REVISION DATE: 4/20/2018; 3/23/2018; 10/15/2015; 9/21/2015; 5/27/2014

General Information on the ADA 2012 Claim Form & Claim Submissions

Please read the below section in full, prior to proceeding to the section called *Completing the ADA 2012 Claim Form*.

The following instructions explain how to complete the revised American Dental Association (ADA) 2012 claim form and whether a field is "Required," "Required if applicable," or "Not required."

These instructions are only applicable to filling out a **paper ADA 2012 claim form.**

- Note: The preferred method of claims submission remains the HIPAA-compliant 837D transaction process.

  If a provider is not set up to perform the 837D transaction process, then submission of a claim via the AHCCCS Online Provider Portal is the preferred method of claim submission.

  For information on how to submit claims using the HIPAA-compliant 837D transaction process or the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate implementation guides. Companion documents for 837 transactions are available on the AHCCCS website at **www.azahcccs.gov**. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

Claims cannot be handwritten, as handwriting is considered an alteration of the claim. **Effective June 1st, 2018,** claim forms with handwriting on **any part of the claim form** will be returned to the provider. This includes handwriting in the top margins, sides, and remarks section.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim. However, stamped provider signatures will be accepted in field 53.

The preferred font for claims submission is Lucinda Console and the preferred font size is 10.

When submitting claims via fax it is recommended to fax in the following order: ADA 2012 claim form first, the Explanation of Benefits (EOB) second (if applicable), and any applicable medical documentation third.

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-10) under fields 24-31 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-8 filled out, but lines 9 and 10 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

AHCCCS will only accept the ADA 2012 claim form. Other ADA forms received will be returned to the provider. Timely filing will not begin until a claim is submitted that is compliant.

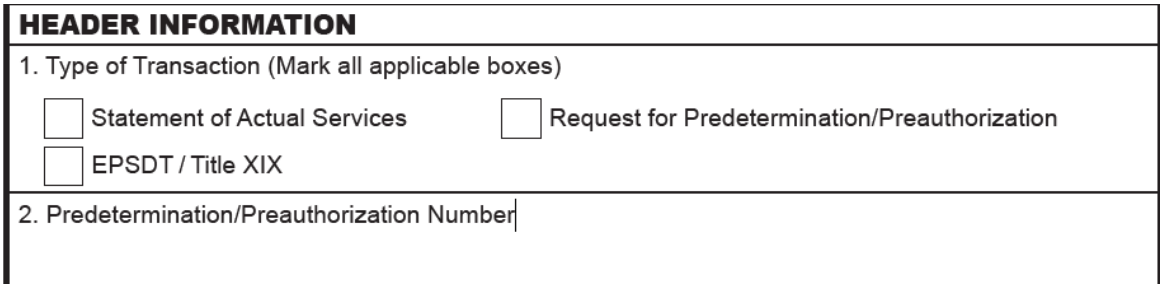
> Note: Effective 8/1/2014, the ADA 2012 claim form became mandatory and the old ADA 2006 claim form was no longer accepted by AHCCCS. There was a grace period between 6/1/2014 and 7/31/2014 where both forms were accepted. Since 8/1/2014 AHCCCS has only accepted the 2012 claim form.

When an applicable dental claim requires a diagnosis code, it must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.

For the purposes of this chapter the term "member" refers to an AHCCCS eligible member.

Completing the ADA 2012 Claim Form

Header Information Section


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

1 Type of Transaction **Required**

Mark an **X** in the Statement of Actual Services box when submitting a claim.

Mark an **X** in the Statement of Actual Services and EPSDT/Title XIX if the claim is for a

member under the age of 21.

If requesting a predetermination or pre-authorization, mark an **X** in the Request for Predetermination/Preauthorization box.

2 Predetermination/Preauthorization Number **Not Required**

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. The preauthorization number is not to be confused with the CRN. The CRN **should not** be entered under Field 2.

This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process.

Insurance Company/Dental Benefit Plan Information Section

Sections 3 – 11 are to be completed when there is other coverage (TPL) for the member.

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

3 Company/Plan Name, Address, City, State, Zip Code **Required if applicable**

This is the address of the primary payer.

Other Coverage Section

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	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		

4 (Other) Dental or Medical Coverage **Required**

Mark the appropriate box to indicate if the member has third party coverage.

5 Name of Policyholder/Subscriber in #4 **Required if applicable**

6 Date of Birth **Required if applicable**

7 Gender **Required if applicable**

8 Policyholder/Subscriber ID (SSN or ID#) **Required if applicable**

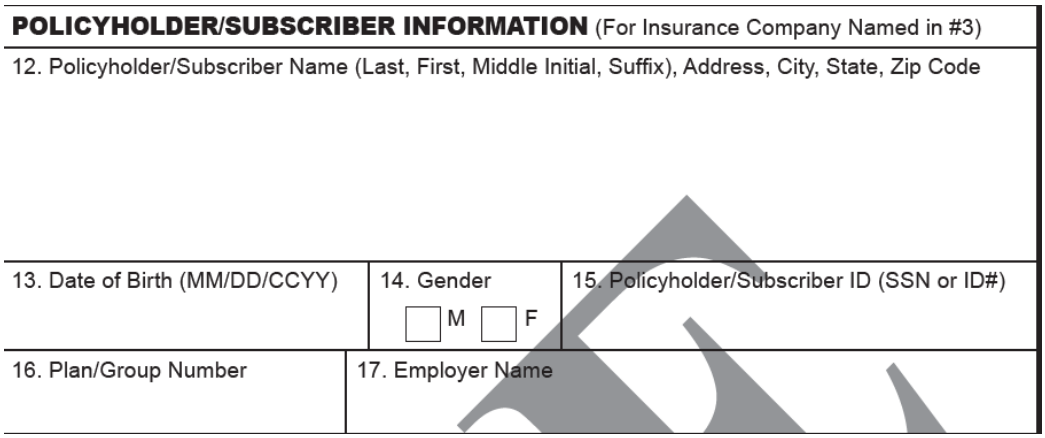
9 Plan/Group Number **Required if applicable**

10 Patient's Relationship to Person named in #5 **Required if applicable**

What is the member's relationship to the primary policyholder?

11 Other Insurance Company/Dental Benefit Plan Name, Address, City State, Zip Code **Required if applicable**

Policyholder/Subscriber Information Section



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	

12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code **Required**

13 Date of Birth (MM/DD/CCYY) **Required**

Enter the member's date of birth in MM/DD/CCYY format

14 Gender **Required if applicable**

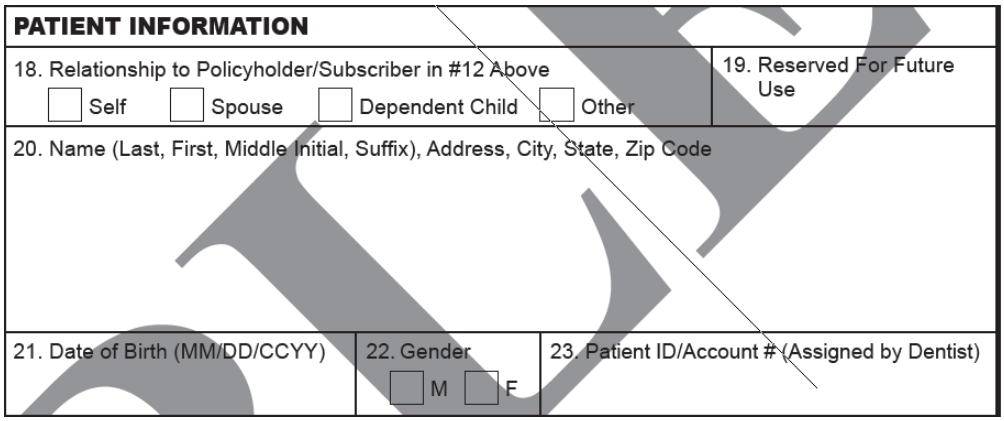
15 Policyholder/Subscriber ID (SSN or ID#) **Required**

Enter the AHCCCS member's 9 digit *AHCCCS ID number (example: A99999999).* Contact the AHCCCS Verification Unit if there are questions about eligibility or the AHCCCS ID number. For additional information please refer to Chapter 2, Eligibility, of the Fee-For-Service Provider Billing Manual.

16 Plan/Group Number **Not required**

17 Employer Name **Not required**

Patient Information Section



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	23. Patient ID/Account # (Assigned by Dentist)

18 **Relationship to Primary Subscriber** in field # 12 **Required**

19 **Reserved for Future Use** **Not Required**

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

21 **Date of Birth (MM/DD/CCYY)** **Required**

22 **Gender** **Required if applicable**

23 **Patient ID/Account Number (Assigned by Dentist)** **Required**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.

Record of Services Provided Section

A NOTE regarding multi-page claims and fields 24-31:

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-10) under fields 24-31 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-8 filled out, but lines 9 and 10 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

24 Procedure Date **Required**

Enter the date of service in MM/DD/CCYY format.

25 Area of Oral Cavity **Not Required**

Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 *Designation System for Teeth and Areas of the Oral Cavity* for codes.

Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as D4263 bone replacement graft-first site in quadrant.

Do not report the applicable area of the oral cavity when the procedure either:

1) Incorporates a specific area of the oral cavity in its nomenclature, such as D5110 complete denture-maxillary; or
2) Does not relate to any portion of the oral cavity, such as D9220 deep sedation/general anesthesia for the first 30 minutes.

26 Tooth System **Required**

Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation system. Enter "JO" when using ANSI/ADA/ISO Specification No. 3950.

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)
1	11/01/2017		JO	01
2	11/01/2017		JO	01
3	11/01/2017		JO	11
4	11/01/2017		JO	03
5	11/1/2017		JO	
6	11/1/2017		JO	
7	11/1/2017		JO	
8	11/1/2017		JO	
9	11/1/2017		JO	
10	11/1/2017		JO	

27 Tooth Number(s) or Letter(s) **Required**

Enter the tooth number when the procedure directly involves a tooth.

If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines of the claim form.

There are 10 lines on the ADA claim form and multiple pages of the ADA 2012 claim form may be used if needed.

When using "JP" (ADA's Universal/National Tooth Designation system) use only 1 letter to indicate the tooth.

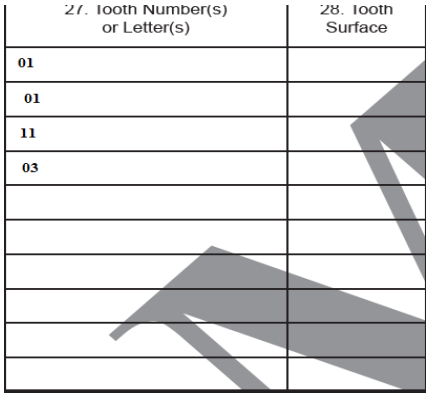
When using "JO" (ANSI/ADA/ISO Specification No. 3950) use **two** digits to indicate the tooth system. If a procedure is done to tooth 1 enter in 01. If a procedure is done to tooth 2, enter 02. Failure to list the tooth number in a two digit format can result in return of the claim to the provider or denial.

28 Tooth Surface **Required**

Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.

The following single letter codes are used to identify surfaces: **B** for buccal; **D** for distal; **F** for facial; **I** for incisal; **L** for lingual; **M** for mesial and **O** for occlusal.

Multiple areas/surfaces of the same tooth can be submitted on the same claim.



27. Tooth Number(s) or Letter(s)	28. Tooth Surface
01	
01	
11	
03	

29 Procedure Code **Required**

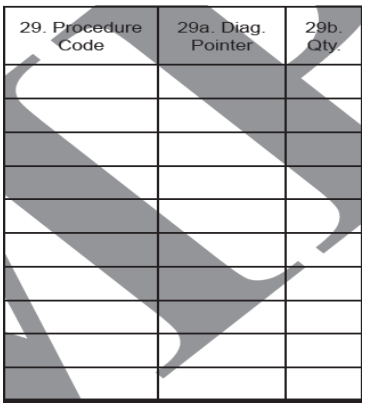
Enter the appropriate procedure code from the *CDT-4 Manual*.

29a Diagnosis Code Pointer **Required if applicable**

Enter the letter(s) from Field 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

29b Quantity **Required**

Enter the number of times (01 – 99) the procedure code in Field 29 is delivered to the patient on the date of service shown in Field 24. The default value is "01".



30 Description **Required if applicable**

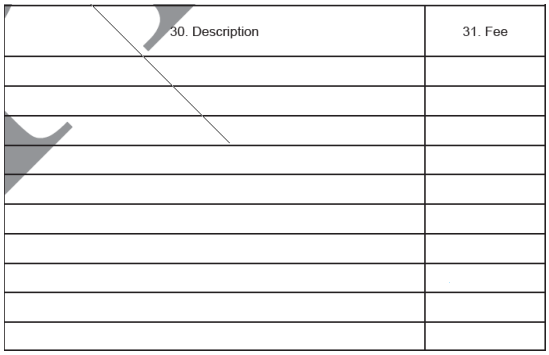
Enter the description of the procedure code billed in Field 29.

31 Fee **Required**

Enter the fee for the procedure code billed in Field 29. This field cannot be left blank, but a 0 can be entered in.

We cannot accept negative numbers in any fees. Claims with negative fees listed will be returned to the provider.

31a. Other Fees **Not required**



32 Total Fee **Required**

Enter the sum of all fees in Field 32.

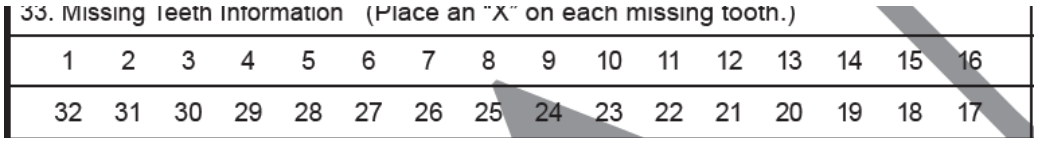
Note: For multi-page claims **do not** enter anything into the Total Fees field (Field 32) on any page other than the **last** page.

For multi-page claims only enter in the total of all fees, from all claim pages on the **last** page of the submitted claim. If a total is entered on each individual page, for a multi-

page claim, then *each* page will be treated as a separate claim, which may result in denial.

33 Missing Teeth **Required**

Place an "X" on each missing tooth.



34 Diagnosis Code List Qualifier **Required**

Enter the qualifier ("B" for the ICD-9; "AB" for the ICD-10) when diagnosis codes are entered in Field 34a.

When an applicable dental claim requires a diagnosis code, it must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.

34a Diagnosis Code(s) **Required if applicable**

Enter up to 4 applicable diagnosis codes after each letter (A – D). The principal diagnosis code is entered in field "A".

Per the ADA 2012 manual, this is "required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions."

34. Diagnosis Code List Qualifier	(ICD-9 = B; ICD-10 = AB)	31a. Other Fee(s)	
34a. Diagnosis Code(s)	A _____ C _____		
(Primary diagnosis in "**A**")	B _____ D _____	32. Total Fee	Leave blank. The total will go on page 2 of the claim.

35 Remarks **Required if applicable**

Any additional information required for the processing of a claim that is not found in another field shall be entered under remarks.

The standard format is as follows (with parentheses removed):
(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Indicator)\(Any other additional information)

Enter the appropriate code ("7" or "8") to indicate whether the claim is a replacement (resubmission/7) of a denied or paid claim, an adjustment of a previously paid or denied claim (7), or a void (8) of a paid claim. Enter the

AHCCCS Claims Reference Number (CRN) for the denied or paid claim that you want to replace.

Claims that are being submitted for the first time (original submissions) will not have any number or CRN entered here.

Any claim that is submitted with **only** a CRN number and no indication of whether it is a replacement or void (with a 7 or 8) will be processed as an **original** claim submission, which can cause the claim to deny as a duplicate.

See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.

If the claim is a replacement of a previously submitted claim or a request to void a claim, has a previous CRN number, or is a claim for emergency dental than the remarks section should *begin* with the following standard format, separated by backslashes:

7 or 8 to indicate if the claim is a replacement or void (enter 7 for a replacement and 8 for a void), followed by the CRN, followed by a Y (to indicate emergency dental) or N (to indicate it was *not* emergency dental).

For example, if a provider was submitting:

- A replacement claim for an emergency dental visit, for a member over 21 years of age, the remarks section would begin with **7\CRN\Y**.
- A request to void a previous claim, that was for a non-emergency dental visit, for a member under 21 years of age, then the remarks section would begin with **8\CRN\N**.
- An original claim for an emergency dental visit, for a member over 21 years of age, would have the remarks section **begin** with **Y**. There would be no number (7 or 8) or CRN since it would be an **original claim.**

No handwriting can be done in the Remarks section. Claims with handwriting will be returned to the provider.

The CRN and the original reference number are the same.

If the provider is an FQHC and the claim is for a professional practitioner it must be indicated here. To indicate this in a manner that will allow the claims system to read it, it must be entered in **after the CRN format described above and separated by a backslash** in the following format (with the parentheses removed):

(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Information in the Standard FQHC Format)

In the remarks section, for FQHC professional claims, the claims processing system is only able to accept *one* provider name at a time. If two providers are providing services to a member at the FQHC, please see Chapter 10, Addendum FQHC/RHC, for additional information. The standard FQHC format is as follows:

- If the provider has a NPI: XXNPIProviderName; *or*
- If the provider does not have a NPI: 999999999ProviderName
  - Example: XX1234567890Smith, Hillary

For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.

Any additional information should be entered in **after** this standard format of (with parentheses removed):
(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC)\(Additional information here)

Examples:

- An FQHC provider is submitting an original claim that is not a dental emergency.
  N\XX1234567890Smith, Andrew

  If this provider had additional information to add after the FQHC indicator, then another backslash would be needed after the provider name.
  N\XX1234567890Smith, Andrew\Additional information here

- An FQHC provider is billing for a replacement claim of a previous submission. It was for a dental emergency
  7\CRN\Y\XX1234567890Smith, Hillary

  If this provider had additional information to add after the FQHC indicator, then another backslash would be needed after the provider name.
  7\CRN\Y\XX1234567890Smith, Stacy\Additional information here

For questions on this field please outreach the provider training e-mail inbox at ProviderTrainingFFS@azahcccs.gov.

35. Remarks

Authorizations Section

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

36 Parent/Guardian Signature and Date **Not required**

If a signature is on file, stating that the signature is on file is acceptable.

37 Subscriber Signature and Date **Required**

If a signature is on file, stating that the signature is on file is acceptable.

Ancillary Claim/Treatment Information

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment ☐ (e.g. 11=office; 22=O/P 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

38 Place of Treatment **Required**

Enter the appropriate 2 digit Place of Service Code for professional claims. Refer to the CPT Manual for a complete listing of Place of Service Codes.

39 Enclosures **Required if applicable**

Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g. radiograph, oral images, or models).

40 Is Treatment for Orthodontics? **Required if applicable**

Mark the appropriate box. If "Yes" is marked, complete Fields 41 and 42. If "No" is marked, skip to 43.

41 Date Appliance Placed **Required if applicable**

42 Months of Treatment **Required if applicable**

Enter the total number of months required to complete the orthodontic treatment.

Note: This is the total number of months from the start of the treatment to the end of the treatment. Some versions of the claim form incorrectly include the word "Remaining" at the end of this data element's name, however the true number of months to be entered in this field is the total from start to finish.

43 Replacement of Prosthesis **Required if applicable**

Mark the appropriate box. If "Yes" is marked, complete Field 44. This item applies to crowns and all fixed or removable prostheses (e.g., bridges and dentures).

44 Date of Prior Placement **Required if applicable**

If "Yes" is checked in Field 43, enter the date of prior placement in MM/DD/CCYY format.

45 Treatment Resulting From **Required if applicable**

Mark the appropriate box, as applicable.

46 Date of Accident **Required if applicable**

Enter the date in MM/DD/CCYY format.

47 Auto Accident State **Required if applicable**

Enter the 2 character abbreviation of the state where the accident occurred.

Billing Dentist or Dental Entity

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	

48 Billing Dentist/Dental Entity Name and Address **Required**

Enter the full name, address, city, state and zip code of the billing dentist or dental entity.

49 NPI **Required**

Enter the NPI of the billing dentist or dental entity.

50 License Number **Required if applicable**

If the billing dentist is an individual, then enter the dentist's license number in this field. If the billing entity (e.g. corporation) is submitting the claim, then this field can be left blank.

51 SSN or TIN **Required**

Enter the Social Security Number (SSN) or Tax ID Number (TIN) of the billing dentist or group entity.

52 Phone Number **Not required**

Enter the business phone number of the billing dentist or group entity.

52a Additional Provider ID **Required if Applicable**

Treating Dentist and Treatment Location Information

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

53 Signature of Treating Dentist **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable. Enter the date on which the claim was signed.

This is an exception to the no handwriting on the claim rule. The signature may be handwritten, but it must be done in black pen.

54 NPI **Required**

Enter the NPI of the treating dentist.

55 License Number **Required**

Enter the license number of the **treating dentist**. This may differ from that of the *billing* dentist or dental entity.

56 Address, City, State, Zip Code (Treating Dentist) **Required**

56a Provider Specialty Code **Required**

Enter the specialty code that indicates the type of dental professional rendering the treatment (e.g., 1223X0400X for Orthodontics, 1223P0221X for Pediatric Dentistry). The general code listed as “Dentist” may be used instead of other dental practitioner codes.

57 Phone Number (Treating Dentist) **Not required**

58 Additional Provider ID **Required if Applicable**

Revision History

Date	Description of changes	Page(s)
4/20/2018	Clarifications added regarding the need to have lines 1-10 filled out (under fields 24-31) in entirety before proceeding to the second page.	2 & 6
3/23/2018	Completing the ADA 2012 Claim Form introduction updated to include information on the 837 D transaction process, the use of labels and stamps on claim forms, handwriting on claims forms, the preferred font and faxing order for claims forms, and the use of ICD-10 codes.	1-2
	Clarified that no handwriting is permitted on claims, effective 6/1/18.	1
	Field 1 – Clarification added.	2
	Field 2 – Clarification added regarding the non-use of the predetermination/preauthorization number.	2-3
	Field 10 – Clarification added.	4
	Field 15 – Clarification added.	5
	Field 25 – The Area of Oral Cavity field was updated with examples.	6
	Field 27 – The Tootle Number or Letter section was updated to clarify the needed formats for claims processing.	6-7
	Field 28 – Clarification added to the Tooth Service section.	7
	Field 31 – Clarification added that the field cannot be left blank.	8
	Field 32 – Clarification added to the to Total Fee field to explain that in multi-page claims only the last page of the claim needs this field filled in.	8-9
	Field 34 – Clarification added.	9
	Field 35 – Remarks field extensively updated to clarify how it is to be used and what format should be used when indicating voids, replacements, original submissions, emergency dental visits, claims associated with a previous CRN, and FQHC professional claims.	9-11
	Field 36 – Clarification added.	12
	Field 37 – Clarification added.	12
	Field 39 – Enclosures description added.	13
	Field 40 – Clarification added.	13
	Field 42 - Description added to clarify that it is the total months of treatment from start to finish and not the number of months remaining.	13
	Field 43 – Examples added to lend further clarity.	13
	Field 49 - The field was updated to reflect that it is a field for the NPI requirement and not for the provider ID.	14
	Field 50 – Clarification added to describe license number field.	14
	Field 52 – Description added to clarify what phone number is needed.	14

	Field 52a – Description added to explain what the additional provider ID is. Field 53 – Clarification added to signature requirement. Field 55 – Clarification added to field 55. Field 56a - Description added to explain what a specialty code is, with examples. Field 58 – Description added to explain what the additional provider ID is. Clarification that only ICD-10 codes will be accepted added. Field names matched to the updated ADA 2012 Claim Form Formatting	14 15 15 15 6 All All All
10/15/2015	Correction for field 35: Required if applicable	4
09/21/2015	"ICD-9" replaced with "ICD" ADA Form *Correction* for field 34a: based on ADA manual, ICD diagnosis codes and related fields are "Required if Applicable"	multiple 4
05/27/2014	New format Update language for new ADA 2012 form	All