

Place of Service (POS) Coding for Scion

Information for dental providers in all networks

Per the American Dental Association (ADA) billing guidelines, a provider can bill any valid place of service.

If a provider bills a place of service other than his/her own office (POS code 11), the provider needs to indicate the place of service facility name and address, or the claim will deny.

Additional coding information is available at <http://cms.gov>. Go to the "Medicare" tab, then "Coding" and click "Place of Service Codes." Select the "Place of Service Code Set" to view a list of service codes and descriptions.

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Your claim may be denied if the NPI for the billing and treating dentist is not filled out on the Dental Claim Form.

Questions?

Provider Services – (855) 322-4079
 8 a.m. to 5 p.m., Monday to Friday
 (MyCare Ohio available until 6 p.m.)

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes):
 Statement of Actual Services Request for Predetermination/Preadjustment
 RPSDT / TPA XXX

2. Predetermination/Preadjustment Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/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. Resorced Procedures Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender M F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

24. Procedure Code (MM/DD/CCYY)	25. ICD-9-CM Code (ICD-9-CM-9)	26. Tooth Number (or Letter)	27. Tooth Surface	28. Procedure Code	29. ICD-9-CM Code (ICD-9-CM-9)	30. Description	31. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

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

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

31a. Other Fee(s)
 32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated charges. I am responsible for all charges for dental services and materials not covered by this benefit, and I agree to pay for all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my personal health information to carry out the treatment activities in connection with this claim.

X Patient/Named or Subscriber Date

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

X Submitter Signature Date

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

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

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

52. Phone () - () - () 53a. Additional Provider ID 54. Additional Provider ID

59. Phone Number () - () - () 68. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. H=Home, S=OP Hospital) (Use Place of Service Codes for Professional Claims)

39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?
 No (Skip 41-42) Yes (Complete 41-42)

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

42. Months of Treatment 43. Replacement of Prosthesis
 No Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
 Occupational Illness/Injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

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, all have been completed).

X Signed (Treating Dentist) Date

54. NPI 55. License Number
 56. Address, City, State, Zip Code 57. Provider Specialty Code

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 ADA Form 92-ADA Dental Claim Form - 4301, 4311, 4331, 4332, 4341

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#48: List full name, address, city, state and ZIP code for Billing Dentist or Dental Entity

#49: List NPI for Billing Dentist or Dental Entity

#53: Signature of Treating Dentist

#54: List NPI for Treating Dentist