

**INSTRUCTIONS FOR COMPLETION OF ADA J430D**

<b>Box/Field Number on Dental Form</b>	<b>Description</b>
1.Type of Transaction	Check Statement of Actual Services
3.Company/Plan Name	County of LA - MHLA Dental P O Box 17908 Los Angeles CA 90017
12. Policy Holder/Subscriber Information	Fill in Participant Name, Address, City, ST and Zip. If homeless, put address of Clinic where services rendered
13.Date of Birth	Date of Birth of Participant
14.Gender	Check either M (Male) or F (Female)
15. Policyholder/Subscriber ID	MHLA ID Number
18. Relationship to Subscriber #12 above	Check Box marked SELF.
20.Name/Address	Should be same information as Box 12.
21. Date of Birth	Should be same information as Box 13.
22. Gender	Should be same information as Box 14.
23. Patient ID/Account #	Internal Account number assigned by Clinic to patient.
Record of Services Provided	Fill in fields 24 through 30 as necessary based on procedure performed.
31. Fee	Clinic's Charges for procedure performed
32. Total Fee	Total charges for all services performed in lines 1 -10.
33. Missing Teeth Information	Fill in as necessary
<b>34. Diagnosis Code List Qualifier</b>	<b>Fill in the Diagnosis Code (ICD10) List Qualifier</b>
<b>34a. Diagnosis Code(s)</b>	<b>Fill in the Diagnosis Codes(s) (ICD10) in boxes A, B, C, &amp; D. Primary Diagnosis in box 'A'</b>
35. Remarks	Put Language, Ethnicity and Homeless Code.
36/37.Authorizations	Signature of Patient or Signature on File
38.Place of Treatment	11 – Office
40/47.Ancillary Claim/Treatment Info	Input as applicable for services performed
48.Billing Dentist/Dental Entity	Input Clinic Name, Address, City, St ZIP.
49.NPI	Include NPI Number of Clinic where services were rendered.
51/58.SSN or TIN	Input TAX ID and Suffix (if assigned by County) for Clinic where services were rendered.
52.Phone Number	Put Phone number of Clinic contact for AIA to use in case there is problem with forms.
53-55.Treating Dentist	Input applicable signature and information regarding dentist who performed the dental procedures at the clinic.
56.Treatment Location – Address	Input the Clinic's Address, City, State and Zip where the services were rendered to the patient.
56a. Provider Specialty Code	Use ADA standard code for this section.

**All Paper Dental Claims should be sent to:**  
**American Insurance Administrators (AIA)**  
**P O Box 17908, Los Angeles, CA 90017-0908**  
**Phone: 800.303.5242 Please ask for the MHLA Program**

**If you have any questions, please email [mhlaclinics@mapinc.com](mailto:mhlaclinics@mapinc.com)**