

# FILING CLAIMS

## DIRECT AND TIMELY BILLING

As a Participating Provider, you have agreed to bill Regence directly for services provided to your patients. You may require payment at the time of service for the deductible, coinsurance, and non covered services.

Claims submitted more than twelve months after the service date will not be paid by Regence and may not be billed to the patient.

### **USE YOUR PROVIDER NUMBER/TAX IDENTIFICATION NUMBER**

In order for your claim to be processed, each claim should include your National Provider Identifier (NPI) and Regence number. If you do not include these numbers, or include the wrong numbers, your claim will be denied. Also include your Tax Identification Number (TIN) or Social Security Number (SSN), whichever is used for income reporting purposes. If you are unsure of your Provide number, check your payment voucher or call Customer Service or your dental relations representative for assistance.

### **OFFICES WITH MULTIPLE DENTISTS**

Please submit claims using the name of the dentist who provided the service, not the name of the dentist who owns the practice. If you are participating with Regence and have associate dentists in your office who are paid as employees, please call us. Your dental relations representative will assist you by setting up appropriate Regence provider file records.

Associates of participating providers who have not previously completed a participating provider application and agreement will need to do so to ensure continuation of direct reimbursement. A separate agreement must also be signed to receive direct reimbursement for each network association.

## CLAIM FORMS AND CODING

All dental providers must submit claims using the current American Dental Association (ADA) standard claim form, unless submitting electronically. The ADA has compiled dental procedure codes into a Current Dental Terminology User Manual (CDT). American Dental Association forms and the manual may be ordered from:

American Dental Association  
Department of Salable Materials  
211 East Chicago Avenue  
Chicago, Illinois 60611  
1 (800) 947-4746

Please clearly label any reports or x-rays with the patient's name and identification number, the date of the x-ray, and the provider's name and address, and attach securely to the claim form.

All Dental claims involving a procedure performed on or contiguous to a tooth must be coded with current, CDT codes in order to be processed correctly. If a member does not have dental coverage, but the service may be payable under their medical coverage, CDT coding is still required.

Note: If a miscellaneous code is used, please include a full narrative description in the remarks section of the claim form. A miscellaneous code is not acceptable if there is a current, valid CDT code assigned to the procedure(s).

If the procedure performed was in an area of the oral cavity not on or contiguous to a tooth (e.g. lesion removal from the roof of the mouth), medical CPT codes must be used.

Medical codes are compiled in the Current Procedural Terminology (CPT) User Manual. This manual may be ordered by calling the American Medical Association at 1-800-621-8335, or online at [www.ama-assn.org](http://www.ama-assn.org).

# ADA Dental Claim Form

## HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

## PRIMARY PAYER INFORMATION

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

## OTHER COVERAGE

4. Other Dental or Medical Coverage?  No (Skip 5-11)  Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender  M  F 8. Subscriber Identifier (SSN or ID#)  
 9. Plan/Group Number 10. Relationship to Primary Subscriber (Check applicable box)  
 Self  Spouse  Dependent  Other

11. Other Carrier Name, Address, City, State, Zip Code

## PRIMARY SUBSCRIBER INFORMATION

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

13. Date of Birth (MM/DD/CCYY) 14. Gender  M  F 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number 17. Employer Name

## PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) 19. Student Status  
 Self  Spouse  Dependent Child  Other  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. <input type="checkbox"/> 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										32. Other Fee(s)	33. Total Fee
	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		

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 (Check applicable box) 39. Number of Enclosures (00 to 99)  
 Provider's Office  Hospital  ECF  Other Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)  
 No (Skip 41-42)  Yes (Complete 41-42)

42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)  
 No  Yes (Complete 44)

45. Treatment Resulting from (Check applicable box)  
 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. Provider ID 50. License Number 51. SSN or TIN

52. Phone Number ( ) -

## 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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X \_\_\_\_\_  
 Signed (Treating Dentist) Date

54. Provider ID 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) - 58. Treating Provider Specialty

General Instructions:

- The form is designed so that the Primary Payer's name and address (Item 3) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the left and right margins. The upper-right blank space is provided for insertion of the third-party payer's claim or control number.
- a) All data elements are required unless noted to the contrary on the face of the form, or in the Data Element Specific Instructions that follow.
  - b) When a name and address field is required, the full entity or individual name, address and zip code must be entered (i.e., Items 3, 11, 12, 20 and 48).
  - c) All dates must include the four-digit year (i.e., Items 6, 13, 21, 24, 36, 37, 41, 44, and 53).
  - d) If the number of procedures being reported exceeds the number of lines available on one claim form the remaining procedures must be listed on a separate, fully completed claim form. Both claim forms are submitted to the third-party payer.

Data Element Specific Instructions

- 1.  **EPSDT / Title XIX** -- Mark box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for  persons under age 21.
- 2.  Enter number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
- 4-11.  Leave blank if no other coverage.
- 8.  The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
- 15.  The subscriber's Social Security Number (SSN) or other identifier (ID#) assigned by the payer.
- 16.  Subscriber's or employer group's Plan or Policy Number. May also be known as the Certificate Number. [Not the subscriber's identification number.]
- 19-23.  Complete only if the patient is **not** the Primary Subscriber. (i.e., "Self" not checked in Item 18)
- 19.  Check "FTS" if patient is a dependent and full-time student; "PTS" if a part-time student. Otherwise, leave blank.
- 23.  Enter if dentist's office assigns a unique number to identify the patient that is **not** the same as the Subscriber Identifier number assigned by the  payer (e.g., Chart #).
- 25.  Designate tooth number or letter when procedure code directly involves a tooth. 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'.
- 26.  Enter applicable ANSI ASC X12 code list qualifier: Use "JP" when designating teeth using the ADA's Universal/National Tooth Designation   System. Use "JO" when using the ANSI/ADA/ISO Specification No. 3950.
- 27.  Designate tooth number when procedure code reported directly involves a tooth. 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.
- 28.  Designate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes,   without spaces: **B** = Buccal; **D** = Distal
- 29.  Use appropriate dental procedure code
- 31.  Dentist's full fee for the dental procedure
- 32.  Used when other fees applicable to the procedure are reported here applicable, and other fees   imposed by regulatory bodies.
- 33.  Total of all fees listed on the claim form
- 34.  Report missing teeth on each claim form
- 35.  Use "Remarks" space for additional information such as 'reports' for '999' codes or multiple supernumerary teeth.
- 36.  **Patient Signature:** The patient is defined as an individual who has established a professional relationship with the dentist for the delivery   of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker,   guardian, or other individual as appropriate under state law and the circumstances of the case.
- 37.  **Subscriber Signature:** Necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization   of payment. It does not create a contractual relationship between the dentist and the payer.
- 38.  ECF is the acronym for **Extended Care Facility** (e.g., nursing home).
- 48-52.  Leave blank if dentist or dental entity is **not** submitting claim on behalf of the patient or insured/subscriber.
- 48.  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.
- 49.  Identifier assigned to Billing Dentist of Dental Entity other than the SSN or TIN. Necessary when assigned by carrier receiving the claim
- 50.  Refers to the license number of the billing dentist. This may differ from that of the treating (rendering) dentist that appears in the treating   dentist's signature block.
- 52.  The Internal Revenue Service requires that either the Social Security Number (SSN) or Tax Identification Number (TIN) of the billing dentist or   dental entity be supplied **only** if the provider accepts payment directly from the third-party payer.
- When the payment is being accepted directly report the: 1) SSN if the billing dentist is unincorporated; 2) Corporation TIN if the billing dentist   is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
- 53.  The treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal   obligations to refund fees for services that are paid in advance but not completed.
- 56.  Full address, including city, state and zip code, where treatment performed by treating (rendering) dentist.
- 58.  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. The current list is posted at: <http://www.wpc-edi.com/codes/codes.asp>. The available taxonomy codes, as of the   first printing of this claim form, follow printed in **boldface**.



- 122300000X Dentist -- A dentist is a person qualified by a   Other dentists practice in one of nine specialty areas recognized by the American   doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.)  Dental Association:
- licensed by the state to practice dentistry, and practicing within  **1223D0001X** Dental Public Health  **1223P0221X** Pediatric Dentistry
- the scope of that license.  **1223E0200X** Endodontics  (Pedodontics)
- Many dentists are general practitioners who handle a wide   **1223P0106X** Oral & Maxillofacial Pathology  **1223P0300X** Periodontics
- variety of dental needs.   **1223D0008X** Oral and Maxillofacial Radiology  **1223P0700X** Prosthodontics
- 1223G0001X** General Practice   **1223S0112X** Oral & Maxillofacial Surgery
- 1223X0400X** Orthodontics

## WHERE TO SEND CLAIMS: OREGON

Submit all paper claims (except for FEP) to the following address:

Regence BlueCross/BlueShield  
P.O. Box 30805  
Salt Lake City UT 84130-0805

Submit all FEP claims to the following address:

Federal Employee Program (FEP)  
P.O. Box 31105  
Salt Lake City UT 84130-0105

Regence Life and Health  
P.O. Box 1071  
Portland OR 97207-1071

MedAdvantage  
P.O. Box 30805  
Salt Lake City, UT 84130

## ELECTRONIC CLAIMS

Electronic claim submission is the preferred method of submitting claims. If you use a personal computer or an electronic billing service, electronic claims submission has many advantages.

- Improved cash flow
- Expedited claims processing
- Reduction in paperwork
- Savings in claim preparation time and postage
- Reduction in potential for human error
- Confirmation of claims received

To find out more information about how your office may submit claims electronically, please call Electronic Data Interchange (EDI) at 1 (800) 713-1693 for:

- General information about billing electronically
- Testing for EDI submission
- Assisting providers with their EDI-related problems
- Questions about EDI reports