimiters and therefore process the information incorrectly.

Used for: Direct the claim to the carrier.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 3** **Primary Payer Information** **Name, Address, City, State, Zip Code** 2010BB | NM103 | 1035 2010BB | N301 | 166 2010BB | N401 | 19 2010BB | N402 | 156 2010BB | N403 | 116

OTHER COVERAGE

Box Number 4

Title: OTHER DENTAL OR MEDICAL COVERAGE?

Instructions: Enter an X in the correct box. When no, skip boxes 5 - 11. When yes, complete boxes 5 - 11.

Example: X

Definitions: Is there other dental or medical coverage means the patient has insurance coverage other than the plan indicated in box 3.

Format: Alpha. Use one capital X.

Used for: Identification of additional insurance source.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 4** **Other Coverage** **Other Dental or Medial Coverage (Yes)** 2320 | SBR (is present) **ADA Form Locator 4** **Other Coverage** **Other Dental or Medial Coverage (No)** 2320 | SBR (is absent)

OTHER COVERAGE

Box Number 5

Title: NAME OF POLICY/HOLDER/SUBSCRIBER IN #4 (Last, First, Middle Initial, Suffix)

Instructions: Enter the subscriber's last name, first name and middle initial. If the subscriber uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Do not use punctuation, except "-"which may be used in hyphenated names.

Example: Anderson Edwin D
Davis Sr John S

Definitions: Subscriber's name means the holder of another policy that may cover the patient.

Format: Alphanumeric. Use spaces to separate characters.

Used for: Identify additional source of insurance.

Required: Recommended if other insurance exists.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 5** **Other Coverage** **Subscriber Name (Last, First, Middle Initial, Suffix)** 2330A | NM103 | 1035 2330A | NM104 | 1036 2330A | NM105 | 1037 2330A | NM107 | 1039

OTHER COVERAGE

Box Number 6

Title: DATE OF BIRTH (MM/DD/CCYY)

Instructions: Enter the subscriber date of birth.

Example: 05/15/1978

Definitions: Subscribers birth date.

Format: Use eight-digit numeric date: MM/DD/CCYY. Use slashes to separate parts of field.

Used for: Identify additional insurance source. Used to determine primary source of insurance.

Required: Recommended if other insurance exists.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 6** **Other Coverage** **Date of Birth** 2320 | DMG02 | 1254

OTHER COVERAGE

Box Number 7

Title: GENDER

Instructions: Enter an X in the correct box to indicate the sex of the subscriber.

Example: X

Definitions: Gender means the sex of the subscriber (male or female).

Format: Alpha. Use one capital X.

Used for: Identify additional insurance source. Used to determine primary source of insurance.

Required: Recommended if other insurance exists.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 7** **Other Coverage** **Gender** 2320 | DMG03 | 1068

OTHER COVERAGE

Box Number 8

Title: POLICYHOLDER/SUBSCRIBER ID (SSN OR ID#)

Instructions: Enter the subscriber 9-digit Social Security Number (SSN) or other identifier (ID#) assigned by the payer. Payer identifiers may vary in length.

Example: 123456789

Definitions: Subscriber Social Security Number or ID# means the identification number of the person who holds another policy that may cover the patient.

Format: Numeric.

Used for: Identify additional insurance source. Used to determine primary source of insurance.

Required: Recommended if other insurance exists.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 8** **Other Coverage** **Subscriber Identifier (SSN or ID#)** 2330A | NM109 | 67

OTHER COVERAGE

Box Number 9

Title: PLAN/GROUP NUMBER

Instructions: Enter the plan or group number of the subscriber with other coverage.

Example: ABC9876543

Definitions: Plan or group number means the plan or group number for coverage of insured as indicated in Box 5.

Format: Alpha and/or numeric. Copy the number from the health care identification card.

Used for: Identify additional insurance source.

Required: Recommended if other insurance exists.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 9** **Other Coverage** **Plan / Group Number** 2320 | SBR03 | 127

OTHER COVERAGE

Box Number 10

Title: PATIENT'S RELATIONSHIP TO PERSON NAMED IN #5

Instructions: Enter an X in the correct box to indicate the relationship to the Primary Subscriber.

Example: X

Definitions: Relationship to primary subscriber means how the subscriber with other coverage is related to the primary subscriber. Self means the insured is the also the primary subscriber. Spouse means the insured is the husband or wife or qualified partner as defined by the insured's plan. Dependent means the patient is the dependent as defined by the insured's plan. Other means the insured is other than the self, spouse or dependent.

Format: Alpha. Use one capital X.

Used for: Identify additional insurance source and to distinguish patient from the insured.

Required: Recommended if other insurance exists.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 10** **Other Coverage** **Relationship to Primary Subscriber** 2320 | SBR02 | 1069

OTHER COVERAGE

Box Number 11

Title: OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE

Instructions: Enter the Other Carrier name, address, city, state and zip code. Do not use punctuation except "#" and "-".

Example: SECOND DENTAL PLAN
ATTN JANE JETSON - CLAIMS
56789 ALTA VISTA DRIVE #100
ANYWHERE MN 55440-1234

Definitions: Other Carrier is the insurance plan, Third Party Administrator or other payer with whom coordination of benefits may occur.

Format: Use two-digit state code and, if available, nine-digit zip code. Avoid punctuation except "#" and "-". Scanning technology may read punctuation as delimiters and therefore process the information incorrectly.

Used for: Identify additional insurance source.

Required: Recommended if other insurance exists.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 11** **Other Coverage** **Other Carrier Name, Address, City, State, Zip Code** 2330B | NM103 | 1035 2330B | N301 | 166 2330B | N401 | 19 2330B | N402 | 156 2330B | N403 | 116

PRIMARY SUBSCRIBER INFORMATION
Box Number 12

Title: POLICYHOLDER/SUBSCRIBER NAME (Last, First, Middle Initial, Suffix)
ADDRESS, CITY, STATE, ZIP CODE

Instructions: Enter the primary subscriber's last name, first name and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Do not use punctuation except "-", which may be used for hyphenated names.

Enter the primary subscriber's street, city, state and zip code. If an Attention line is needed, add to first line of address (e.g., Guardian or Legal Representative). Do not use punctuation except "#" and "-". If patient's address is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code. For foreign addresses, use abbreviations stated in Appendix 1.

Example: Anderson Jr Edwin J
1234 Main St
Any town, MN 55440-1234

Definitions: Primary subscriber's name means the name of the person who holds the policy; usually the employee, for employer-provided group insurance.

Format: Use two-digit state code and, if available, nine-digit zip code. Avoid punctuation except "#" and "-". Scanning technology may read punctuation as delimiters and therefore process the information incorrectly.

Used for: Identify the primary subscriber.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 12** **Primary Subscriber Information** **Name (Last, First, Middle Initial, Suffix, Address, City, State, Zip Code)** 2010BA | NM103 | 1035 2010BA | NM104 | 1036 2010BA | NM105 | 1037 2010BA | NM107 | 1039 2010BA | N301 | 166 2010BA | N401 | 19 2010BA | N402 | 156 2010BA | N403 | 116

PRIMARY SUBSCRIBER INFORMATION

Box Number 13

Title: DATE OF BIRTH (MM/DD/CCYY)

Instructions: Enter the primary subscriber's date of birth.

Example: 05/15/1978

Definitions: Primary subscriber's birth date.

Format: Use eight-digit numeric date: MM/DD/CCYY. Use slashes to separate parts of field.

Used for: Identifies primary subscriber.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 13** **Primary Subscriber Information** **Date of Birth** 2010BA | DMG02 | 1254

PRIMARY SUBSCRIBER INFORMATION

Box Number 14

Title: GENDER

Instructions: Enter an X in the correct box to indicate the sex of the primary subscriber.

Example: X

Definitions: Gender means the sex of the primary subscriber (male or female).

Format: Alpha. Use one capital X.

Used for: Further identifies the primary subscriber.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 14** **Primary Subscriber Information** **Gender** 2010BA | DMG03 | 1068

PRIMARY SUBSCRIBER INFORMATION

Box Number 15

Title: POLICYHOLDER/SUBSCRIBER ID (SSN or ID#)

Instructions: Enter the primary subscriber 9-digit Social Security Number (SSN) or other identifier (ID#) assigned by the payer. Payer identifiers may vary in length.

Example: 123456789

Definitions: Primary subscriber Social Security Number or ID# means the identification number of the person who holds the policy.

Format: Alphanumeric.

Used for: Further identifies primary subscriber.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 15** **Primary Subscriber Information** **Subscriber Identifier** 2010BA | NM109

PRIMARY SUBSCRIBER INFORMATION

Box Number 16

Title: PLAN/GROUP NUMBER

Instructions: Enter the plan or group number of the primary subscriber.

Example: ABC9876543

Definitions: Plan or group number means the plan or group number for coverage of primary subscriber as indicated in Box 12.

Format: Alpha and/or numeric. Copy the number from the health care identification card.

Used for: Identify primary subscriber plan or group number.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 16** **Primary Subscriber Information** **Plan / Group Number** 2010BA | SBR03 | 127

PRIMARY SUBSCRIBER INFORMATION

Box Number 17

Title: EMPLOYER NAME

Instructions: Enter the name of the primary subscriber's employer.

Example: Acme Engineering

Definitions: Primary subscriber's employer name means the name of the employer of the insured as indicated in Box 12.

Format: Alphanumeric.

Used for: Identify primary subscriber's plan or employer group.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 17** **Primary Subscriber Information** **Employer Name** N/A

PATIENT INFORMATION

Box Number 18

Title: RELATIONSHIP TO POLICYHOLDER/SUBSCIRBER IN #12 ABOVE

Instructions: Enter an X in the correct box to indicate patient's relationship to primary subscriber.

Example: X

Definitions: Patient relationship to primary subscriber means how the patient is related to the insured. Self means the insured is the patient. Spouse means the patient is the husband or wife or qualified partner as defined by the insured's plan. Dependent Child means the patient is the minor dependent as defined by the insured's plan. Other means the patient is other than the self, spouse or dependent child. Other may include employee, ward, or dependent as defined by the insured's plan.

Format: Alpha. Use one capital X.

Used for: Identify patient's source of insurance and to distinguish patient from the insured.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 18** **Patient Information** **Relationship to Primary Subscriber** 2010CA | PAT01 | 1069 2010BA | SBR02 | 1069

PATIENT INFORMATION

Box Number 19

Title: STUDENT STATUS

Instructions: Enter an X in the correct box to indicate patient student status.

Example: X

Definitions: Full-time student (FTS) means the patient is registered for a full course load as defined by the post-secondary school or university. Part-time student (PTS) means the patient is registered for less than a full course load as defined by the post-secondary school or university.

Format: Alpha. Use one capital X.

Used for: Allows determination of liability and COB. Persons who have Medicare and also work may have primary insurance before Medicare. COB may apply if married. Parents may have primary or secondary insurance if patient is a student.

Required: Recommended.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 19** **Patient Information** **Student Status** 2010CA | PAT04 | 1220

PATIENT INFORMATION

Box Number 20

Title: NAME (Last, First, Middle Initial, Suffix), ADDRESS, CITY, STATE, ZIP CODE

Instructions: Enter the patient's last name, first name and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Do not use punctuation except "-", which may be used for hyphenated names.

Enter the patient's address, city, state and zip code. If an Attention line is needed, add to first line of address (e.g., Guardian or Legal Representative). Do not use punctuation except "#" and "-". If patient's address is unknown, leave blank. Use two-digit state code and, if available, nine-digit zip code. For foreign addresses, use abbreviations stated in Appendix 1.

Example: Anderson Jr Edwin J
1234 Main St
Any town, MN 55440-1234

Definitions: Patient's name means the name of the person who received the treatment or supplies. Patient's address means the patient's permanent residence. Do not enter a temporary or school address.

Format: Alphanumeric. Use spaces to separate parts of field.

Used for: Identifies the patient. Allows contact for questions.

Required: Required for all programs.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 20** **Patient Information** **Name (Last, First, Middle Initial, Suffix),** **Address, City, State, Zip Code** 2010CA | NM103 | 1035 2010CA | NM104 | 1036 2010CA | NM105 | 1037 2010CA | NM107 | 1039 2010CA | N301 | 166 2010CA | N401 | 19 2010CA | N402 | 156 2010CA | N403 | 116

PATIENT INFORMATION

Box Number 21

Title: DATE OF BIRTH (MM/DD/CCYY)

Instructions: Enter the patient's date of birth.

Example: 03/10/1989

Definitions: Patient's birth date.

Format: Use eight-digit numeric date: MM/DD/CCYY. Use slashes to separate parts of field.

Used for: Identifies the patient. May distinguish persons with similar names.

Required: Required for all programs.

Electronic concordance:

ANSI ASC X12-837 **Version 004050X0142**	**ADA Form Locator 21** **Patient Information** **Date of Birth** 2010CA | DMG02 | 1254

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PATIENT INFORMATION

Box Number 22

Title: GENDER

Instructions: Enter an X in the correct box to indicate sex of the patient.

Example: X

Definitions: Gender means the sex of the patient.

Format: Alpha. Use one capital X.

Used for: Further identifies the patient.

Required: Required for all programs.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 22** **Patient Information** **Gender** 2010CA | DMG03 | 1068

PATIENT INFORMATION

Box Number 23

Title: PATIENT ID/ACCOUNT # (Assigned by Dentist)

Instructions: Enter the patient's ID/account number assigned by the billing provider.

Example: 72321456

Definitions: Patient's ID/account number means the identifier assigned by the billing provider.

Format: Alphanumeric.

Used for: Apply benefits to the patient's account.

Required: Required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 23** **Patient Information** **Patient ID/Account # (Assigned by Dentist)** 2010CA | NM109 | 67 2010CA | REF02 | 127

RECORD OF SERVICES PROVIDED

Box Number 24

Title: PROCEDURE DATE (MM/DD/CCYY)

Instructions: Enter the date the service was provided.

Example: 07/04/2003

Definitions: Procedure date means the actual month, day and year the service was provided.

Format: Use eight-digit numeric date: MM/DD/CCYY. Use slashes to separate parts of field.

Used for: Inform payers of the date of the current service.

Required: Required for all payers. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 3 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 24** **Record of Services Provided** **Procedure Date** 2300 | DTP03 | 1251 (DTP01 = 472) 2400 | DTP03 | 1251 (DTP01 = 472)

RECORD OF SERVICES PROVIDED

Box Number 25

Title: AREA OF ORAL CAVITY

Instructions: Use area of the oral cavity code set from ANSI/ADA/ISO Specification No. 3950 'Designation System for Teeth and Areas of the Oral Cavity'.

Example: 01

Definitions: The areas of the oral cavity are designated by a two-digit code.

Format: Use two-digit numeric code.

Used for: To identify areas of the oral cavity.

Required: Required, if applicable.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 25** **Record of Services Provided** **Area of Oral Cavity** 2400 | SV304-1 | 1361

RECORD OF SERVICES PROVIDED

Box Number 26

Title: TOOTH SYSTEM

Instructions: Enter applicable ANSI ASC X12 code list qualifier.

Example: JP

Definitions: A tooth system designed to uniquely identify permanent and primary dentition.

Format: Use two-digit alpha code.

Used for: Inform payer as to tooth numbering system used in Box 27.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 26** **Record of Services Provided** **Tooth System** 2400 | TOO01 | 1270

RECORD OF SERVICES PROVIDED

Box Number 27

Title: TOOTH NUMBER(S) OR LETTER(S)

Instructions: Enter the tooth number or letter when procedure code reported directly involves a tooth.

Example: 18 or A

Definitions: A number or letter that identifies each tooth in the oral cavity.

Format: Alphanumeric. If a range of teeth is being reported use a hyphen ('-') to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.

Used for: Identify the tooth.

Required: Required, if applicable.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 27** **Record of Services Provided** **Tooth Number(s) or Letter(s)** 2400 | TOO02 | 1271

RECORD OF SERVICES PROVIDED

Box Number 28

Title: TOOTH SURFACE

Instructions: Enter the tooth surface when the procedure code reported directly involves one or more tooth surfaces.

Example: B

Definitions: A letter that identifies each tooth surface.

Format: Alpha.

Used for: Inform the payer as to which tooth surface(s) were directly involved in the procedure.

Required: Required, if applicable.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 28** **Record of Services Provided** **Tooth Surface** 2400 | TOO03-1 | 1369 2400 | TOO03-2 | 1369 2400 | TOO03-3 | 1369 2400 | TOO03-4 | 1369 2400 | TOO03-5 | 1369

RECORD OF SERVICES PROVIDED

Box Number 29

Title: PROCEDURE CODE

Instructions: Enter the appropriate dental procedure code from current version of *Code on Dental Procedures and Nomenclature*.

Example: D1110

Definitions: A listing of identifying codes for reporting services and procedures.

Format: Alphanumeric.

Used for: Inform payer what services were performed.

Required: Required for all payers. Narrative descriptions may be required by contract.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 29** **Record of Services Provided** **Procedure Code** 2400 | SV301-2 | 234

RECORD OF SERVICES PROVIDED

Box Number 30

Title: DESCRIPTION

Instructions: Enter information as directed by payer.

Example: Prophylaxis - adult

Definitions: Free form field used to provide additional information as required by payer.

Format: Alphanumeric.

Used for: Provide additional information.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 30** **Record of Services Provided** **Description** N/A

RECORD OF SERVICES PROVIDED

Box Number 31

Title: FEE

Instructions: Enter the dollar amount for each service.

Example: 100.00

Definitions: Fee means the total billed amount for each service line.

Format: Numeric.

Used for: Inform the payer of the total amount charged for each service line.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 31** **Record of Services Provided** **Fee** 2400 | SV302 | 782

RECORD OF SERVICES PROVIDED

Box Number 32

Title: OTHER FEE(S)

Instructions: Enter other fees applicable to dental services provided.

Example: 1.23

Definitions: Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.

Format: Numeric. Do not use dollar signs. Do not use commas as thousands marker.

Used for: Inform the payer of total amount of other fees applicable to the claim.

Required: Not required. Special contract requirements may apply.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 32** **Record of Services Provided** **Other Fees** 2400 | AMT02 | 782 (AMT01 = T)

RECORD OF SERVICES PROVIDED

Box Number 33

Title: TOTAL FEE

Instructions: Enter the sum of the charges of Box 31 and Box 32.

Example: 101.23

Definitions: Total charge means the total billed amount for all services reported.

Format: Numeric. Do not use dollar signs. Do not use commas as thousands marker.

Used for: Inform the payer of the total amount charged for the billed services.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 33** **Record of Services Provided** **Total Fee** 2300 | CLM02 | 782

MISSING TEETH INFORMATION

Box Number 34

Title: (PLACE AN "X" ON EACH MISSING TOOTH)

Instructions: Place an X through each tooth number and/or letter to identify missing teeth.

Example: X

Definitions: Report missing teeth on each claim submission.

Format: Alpha. Use one capital X.

Used for: To report missing teeth.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 34** **Missing Teeth Information** 2300 | DN201 | 127 (DN202 = M)

RECORD OF SERVICES PROVIDED

Box Number 35

Title: REMARKS

Instructions: Enter additional information as directed by payer.

Example: D9999 – translator services required for informed consent compliance.

Definitions: Free form field used to provide additional information as required by payer.

Format: Alphanumeric.

Used for: Provide additional information.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 35 Remarks** 2300 | NTE02 | 352

AUTHORIZATIONS

Box Number 36

Title: PATIENT/GUARDIAN SIGNATURE DATE

Instructions: Enter "Signature on File", "SOF" or legal signature. When legal signature, enter date signed.

Example: Signature on File

Definitions: Patient's or authorized person's signature means there is an authorization on file for the release of any health or other information necessary to process and/or adjudicate the claim.

Format: Alphanumeric.

Used for: Release of information.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 36 Authorizations - Release of Information Signature** 2300 | CLM09 | 1363	**ADA Form Locator 36 Authorizations - Release of Information Date** N/A

AUTHORIZATIONS

Box Number 37

Title: SUBSCRIBER SIGNATURE DATE

Instructions: Enter "Signature on File", "SOF" or legal signature. When legal signature, enter date signed.

Example: Signature on File

Definitions: Insured's or authorized person's signature means there is a signature on file authorizing payment of benefits.

Format: Alpha.

Used for: Authorize payment of benefits to provider listed in Box 48.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 37 Authorizations - Assignment of Benefits Signature** 2300 | CLM08 | 1073	**ADA Form Locator 37 Authorizations - Assignment of Benefits Date** N/A

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 38

Title: PLACE OF TREATMENT

Instructions: Enter an X in the correct box to indicate place of treatment.

Example: X

Definitions: Place of treatment means the location where the service was rendered. Provider's office, hospital, ECF or other.

Format: Alpha. Use one capital X.

Used for: Inform the payer where the service was rendered.

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 38** **Ancillary Claim/Treatment Information** **Place of Treatment** 2300 | CLM05-1 | 1331

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 39

Title: NUMBER OF ENCLOSURES (00 to 99)

Instructions: Enter a number in the correct box to identify the number of enclosures included with the claim.

Example: 1

Definitions: Enclosures are radiographs, oral images and/or models provided to support the claim.

Format: Numeric.

Used for: Inform payer of additional information related to the claim.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 39 Ancillary Claim/Treatment Information Number of Enclosures (Radiographs)** N/A	**ADA Form Locator 39 Ancillary Claim/Treatment Information Number of Enclosures (Oral Images)** N/A	**ADA Form Locator 39 Ancillary Claim/Treatment Information Number of Enclosures (Model(s))** N/A

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 40

Title: IS TREATMENT FOR ORTHODONTICS?

Instructions: Enter an X in the correct box. When no, skip Boxes 41-42. When yes, complete Boxes 41-42.

Example: X

Definitions: Identifies if treatment is for orthodontics.

Format: Alpha. Use one capital X.

Used for: Inform the payer if treatment is for orthodontics.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 40** **Ancillary Claim/Treatment Information** **Is Treatment for Orthodontics? (No)** 2300 | DN1 (is absent)	**ADA Form Locator 40** **Ancillary Claim/Treatment Information** **Is Treatment for Orthodontics? (Yes)** 2300 | DN1 (is present)

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 41

Title: DATE APPLIANCE PLACED (MM/DD/CCYY)

Instructions: Enter the date the orthodontic appliances were placed.

Example: 07/04/2003

Definitions: Date orthodontic appliances are placed.

Format: Use eight-digit numeric date: MM/DD/CCYY. Use slashes to separate parts of field.

Used for: Inform payer of the date orthodontic appliances were placed.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 41** **Ancillary Claim/Treatment Information** **Date Appliance Placed** 2300 | DTP03 | 1251 (DTP01 = 452)

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 42

Title: MONTHS OF TREATMENT REMAINING

Instructions: Enter the number of months of orthodontic treatment remaining once appliances have been placed.

Example: 24

Definitions: Number of months of orthodontic treatment remaining.

Format: Numeric.

Used for: To provide information to payer for benefit calculation.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 42** **Ancillary Claim/Treatment Information** **Months of Treatment Remaining** 2300 | DN102 | 380

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 43

Title: REPLACEMENT OF PROSTHESIS?

Instructions: Enter an X in the correct box. If no, skip Box 44. If yes, complete Box 44.

Example: X

Format: Alpha. Use one capital X.

Used for: To provide additional information to payer.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 43** **Ancillary Claim/Treatment Information** **Replacement of Prosthesis?** 2400 | SV305 | 1358 (SV305 = 'R')

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 44

Title: DATE PRIOR PLACMENT (MM/DD/CCYY)

Instructions: Enter the first date the patient had the same or a similar service. Leave blank if unknown.

Example: 05/08/2006

Definitions: Patient has had same or similar prosthesis previously placed.

Format: Use eight-digit numeric date: MM/DD/CCYY. Use slashes to separate numbers.

Used for: Allow determination of liability and COB.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 44** **Ancillary Claim/Treatment Information** **Date Prior Placement** 2400 | DTP03 | 1251 (DTP01 = 441)

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 45

Title: TREATMENT RESULTING FROM

Instructions: Enter an X in the correct box if treatment is result of an occupational illness, injury, auto accident or other accident.

Example: X

Definitions: Indicates treatment is result of an occupational illness, injury, auto accident or other accident.

Format: Alpha. Use one capital X.

Used for: Identify if treatment is a result of an occupational illness, injury, auto accident or other accident.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 45** **Ancillary Claim/Treatment Information** **Treatment Resulting From Occupational illness/injury** 2300 | CLM11-1 | 1362 (CLM11-1 = 'EM') 2300 | CLM11-2 | 1362 (CLM11-1 = 'EM') 2300 | CLM11-3 | 1362 (CLM11-1 = 'EM')	**ADA Form Locator 45** **Ancillary Claim/Treatment Information** **Treatment Resulting From Auto Accident** 2300 | CLM11-1 | 1362 (CLM11-1 = 'AA') 2300 | CLM11-2 | 1362 (CLM11-1 = 'AA') 2300 | CLM11-3 | 1362 (CLM11-1 = 'AA')	**ADA Form Locator 45** **Ancillary Claim/Treatment Information** **Treatment Resulting From Other Accident** 2300 | CLM11-1 | 1362 (CLM11-1 = 'OA') 2300 | CLM11-2 | 1362 (CLM11-1 = 'OA') 2300 | CLM11-3 | 1362 (CLM11-1 = 'OA')

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 46

Title: DATE OF ACCIDENT (MM/DD/CCYY)

Instructions: Enter the date of the accident, occupational injury, illness or injury checked in Box 45.

Example: 12/10/2006

Definitions: The date of the accident, occupational injury, illness or injury checked in Box 45

Format: Use eight-digit numeric date. Use slashes to separate parts of field.

Used for: To identify the date of the occupational injury, illness, auto accident or other accident.

Required: Required if Box 45 is checked.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 46** **Ancillary Claim/Treatment Information** **Date of Accident** 2300 | DTP03 | 1251 (DTP01 = '439')

ANCILLARY CLAIM / TREATMENT INFORMATION

Box Number 47

Title: AUTO ACCIDENT STATE

Instructions: Enter the state in which the auto accident occurred.

Example: MN

Definitions: The state in which the auto accident occurred.

Format: Use two-digit alpha state code.

Used for: Identify state in which the auto accident occurred.

Required: Required if auto accident is checked in Box 45.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 47** **Ancillary Claim/Treatment Information** **Auto Accident State** 2300 | CLM11-4 | 156

BILLING DENTIST OR DENTAL ENTITY

Box Number 48

Title: NAME, ADDRESS, CITY, STATE, ZIP CODE

Instructions: Enter billing dentist or dental entity name, address, city, state and zip code. Do not use punctuation except "#" and "-".

Example: XYZ Diagnostic
123 Healthcare Ln
St Paul MN 55101-1234

Definitions: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.

Format: Use two-digit state code and, if available, nine-digit zip code. Avoid punctuation except "#" and "-". Scanning technology may read punctuation as delimiters and therefore process the information incorrectly.

Used for: Identify billing dentist or dental entity.

Required: Required by all payers.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 48** **Billing Dentist or Dental Entity** **Name, Address, City, State, Zip Code** 2010AA | NM103 | 1035 2010AA | NM104 | 1036 2010AA | NM105 | 1037 2010AA | NM107 | 1039 2010AA | N301 | 166 2010AA | N401 | 19 2010AA | N402 | 156 2010AA | N403 | 116

BILLING DENTIST OR DENTAL ENTITY

Box Number 49

Title: NPI

Instructions: Enter the NPI number of the billing entity.

Example: 1234567890

Definitions: NPI number means the ten-digit National Provider Identifier as required under HIPAA regulations.

Format: Numeric.

Used for: Identify billing entity.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 3 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 49** **Billing Dentist or Dental Entity Provider ID** 2010AA | NM109 | 67 (NM108 = 'XX') 2010AA | REF02 | 127

BILLING DENTIST OR DENTAL ENTITY

Box Number 50

Title: LICENSE NUMBER

Instructions: Enter license number of the billing dentist or dental entity.

Example: 11100

Definitions: Dental license number of the billing dentist or dental entity.

Format: Numeric.

Used for: Identify billing dentist or dental entity.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 50** **Billing Dentist or Dental Entity License Number** 2010AA | REF02 | 127 (REF01 = ‘0B’) 2010AA | REF02 | 127 (REF01 = ‘1E’)

BILLING DENTIST OR DENTAL ENTITY

Box Number 51

Title: SSN OR TIN

Instructions: Enter the billing dentist's or dental entity's federal tax identification number or social security number.

Example: 41 1400000
468 00 8888

Definitions: Federal tax ID number means the unique identifier assigned by a federal or state agency.

Format: Numeric.

Used for: Identify billing dentist or dental entity.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 51** **Billing Dentist or Dental Entity** **SSN or TIN** 2010AA | NM109 | 67 (NM108 = '24') 2010AA | NM109 | 67 (NM108 = '34') 2010AA | REF02 | 127 (REF01 = 'EI') 2010AA | REF02 | 127 (REF01 = 'SY')

BILLING DENTIST OR DENTAL ENTITY

Box Number 52

Title: PHONE NUMBER

Instructions: Enter the phone number of the billing dentist or dental entity.

Example: 123-456-7899

Definitions: The phone number of the billing dentist or dental entity.

Format: Numeric. Use ten-digit numeric number.

Used for: Contact information.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 52** **Billing Dentist or Dental Entity Telephone** 2010AA | PER04 | 364 (PER03 = 'TE') 2010AA | PER06 | 364 (PER05 = 'TE') 2010AA | PER08 | 364 (PER07 = 'TE')

BILLING DENTIST OR DENTAL ENTITY

Box Number 52A

Title: ADDITIONAL PROVIDER ID

Instructions: Enter billing provider's unique identifier assigned by payer.

Example: D345987

Definitions: Billing provider's unique identifier assigned by payer. When the NPI is implemented, this is where it will be used.

Format: Varies

Used For: Identify billing provider.

Required: May be required by contract.

Electronic Concordance:

ANSI ASC X12-837 Version 004050X0142	ADA Form Locator 52A Billing Dentist or Dental Entity Provider ID 2010AA | NM109| 67 (NM108-"XX') 2010AA | REF02 | 127

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Box Number 53

Title: SIGNED (TREATING DENTIST) DATE

Instructions: Enter the signature of the treating dentist, degree, credentials, or title and the date signed. Personal signature, computer generated signature (facsimile signature or signature stamp) is acceptable.

Example: JA Smith DDS 07 14 02

Definitions: Signature of dentist including degrees or credentials means the authorized person with the degree, credentials or title.

Format: Alphanumeric.

Used for: Identify the provider of service(s).

Required: Required for all payers.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 53** **Treating Dentist and Treatment Location** **Signed (Treating Dentist)** 2300 | CLM06 | 1073 (CLM06 = 'Y')	**ADA Form Locator 53** **Treating Dentist and Treatment Location** **Date** N/A

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Box Number 54

Title: NPI

Instructions: Enter the NPI number of the treating dentist.

Example: 1234567890

Definitions: NPI number means the ten-digit National Provider Identifier as required under HIPAA regulations.

Format: Numeric.

Used for: Identify the treating dentist.

Required: May be required by contract. Government programs such as Medicare or Medicaid may require variations from usual practice. See Appendix 3 for resource information.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 54Treating Dentist NPI**2010AA | NM109 | 67 (NM108='XX') 2010AA | REF02 | 127

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Box Number 55

Title: LICENSE NUMBER

Instructions: Enter the license number of the treating dentist.

Example: 11100

Definitions: The dental license number of the treating dentist.

Format: Numeric.

Used for: Identify treating dentist.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 55** **Treating Dentist and Treatment Location** **License Number** 2310B | REF02 | 127 (REF01 = '0B') 2310B | REF02 | 127 (REF01 = '1E')

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Box Number 56

Title: ADDRESS, CITY, STATE, ZIP CODE

Instructions: Enter treating dentist or dental entity name, address, city, state and zip code. Avoid punctuation except "#" and "-".

Example: XYZ Diagnostic
123 Healthcare Ln
St Paul MN 55101-1234

Definitions: The individual dentist's name or the name of the group practice/corporation responsible for providing the dental care. This may differ from the actual billing dentist's name.

Format: Alphanumeric.

Used for: Identify treating dentist.

Required: May be required by contract.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 56** **Treating Dentist and Treatment Location Address, City, State, Zip Code** 2310C | NM103 | 1035 2310C | NM104 | 1036 2310C | NM105 | 1037 2310C | NM107 | 1039 2310C | N301 | 166 2310C | N401 | 19 2310C | N402 | 156 2310C | N403 | 116

TREATING DENTIST AND RETREATMENT LOCATION INFORMATION

Box Number 56A

Title: PROVIDER SPECIALITY CODE

Instructions: Enter the code that indicates the type of dental professional rendering the service from the "Dental Service Providers' section of the *Healthcare Providers Taxonomy* code list.

1223G0001X General Practice

Other dentists practice in one of nine specialty areas recognized by the American Dental Association:

1223D0001X Dental Public Health
1223E0200X Endodontics
1223P0106X Oral & Maxillofacial Pathology
1223D0008X Oral & Maxillofacial Radiology
1223S0112X Oral & Maxillofacial Surgery
1223X0400X Orthodontics
1223P0221X Pediatric Dentistry (Pedodontics)
1223P0300X Periodontics
1223P0700X Prosthodontics

Example: 1223G001X

Definitions: The American Dental Association recognizes ten areas of dental specialty based on their practice scope.

Format: Alphanumeric

Used for: Identify treating provider specialty.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 56A** **Treating Dentist and Treatment Location** **Treating Provider Specialty** 2310B | PRV03 | 127 2000A | PRV03 | 127

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Box Number 57

Title: PHONE NUMBER

Instructions: Enter the phone number of the treating dentist.

Example: 123-456-7899

Definitions: The phone number of the treating dentist.

Format: Numeric. Use ten-digit numeric number.

Used for: Contact information.

Required: Not required.

Electronic concordance:

ANSI ASC X12-837 Version 004050X0142	**ADA Form Locator 57** **Treating Dentist and Treatment Location Phone Number** (Loop 2310B Rendering Provider not present) 2010AA | PER04 | 364 (PER03 = 'TE') 2010AA | PER06 | 364 (PER05 = 'TE') 2010AA | PER08 | 364 (PER07 = 'TE')

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Box Number 58

Title: ADDITIONAL PROVIDER ID

Instructions: Enter the treating dentist's unique identifier assigned by payer.

Example: D345987

Definitions: The treating dentist's unique identifier assigned by payer.

Format: Alphanumeric

Used for: Identifying treating dentist.

Required: Not required.

Electronic concordance:

ANSI ASC X12 837 Version	ADA Form Locator 58 Treating Dentist and Treatment Location Provider ID 231OB | NM109| 67 (NM108 – "XX") 231OB| REF02 | 127

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Appendix 1: Standard US Post Office Abbreviations

Alabama	AL	Oregon	OR
Alaska	AK	Pennsylvania	PA
Arizona	AZ	Rhode Island	RI
Arkansas	AR	South Carolina	SC
California	CA	South Dakota	SD
Colorado	CO	Tennessee	TN
Connecticut	CT	Texas	TX
Delaware	DE	Utah	UT
District of Columbia	DC	Vermont	VT
Florida	FL	Virginia	VA
Georgia	GA	Washington	WA
Hawaii	HI	West Virginia	WV
Idaho	ID	Wisconsin	WI
Illinois	IL	Wyoming	WY
Indiana	IN		
Iowa	IA		
Kansas	KS	American Samoa	AS
Kentucky	KY	Canal Zone	CZ
Louisiana	LA	Guam	GU
Maine	ME	Puerto Rico	PR
Maryland	MD	Trust Territories	TT
Massachusetts	MA	Virgin Islands	VI
Michigan	MI		
Minnesota	MN		
Mississippi	MS	Alberta	AB
Missouri	MO	British Columbia	BC
Montana	MT	Labrador	LB
Nebraska	NE	Manitoba	MB
Nevada	NV	New Brunswick	NB
New Hampshire	NH	Newfoundland	NF
New Jersey	NJ	Northwest Territories	NT
New Mexico	NM	Nova Scotia	NS
New York	NY	Ontario	ON
North Carolina	NC	Pr. Edward Island	PE
North Dakota	ND	Quebec	QB
Ohio	OH	Saskatchewan	SK
Oklahoma	OK	Yukon	YK

For addresses other than in the United States, territories, and Canada, reference the US Postal Service web page for correct abbreviations: http://www.usps.gov/ncsc.

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Appendix 2: Sample ADA Dental Claim Form (2006)*

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									
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

32. Other Fee(s)

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 | 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

©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

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Appendix 3: Resource List

Use of organization or business names does not constitute endorsement; names are provided for user convenience only.

Workers' Compensation (WC) insurer information should be obtained from the patient; identity of an employer's WC carrier may be obtained from the MN Department of Labor and Industry insurance verification unit. Phone: 1-800-DIAL-DLI (1-800-342-5354) or (651) 284-5170.

Minnesota Medical Assistance program information:

Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155
(651) 296-6117http://www.dhs.state.mn.us

Medicaid manuals are available from MA carrier or the Minnesota Department of Human Services.

ADA Dental Claim Form (2006)s:

Available from the ADA and from medical office supply firms. To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

Current Dental Terminology (CDT)

Published by the American Dental Association. May be purchased from the American Dental Association at 1-800-947-4746 or go online at www.adacatalog.org

Current Procedural Terminology (CPT)

Published by the American Medical Association. May be purchased from the American Medical Association or other large commercial bookstores, and from medical office supply firms.

Healthcare Common Procedural Coding System (HCPCS)

The HCPCS procedure, supply and modifier coding system was developed by CMS to standardize coding systems used to process Medicare and Medicaid (Medical Assistance) claims. It is also used by other third party payers. May be purchased from the American Medical Association or other large commercial bookstores, and from medical office supply firms.

International Classification of Diseases, Ninth Edition (ICD-9-CM)

Published by the World Health Organization and updated yearly by CMS. May be purchased from large commercial bookstores, and from medical office supply firms.

National Provider Identifier (NPI)

For more information on NPI go to www.ada.org/goto/npi.
To apply for your NPI number go to https://nppes.cms.hhs.gov.

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Appendix 4: AUC Mission Statement, History and Governing Principles

(last updated November,2002)

1. Mission: To develop agreement among Minnesota payers and providers on standardized administrative processes when implementation of the processes will reduce administrative costs.

2. History: The Administrative Uniformity Committee (AUC) is a broad-based group representing Minnesota health care public and private payers, hospitals, physicians, other providers and State agencies. The impetus for its establishment came from the Minnesota Council of Health Plans, whose member plans committed in 1991 to standardize their administrative processes and requirements with the goal of reducing administrative costs for both payers and providers. Recognizing that costs can be reduced effectively only if all major stakeholders are involved, the Council=s committee sought the endorsement and active participation of other payers, state agencies, and representatives of key provider groups. By mid-1992, virtually all groups contacted had offered their enthusiastic support and had named representatives to the committee. The expanded AUC agreed that the initial priority was to respond to the MinnesotaCare health care reform mandates. Although the AUC originally reported to the Minnesota Council of Health Plans, the AUC no longer formally reports to any organization, although it may from time to time act as a consulting body to various public and private entities.

3. Purpose and Objectives:

   3.1 To develop agreement among Minnesota payers and providers regarding uniform billing forms, uniform claims procedures, and uniform electronic billing procedures;

   3.2 To participate actively in the implementation of standardization plans enacted as part of health care reform. It is understood that implementation will be a multi-year process;

   3.3 To function as a consulting body on matters related to the AUC=s mission statement;

   3.4 To continue research into new issues that may lead to enhanced administrative uniformity and bring issues and recommendations to private industry and/or governmental entities;

   3.5 To undertake educational efforts and facilitate the members= understanding about how the different stakeholders address specific administrative simplification issues.

4. Membership:

   4.1 Criteria: In order to be considered for membership in the AUC, an individual must represent a stakeholder as defined in this paragraph. A stakeholder must: (1) be a Minnesota broad-based health care provider, association, society, payer, or governmental organization and (2) be capable of implementing recommendations and decisions of the AUC. Each stakeholder will be entitled only to one vote, even if represented by more than one member at any given meeting. Membership

of provider associations will be evaluated on a case by case basis taking into account size, geographic representation, specialty and so forth.

4.2 Roster: As of November, 2000, the members and stakeholders of the AUC shall be those persons listed on the roster attached as Appendix A. As stated in section 5.1, the AUC chair shall be responsible for maintaining the roster and keeping it up-to-date.

4.3 New member approval: Organizations that wish to be AUC members must qualify as a stakeholder as defined in paragraph 4.1 and request membership in writing to the AUC. The request will be presented to the AUC at the next scheduled meeting and voted on at the following meeting. New members and stakeholders may be subject to approval by a two-thirds majority vote of stakeholders represented at a meeting.

5. AUC Membership Structure and Meetings:

5.1 The AUC will annually elect a chair and chair-elect. Nominations for the chair-elect will be considered from the voting membership. It is the intent of the committee to rotate the chair position between representatives from the payer and provider community. Stakeholders making nominations should consider this before the nomination is made. At the end of the chair=s one-year-term, the chair-elect will automatically be elected chair for the coming year. The chair, or a person designated by the chair, shall be responsible for maintaining the AUC=s meeting schedule and membership roster. The chair shall also be responsible for chairing AUC meetings. The chair-elect will be responsible for chairing those meetings which the chair cannot attend, and it is the chair=s responsibility to coordinate with the chair-elect to ensure that at least one of them is present at each meeting.

5.2 Members must commit to participate actively in the AUC by attending meetings, or sending an alternate, and taking minutes. It is the member=s responsibility to arrange for an alternate to represent him or her at meetings which the member cannot attend. Non-voting stakeholders may serve as an alternate member.

5.3 Failure to attend or send an alternate to three meetings in one year shall be grounds for revoking membership of stakeholder organization or individual representative.

5.4 Any stakeholder, whether voting or non-voting, may make a motion or bring forth a proposal to the committee during the meeting.

5.5 Meeting Agenda:

5.5.1 The chair shall be responsible for determining and circulating meeting agendas. AUC members may submit agenda items to the chair a reasonable amount of time in advance of the meeting.

5.5.2 At the outset of each meeting, the chair shall ask the members if the agenda should be supplemented or otherwise changed.

5.5.3 The last item of business for each meeting will be to confirm the time and location of the next meeting, to confirm who will be responsible for taking the minutes, and to set, to the extent possible, the agenda for the meeting.

5.6 If a member is scheduled to take minutes at a particular meeting and cannot do so, it is that member's responsibility to arrange in advance for another AUC member to take the minutes. Within 14 days of the meeting, the member shall provide the minutes to a designated staff person who shall be responsible for circulating them to all of the AUC members.

5.7 The AUC may from time to time establish one or more subgroups which are called Technical Action Groups (TAGs).

5.7.1 Unless otherwise determined by the AUC, membership in a TAG shall be open both to (1) representatives of stakeholders that can implement the TAG=s recommendations or decisions and (2) those who can offer technical expertise to the TAG. Only stakeholders may vote, and each stakeholder shall be limited to one vote, regardless of how many of its representatives are in attendance at any particular meeting. New TAG members and stakeholders may be subject to approval by the AUC.

5.7.2 Each TAG shall include (1) an AUC member or (2) a person who reports to an AUC member. Such AUC member shall be responsible for facilitating communication between the AUC and TAG and conveying the AUC=s directions to the TAG. This AUC member shall also be responsible for presenting, or arranging for another TAG member to present periodic TAG reports to the AUC on the dates designated by the AUC.

5.7.3 TAG members must commit to participate actively in their TAG by attending meetings, or sending an alternate, taking minutes, and chairing meetings upon request. Unless the TAG members agree otherwise, the duties of chairing and taking minutes shall rotate among the TAG members, with the minute taker from one meeting chairing the next. It is each TAG member=s responsibility to arrange for an alternate to represent him or her at meetings which the TAG member cannot attend. If a TAG member is scheduled to take minutes at or chair a particular meeting and cannot do so, it is also that TAG member=s responsibility to arrange in advance for another TAG member to take the minutes or chair the meeting. The minute-taker shall be responsible for circulating the minutes to the TAG members and to an AUC designee who shall then circulate the TAG minutes to the AUC members.

5.8 The AUC may from time to time designate certain of its meetings, or certain TAG meetings, as public meetings.

5.9 Unless the members agree otherwise, the AUC=s standing meetings shall be from 1:00 to 4:00 p.m. on the first Tuesday of every other month. If the first Tuesday follows a holiday, then the AUC will meet on the second Tuesday.

Appendix 5: Minnesota Statutes 2006, Chapter 62J.50 - 62J.61
Administrative Simplification Provisions of
2006 Minnesota Statutes, Chapter 62J

Editor's Notes:
This excerpt of Minnesota Statutes includes only the administrative simplification provisions of *Minnesota Statutes, sections 62J.50 to 62J.61*, the Administrative Simplification Act (ASA). The official 2006 version of chapter 62J was obtained from the Revisor of Statutes Web site.

MINNESOTA STATUTES 2006, CHAPTER 62J
HEALTH CARE COST CONTAINMENT

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50	Citation and purpose.
62J.51	Definitions.
62J.52	Establishment of uniform billing forms.
62J.53	Acceptance of uniform billing forms by group purchasers.
62J.535	Uniform billing requirements for claim transactions.
62J.54	Identification and implementation of unique identifiers.
62J.55	Privacy of unique identifiers.
62J.56	Implementation of electronic data interchange standards.
62J.57	Minnesota center for health care electronic data interchange.
62J.58	Implementation of standard transaction sets.
62J.581	Standards for Minnesota uniform health care reimbursement documents.
62J.59	Implementation of NCPDP telecommunications standard for pharmacy claims.
62J.60	Standards for the Minnesota uniform health care identification card.
62J.61	Rulemaking; implementation.

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50 Citation and purpose.

Subdivision 1. **Citation.** Sections 62J.50 to 62J.61 may be cited as the Minnesota Health Care Administrative Simplification Act of 1994.

Subd. 2. **Purpose.** The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal Health Care Financing Administration in its implementation of nationally accepted electronic transaction sets for its Medicare program. The legislature further recognizes the work done by the workgroup for electronic data interchange and the American National Standards Institute and its accredited standards committee X12, at the national level, and the Minnesota administrative uniformity committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

HIST: 1994 c 625 art 9 s 1

62J.51 Definitions.

Subdivision 1. **Scope.** For purposes of sections 62J.50 to 62J.61, the following definitions apply.

Subd. 2. **ANSI.** "ANSI" means the American National Standards Institute.

Subd. 3. **ASC X12.** "ASC X12" means the American National Standards Institute

committee X12.

Subd. 3a. **Card issuer.** "Card issuer" means the group purchaser who is responsible for printing and distributing identification cards to members or insureds.

Subd. 4. **Category I industry participants.** "Category I industry participants" means the following: group purchasers, providers, and other health care organizations doing business in Minnesota including public and private payers; hospitals; claims clearinghouses; third-party administrators; billing service bureaus; value added networks; self-insured plans and employers with more than 100 employees; clinic laboratories; durable medical equipment suppliers with a volume of at least 50,000 claims or encounters per year; and group practices with 20 or more physicians.

Subd. 5. **Category II industry participants.** "Category II industry participants" means all group purchasers and providers doing business in Minnesota not classified as category I industry participants.

Subd. 6. **Claim payment/advice transaction set (ANSI ASC X12 835).** "Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format developed and approved for implementation in October 1991, and used for electronic remittance advice and electronic funds transfer.

Subd. 6a. **Claim status transaction set (ANSI ASC X12 276/277).** "Claim status transaction set (ANSI ASC X12 276/277)" means the transaction format developed and approved for implementation in December 1993 and used by providers to request and receive information on the status of a health care claim or encounter that has been submitted to a group purchaser.

Subd. 6b. **Claim submission address.** "Claim submission address" means the address to which the group purchaser requires health care providers, members, or insureds to send health care claims for processing.

Subd. 6c. **Claim submission number.** "Claim submission number" means the unique identification number to identify group purchasers as described in section 62J.54, with its suffix identifying the claim submission address.

Subd. 7. **Claim submission transaction set (ANSI ASC X12 837).** "Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format developed and approved for implementation in October 1992, and used to submit all health care claims information.

Subd. 8. **EDI or electronic data interchange.** "EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. **Eligibility transaction set (ANSI ASC X12 270/271).** "Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

Subd. 10. **Enrollment transaction set (ANSI ASC X12 834).** "Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format developed and approved for implementation in February 1992, and used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan.

Subd. 11. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

Subd. 12. **ISO.** "ISO" means the International Standardization Organization.

Subd. 13. **NCPDP.** "NCPDP" means the National Council for Prescription Drug Programs, Inc.

Subd. 14. **NCPDP telecommunication standard format 3.2.** "NCPDP

telecommunication standard format 3.2" means the recommended transaction sets for claims transactions adopted by the membership of NCPDP in 1992.

Subd. 15. **NCPDP tape billing and payment format 2.0.** "NCPDP tape billing and payment format 2.0" means the recommended transaction standards for batch processing claims adopted by the membership of the NCPDP in 1993.

Subd. 16. **Provider.** "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 17. **Uniform billing form CMS 1450.** "Uniform billing form CMS 1450" means the uniform billing form known as the CMS 1450 or UB92, developed by the National Uniform Billing Committee in 1992 and approved for implementation in October 1993, and any subsequent amendments to the form.

Subd. 18. **Uniform billing form CMS 1500.** "Uniform billing form CMS 1500" means the 1990 version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim and any subsequent amendments to the form.

Subd. 19. **Uniform dental billing form.** "Uniform dental billing form" means the most current version of the uniform dental claim form developed by the American Dental Association.

Subd. 19a. **Uniform explanation of benefits document.** "Uniform explanation of benefits document" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a patient.

Subd. 19b. **Uniform remittance advice report.** "Uniform remittance advice report" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a provider.

Subd. 20. **Uniform pharmacy billing form.** "Uniform pharmacy billing form" means the National Council for Prescription Drug Programs/universal claim form (NCPDP/UCF).

Subd. 21. **WEDI.** "WEDI" means the National Workgroup for Electronic Data Interchange report issued in October 1993.

HIST: 1994 c 625 art 9 s 2; 1996 c 440 art 1 s 22-25; 2000 c 460 s 2,3; 2002 c 307 art 2 s 3; 2002 c 330 s 19; 2005 c 106 s 1,2

62J.52 Establishment of uniform billing forms.

Subdivision 1. **Uniform billing form CMS 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, institutionally owned or operated outpatient services rendered by providers in Minnesota, and institutional or noninstitutional home health services that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form CMS 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee, as adopted and finalized by the Minnesota uniform billing committee.

(c) Services to be billed using the uniform billing form CMS 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as waivered services,

hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waivered services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Subd. 2. **Uniform billing form CMS 1500.**

(a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

Subd. 3. **Uniform dental billing form.**

(a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American Dental Association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the administrative uniformity committee dated February 1994, and as amended or further defined by the commissioner.

Subd. 4. **Uniform pharmacy billing form.**

(a) On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the NCPDP/universal claim form, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform claim form shall be in accordance with instructions specified by the commissioner of health, except as provided in subdivision 5.

Subd. 5. **State and federal health care programs.**

(a) Skilled nursing facilities and ICF/MR services billed to state and federal health care programs administered by the department of human services shall use the form designated by the department of human services.

(b) On and after July 1, 1996, state and federal health care programs administered by the department of human services shall accept the CMS 1450 for community mental health center services and shall accept the CMS 1500 for freestanding ambulatory surgical center services.

(c) State and federal health care programs administered by the department of human services shall be authorized to use the forms designated by the department of human services for

pharmacy services.

(d) State and federal health care programs administered by the department of human services shall accept the form designated by the department of human services, and the CMS 1500 for supplies, medical supplies, or durable medical equipment. Health care providers may choose which form to submit.

(e) Personal care attendant and waivered services billed on a fee-for-service basis directly to state and federal health care programs administered by the department of human services shall use either the CMS 1450 or the CMS 1500 form, as designated by the department of human services.

HIST: 1994 c 625 art 9 s 3; 2000 c 460 s 4-6; 1Sp 2003 c 14 art 7 s 14, 15; 2005 c 106 s 3-5

62J.53 Acceptance of uniform billing forms by group purchasers.

On and after January 1, 1996, all category I and II group purchasers in Minnesota shall accept the uniform billing forms prescribed under section 62J.52 as the only nonelectronic billing forms used for payment processing purposes.

HIST: 1994 c 625 art 9 s 4

62J.535 Uniform billing requirements for claim transactions.

Subdivision 1. Repealed, 2002 c 307 art 2 s 9; 2002 c 330 s 35

Subd. 1a. **Electronic claim transactions.** Group purchasers, including government programs, not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, that voluntarily agree with providers to accept electronic claim transactions, must accept them in the ANSI X12N 837 standard electronic format as established by federal law. Nothing in this section requires acceptance of electronic claim transactions by entities not covered under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 1b. **Paper claim transactions.** All group purchasers that accept paper claim transactions must accept, and health care providers submitting paper claim transactions must submit, these transactions with use of the applicable medical and nonmedical data code sets specified in the federal electronic claim transaction standards adopted under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. The paper claim transaction must also be conducted using the uniform billing forms as specified in section 62J.52 and the identifiers specified in section 62J.54, on and after the compliance date required by law. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 2. **Compliance.** Subdivision 1a is effective concurrent with the date of required compliance for covered entities established under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time.

HIST: 1999 c 245 art 2 s 8; 2000 c 483 s 16; 2000 c 488 art 11 s 1; 2002 c 307 art 2 s 4-

6,8; 2002 c 330 s 20-22,33

62J.54 Identification and implementation of unique identifiers.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and any health care provider organization that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a national provider identifier to identify health care provider organizations in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a national provider identifier to identify health provider organizations no later than 36 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for health care provider organizations in Minnesota under this section.

(d) All health care provider organizations in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify health care provider organizations when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Health care provider organizations in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 2. **Unique identification number for individual health care providers.**

(a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers in Minnesota and any individual health care provider that meets the definition of a health care provider under United States Codes, title 42, sections 1320d to 1320d-8, as amended regulations adopted thereunder shall use the national provider identifier to identify an individual health care provider in Minnesota, according to this section, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use the national provider identifier to identify an individual health care provider no later than 36 months after the date on which a national provider identifier for health care providers is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers established by the federal

Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for individual health care providers.

(d) All individual health care providers in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify individual health care providers when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Individual health care providers in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United State Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 3. **Unique identification number for group purchasers.**

(a) Not later than 24 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify group purchasers no later than 36 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for health plans and employers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for group purchasers.

(d) Group purchasers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) The unique group purchaser identifier, as described in this section, shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 4. **Unique patient identification number.**

(a) Not later than 24 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify each patient who receives health care services in

Minnesota no later than 36 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for individuals adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique patient identification number, except as provided in paragraphs (e) and (f).

(d) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) Within the limits of available appropriations, the commissioner shall develop a proposal for an alternate numbering system for patients who do not have or refuse to provide their social security numbers, if:

(1) a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments);

(2) the unique health identifier is the social security number of the patient;

(3) there is no federal alternate numbering system for patients who do not have or refuse to provide their social security numbers; and

(4) federal law or the federal Secretary of Health and Human Services explicitly allows a state to develop an alternate numbering system for patients who do not have or refuse to provide their social security numbers.

(f) If an alternate numbering system is developed under paragraph (e), patients who use numbers issued by the alternate numbering system are not required to provide their social security numbers and group purchasers or providers may not demand the social security numbers of patients who provide numbers issued by the alternate numbering system. If an alternate numbering system is developed under paragraph (e), group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their social security number used as the unique patient identifier.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

HIST: 1994 c 625 art 9 s 5; 1995 c 234 art 5 s 17; 1996 c 440 art 1 s 26-28; 1997 c 228 s 2; 1Sp1997 c 5 s 16; 2005 c 106 s 6,7

62J.55 Privacy of unique identifiers.

(a) When the unique identifiers specified in section 62J.54 are used for data collection purposes, the identifiers must be encrypted, as required in section 62J.321, subdivision 1. Encryption must follow encryption standards set by the National Bureau of Standards and approved by the American National Standards Institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the social security number if it is used as a unique patient identifier, in accordance with section 144.335. The social security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section 144.05.

HIST: 1994 c 625 art 9 s 6; 1995 c 234 art 5 s 18

62J.56 Implementation of electronic data interchange standards.

Subdivision 1. **General provisions.** (a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for a systematic phase in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

(c) The commissioner may grant exemptions to category I and II industry participants from the requirements to implement some or all of the provisions in this section if the commissioner determines that the cost of compliance would place the organization in financial distress, or if the commissioner determines that appropriate technology is not available to the organization.

Subd. 2. **Identification of core transaction sets.**

(a) All category I and II industry participants in Minnesota shall comply with the standards developed by the ANSI ASC X12 for the following core transaction sets, according to the implementation plan outlined for each transaction set.

(1) ANSI ASC X12 835 health care claim payment/advice transaction set.

(2) ANSI ASC X12 837 health care claim transaction set.

(3) ANSI ASC X12 834 health care enrollment transaction set.

(4) ANSI ASC X12 270/271 health care eligibility transaction set.

(5) ANSI ASC X12 276/277 health care claims status request/notification transaction set.

(b) The commissioner, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards, or new versions of existing standards, as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Subd. 3. **Implementation guides.**

(a) The commissioner, with the advice of the Minnesota administrative uniformity committee, and the Minnesota center for health care electronic data interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American Hospital Association through the national Uniform Billing Committee and its state representative organization; the American Medical Association through the uniform claim task force; the American Dental Association; the National Council of

Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

HIST: 1994 c 625 art 9 s 7; 1996 c 440 art 1 s 29

62J.57 Minnesota center for health care electronic data interchange.

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota center for health care electronic data interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota center for health care electronic data interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

(1) coordinating and ensuring the availability of quality electronic data interchange education and training in the state;

(2) developing an extensive, cohesive health care electronic data interchange education curriculum;

(3) developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;

(4) administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents database, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and

(5) providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

HIST: 1994 c 625 art 9 s 8

62J.58 Implementation of standard transaction sets.

Subdivision 1. **Claims payment.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I industry participants and all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version/release 3051) for electronic submission of payment information to health care providers.

Subd. 2. **Claims submission.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim information.

Subd. 2a. **Claim status information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets under section 62J.56, subdivision 3, all category I and II industry participants, excluding pharmacists, may accept or submit the ANSI ASC X12 276/277 health care claim status transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim status information.

Subd. 3. **Enrollment information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56,

subdivision 3, all category I and category II industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version/release 3051) for the electronic transfer of enrollment and health benefit information.

Subd. 4. **Eligibility information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health benefit eligibility information.

Subd. 5. **Applicability.** This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

HIST: 1994 c 625 art 9 s 9; 1995 c 234 art 5 s 19; 1996 c 440 art 1 s 30

62J.581 Standards for Minnesota uniform health care reimbursement documents.

Subdivision 1. **Minnesota uniform remittance advice report.** (a) All group purchasers shall provide a uniform remittance advice report to health care providers when a claim is adjudicated. The uniform remittance advice report shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 2. **Minnesota uniform explanation of benefits document.**

(a) All group purchasers shall provide a uniform explanation of benefits document to health care patients when an explanation of benefits document is provided as otherwise required or permitted by law. The uniform explanation of benefits document shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections 62J.50 to 62J.61, the uniform remittance advice report and the uniform explanation of benefits document format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in subdivisions 1 and 2 if they comply with section 62A.01, subdivisions 2 and 3.

Subd. 4. **Specifications.** The uniform remittance advice report and the uniform explanation of benefits document shall be provided by use of a paper document conforming to the specifications in this section or by use of the ANSI X12N 835 standard electronic format as established under United States Code, title 42, sections 1320d to 1320d-8, and as amended from time to time for the remittance advice. The commissioner, after consulting with the administrative uniformity committee, shall specify the data elements and definitions for the uniform remittance advice report and the uniform explanation of benefits document. The commissioner and the administrative uniformity committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the

use of a paper document for the uniform explanation of benefits document or the uniform remittance advice report for dental care services.

Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

HIST: 2000 c 460 s 7; 2002 c 307 art 2 s 7; 2002 c 330 s 23; 2005 c 106 s 8

62J.59 IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS STANDARD FOR PHARMACY CLAIMS.

(a) Beginning January 1, 1996, all category I and II pharmacists licensed in this state shall accept the NCPDP telecommunication standard format 3.2 or the NCPDP tape billing and payment format 2.0 for the electronic submission of claims as appropriate.

(b) Beginning January 1, 1996, all category I and category II group purchasers in this state shall use the NCPDP telecommunication standard format 3.2 or NCPDP tape billing and payment format 2.0 for electronic submission of payment information to pharmacists.

HIST: 1994 c 625 art 9 s 10

62J.60 Standards for the Minnesota uniform health care identification card.

Subdivision 1. **Minnesota uniform health care identification card.** All individuals with health care coverage shall be issued Minnesota uniform health care identification cards by group purchasers as of January 1, 1998, unless the requirements of section 62A.01, subdivisions 2 and 3, are met. If a health benefit plan issued by a group purchaser provides coverage for prescription drugs, the group purchaser shall include uniform prescription drug information on the uniform health care identification card issued to its enrollees on or after July 1, 2003. Nothing in this section requires a group purchaser to issue a separate card containing uniform prescription drug information, provided that the Minnesota uniform health care identification card can accommodate the information necessary to process prescription drug claims as required by this section. The Minnesota uniform health care identification cards shall comply with the standards prescribed in this section.

Subd. 1a. **Definition; health benefit plan.** For purposes of this section, "health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a group purchaser for the coverage of medical and hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile or homeowners medical payment coverage;

(3) liability insurance or supplemental to liability insurance;

(4) accident-only coverage;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) designed solely to provide coverage for a specified disease or illness;

(8) coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(9) hospital income or indemnity.

Subd. 2. **General characteristics.**

(a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If

a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements.

Subd. 2a. **Issuance.** A new Minnesota uniform health care identification card must be issued to individuals upon enrollment. Except for the medical assistance, general assistance medical care, and MinnesotaCare programs, a new card must be issued upon any change in an individual's health care coverage that impacts the content or format of the data included on the card or no later than 24 months after adoption of any change in the NCPDP implementation guide or successor document that affects the content or format of the data included on the card. Anytime that a card is issued upon enrollment or replaced by the medical assistance, general assistance medical care, or MinnesotaCare program, the card must conform to the adopted NCPDP standards in effect and to the implementation guide in use at the time of issuance. Newly issued cards must conform to the adopted NCPDP standards in effect at the time of issuance and to the implementation guide in use at the time of issuance. Stickers or other methodologies may be used to update cards temporarily.

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota uniform health care identification card:

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) cardholder (insured) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

(4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

(5) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(6) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health.; and

(7) provider/clinic name, which is the name of the primary care clinic the card holder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the card holder.

(b) The following human readable data elements shall be present on the back side of the Minnesota uniform health care identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission names and addresses, which are the names and addresses of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Subd. 4. **Machine readable data content.** The Minnesota uniform health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

Subd. 5. **Annual reporting.** As part of an annual filing made with the commissioner of health or commerce on or after January 1, 2003, a group purchaser shall certify compliance with this section and shall submit to the commissioner of health or commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

HIST: 1994 c 625 art 9 s 11; 1996 c 440 art 1 s 31,32; 1997 c 205 s 17; 1997 c 225 art 2

s 62; 2000 c 460 s 8; 2001 c 110 s 1; 2006 c 255 s 22,23

62J.61 RULEMAKING; IMPLEMENTATION.

Subdivision 1. **Exemption.** The commissioner of health is exempt from chapter 14, including section 14.386, in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59.

Subd. 2. **Procedure.** (a) The commissioner shall publish proposed rules in the State Register or, if the commissioner determines that publishing the text of the proposed rules would be unduly cumbersome, shall publish notice of the proposed rules that contains a detailed description of the rules along with a statement that a free copy of the entire set of rules is available upon request to the agency.

(b) Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish notice in the State Register that the rules have been adopted 30 days before they are to take effect.

(c) If the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules which differ from the proposed rules shall be included in the notice of adoption together with a citation to the prior State Register that contained the notice of the proposed rules.

(d) The commissioner may use rulemaking to implement sections 62J.54, subdivision 4, 62J.55, and 62J.60.

Subd. 3. **Restrictions.** The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Subd. 4. **Patient privacy.** The commissioner shall seek comments from the ethics and confidentiality committee of the Minnesota health data institute and the department of administration, public information policy analysis division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

Subd. 5. **Biennial review of rulemaking procedures and rules.** The commissioner shall biennially seek comments from affected parties about the effectiveness of and continued need for the rulemaking procedures set out in subdivision 2 and about the quality and effectiveness of rules adopted using these procedures. The commissioner shall seek comments by holding a meeting and by publishing a notice in the State Register that contains the date, time, and location of the meeting and a statement that invites oral or written comments. The notice must be published at least 30 days before the meeting date. The commissioner shall write a report summarizing the comments and shall submit the report to the Minnesota health data institute and to the Minnesota administrative uniformity committee by January 15 of every even-numbered year.

HIST: 1994 c 625 art 9 s 12; 1997 c 187 art 4 s 3; 1998 c 254 art 1 s 14