



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 39
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Office of Information Technology
Division of Information Resource Management

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1.0 Introduction

This document provides information for the user pertaining to minor enhancements included in Third Party Billing v2.6 p39. Please distribute this addendum to the billing staff prior to patch installation.

Note: This addendum is not intended to be a process guide. Contact your business office manager or area business office coordinator for questions regarding billing practices.

1.1 Summary of Changes

FID76227–A field called DISPLAY THE COB PAGE was added to Add/Edit Insurer option (TMTP > INTM > EDIN) to allow for disabling the Coordination of Benefits page in the Edit Claim Data option (EDTP > EDCL). Leaving this field blank or setting it to Yes will not change anything – the COB page will be displayed as usual. If the new field is set to No, the COB page will not be displayed in the EDCL option.

FID99168–The ADA v2024 claim form was added as an export mode. This form allows for marking a provider as a locum tenens (box 53a) and for indicating the date of the patient’s last scaling and root planing procedure (box 39a). To allow for including this information on the ADA-2024, minor changes were made to the Questions page and to the Provider Data page in the Edit Claim Data option (EDTP > EDCL).

2.0 Details

2.1 Display the COB Page

A field called DISPLAY THE COB PAGE was added to Add/Edit Insurer option (TMTP > INTM > EDIN) to allow for disabling the Coordination of Benefits page in the Edit Claim Data option (EDTP > EDCL) for a secondary claim's active insurer. Leaving this field blank or setting it to Yes will not change anything – the COB page will be displayed as usual. If the new field is set to No, the COB page will not be displayed in the EDCL option.

Note: It is not necessary to edit this field unless you do not want the COB page displayed in the claim editor. This is a rare scenario. For most insurers, you will leave this field blank.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          THIRD PARTY BILLING SYSTEM - VER 2.6p39          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|                      Add/Edit Insurer                      |
|                      2017 DEMO HOSPITAL                      |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: BILLER,SUPER                                     13-DEC-2024 9:53 AM

WARNING: Before ADDING a new INSURER you should ensure that it
         does not already exist!

         Select one of the following:

         1          EDIT EXISTING INSURER
         2          ADD NEW INSURER

Select DESIRED ACTION: 1//  EDIT EXISTING INSURER

Screen-out Insurers with status of Unselectable? Y// ES

Select INSURER: DEMO INSURER

DEMO INSURER                                     - PO BOX 123
                                                ANYTOWN, ST 12345

OK? Y//

<----- MAILING ADDRESS ----->
Street...: PO BOX 123//
City.....: ANYTOWN//
State....: STATE//
Zip Code.: 12345//

<----- BILLING ADDRESS ----->
(if Different than Mailing Address)
Billing Office.:

Phone Number.....: (505)555-5555//
Contact Person.....:
Federal Tax ID#....: 123456789//

```

```

AO Control Number...:
Insurer Status.....: BILLABLE//
Type of Insurer....: PRIVATE//
All Inclusive Mode..: NO//
Backbill Limit (months): 48//
Dental Bill Status.: DENTAL VISITS ARE UNBILLABLE
//
Rx Billing Status...: OUTPATIENT DRUGS ONLY//

Select CLINIC UNBILLABLE:

EMC SUBMITTER ID:
EMC PASSWORD:
EMC TEST INDICATOR:
USE PLAN NAME?:
72 HOUR RULE:
NPI USAGE: NPI ONLY//
TRIBAL SELF-INSURED?:
DISPLAY THE COB PAGE: NO// ?
    Answer NO if you do NOT want to see COB page for secondary billing. Blank
    is the same as YES
    Choose from:
        N        NO
        Y        YES
DISPLAY THE COB PAGE: NO//
    
```

Figure 2-1: New field added to the EDIN option

2.2 ADA v2024 Claim Form

Version 2024 of the ADA claim form was added to Third Party Billing. This form allows for marking a provider as a locum tenens in box 53a and for indicating the date of the patient’s last scaling and root planing procedure in box 39a. To allow for including this information on the ADA-2024, minor changes were made to the Questions page and to the Provider Data page in Edit Claim Data option (EDTP > EDCL).

When a claim’s export mode is set to ADA-2024, a question will be displayed on page 3 of the Edit Claim Data option for Date Last SRP (SRP is abbreviated for scaling and root planing). To add a Date Last SRP, select the Edit option and field number, and <enter>. Type the date and <enter>. This date will be populated in box 39a (Date Last SRP) of the ADA-2024.

```

~~~~~ PAGE 3 ~~~~~
Patient: DEMO,PATIENT      [HRN:1234]      Claim: 1234567
..... (QUESTIONS) .....

[1] Release of Information...: YES      From: 08/14/2024
[2] Assignment of Benefits...: NO
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Date of First Symptom...:
[6] Radiographs Enclosed...: NO
[7] Orthodontic Related.....: NO
[8] Replace Prosthesis.....: NO
[9] Number of Enclosures.....: 0
    
```

```
[10] Other Dental Charges....: 0.00

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N// E11

[11] Date Last SRP: 7/12/23

~~~~~ PAGE 3 ~~~~~
Patient: DEMO,PATIENT      [HRN:1234]      Claim: 1234567
..... (QUESTIONS) .....

[1] Release of Information...: YES   From: 08/14/2024
[2] Assignment of Benefits...: YES   From: 08/14/2024
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Date of First Symptom...:
[6] Radiographs Enclosed....: NO
[7] Orthodontic Related.....: NO
[8] Replace Prosthesis.....: NO
[9] Number of Enclosures....: 0
[10] Other Dental Charges....: 0.00
[11] Date Last SRP.....: 07/12/2023

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 2-2: Date Last SRP question displayed on page 3 when claim’s mode of export is ADA-2024

A locum tenens provider is a provider who temporarily fills in for another provider. To allow for indicating an attending provider as a locum tenens, a field for locum tenens was added to page 4 of the Edit Claim Data option. This field is only displayed if the claim’s mode of export is set to ADA-2024 and only for the attending provider.

An Edit command was also added to page 4. The Edit command is available for all export modes.

In the example below, an attending provider was already populated on page 3 and the claim’s export mode was set to ADA-2024. The Edit command was used to indicate the provider is a locum tenens. This will populate box 53a of the ADA-2024 with an ‘X’ (Locum Tenens Treating Dentist?).

```
~~~~~ PAGE 4 ~~~~~
Patient: DEMO,PATIENT      [HRN:1234]      Claim: 1234567
..... (PROVIDER DATA) .....

                PROVIDER                NPI                DISCIPLINE
                =====                =====                =====
(attn)  DENTIST,DEMO                1234567890                DENTIST

Desired ACTION (Add/Edit/Del/View/Next/Jump/Back/Quit): N// E
Select Provider: DENTIST,DEMO                DENTIST - ATTENDING

Select one of the following:

    A      Attending
    O      Operating
    T      Other
```

```
F      Referring
R      Rendering
P      Purchased Service
S      Supervising

Provider Status: A// ttending
LOCUM TENENS?: NO// ??

Choose from:
  Y      YES
  N      NO
LOCUM TENENS?: NO// YES

~~~~~ PAGE 4 ~~~~~
Patient: DEMO,PATIENT      [HRN:1234]      Claim: 1234567
..... (PROVIDER DATA) .....

              PROVIDER              NPI              DISCIPLINE
              =====              =====              =====
(attn)  DENTIST,DEMO              (Locum)  1234567890  DENTIST

Desired ACTION (Add/Edit/Del/View/Next/Jump/Back/Quit): N//
```

Figure 2-3: Locum tenens field displayed on page 4 for attending providers

Appendix A ADA-2024 Claim Form Sample

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) Request for Predetermination/Preauthorization
 Statement of Actual Services EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M F J 8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 J 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
 Self Spouse Dependent Child Other

19. Reserved For Future Use

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

21. Date of Birth (MM/DD/CCYY) 22. Gender M F J 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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier (ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____
 (Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s) _____
 32. 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 (all dates in MM/DD/CCYY format)

38. Place of Treatment (e.g. 11=office; 22=DIP Hospital) 39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims") 39a. Date Last SRP _____

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) or have been completed.

X Signed (Treating Dentist) _____ Date _____

53a. Locum Tenens Treating Dentist?

54. NPI _____ 55. License Number _____

56. Address, City, State, Zip Code _____ 56a. Provider Specialty Code _____

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

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

57. Phone Number () - _____ 58. Additional Provider ID _____

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 J43024 (Same as ADA Dental Claim Form -- J43124, J43224, J43424, J43024T)

Figure 2-4: ADA-2024 Claim Form Sample

Acronym List

Acronym	Term Meaning
ADA	American Dental Association
COB	Coordination of Benefits
FID	Feature Identification (a number assigned to a change request)
SRP	Scaling and planing (a dental procedure)

Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

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