BlueCross BlueShield of North Carolina

The Blue Book℠

DENTAL E-MANUAL

Dental e-Manual

A GUIDE for dental care providers

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October 2021

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Dental e-Manual

Nothing in this e-manual is intended or should be understood to modify the requirements, limitations and/or exclusions in the Blue Cross NC member's policy.

Note: In the event of any inconsistency between information contained in this e-manual and the Dental Network Participation Agreement between your dental care practice and Blue Cross and Blue Shield of North Carolina (Blue Cross NC), the terms of such agreement shall govern. Also, please note that Blue Cross NC and other Blue Cross and Blue Shield plans may provide information regarding a member's benefits such as individual status, eligibility and level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, an individual's possession of a Blue Cross NC identification card in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. For the purposes of this e-manual: insured, policyholder, participant, patient, member, enrollee, subscriber and covered person are terms used to refer to a person who is entitled to receive benefits underwritten or administered by Blue Cross NC, however such person may be referred to or described in said policy.

Blue Cross NC may provide notices of updates to the dental e-manual and updates to dental policies and procedures generally by posting them on ***bluecrossnc.com***. More information regarding such electronic notices is set out in the Dental e-Manual.

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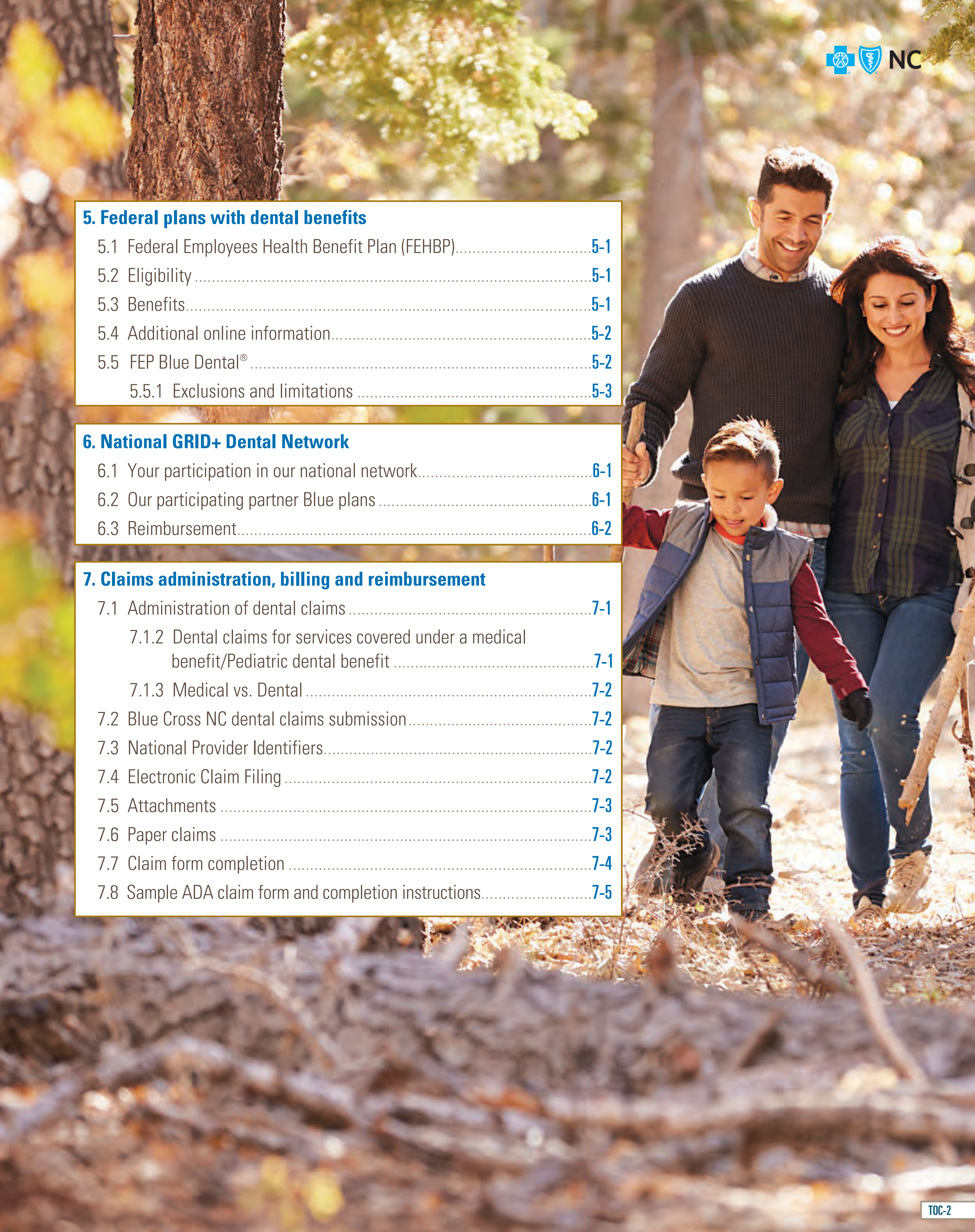

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CHAPTER 1 | Introduction

1.1 About The Blue Book Dental e-Manual

Blue Cross NC is pleased to provide you with The Blue Book Dental e-Manual for dental care providers. This e-manual has been designed to make sure that you and your office staff have the information necessary to effectively administer Blue Cross NC dental products and certain services covered under Blue Cross NC medical products. This e-manual contains information that dental providers need in order to administer Blue Cross NC dental care programs efficiently and understand policies and procedures used in the management of the Blue Cross NC member's dental benefits.

The e-manual is intended as a supplement to the Network Participation Agreement "Agreement" between you the dental provider and Blue Cross NC. The agreement is the primary document controlling the relationship between participating dental providers and Blue Cross NC. Nothing contained in this e-manual is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the agreement. Blue Cross NC policies and procedures will change periodically, and pursuant to the terms of your agreement, dental providers will be deemed to receive electronic notification of such changes when Blue Cross NC posts new or amended policies and procedures in this e-manual or in another applicable section of ***bluecrossnc.com***. The latest news for dental providers in the Blue Cross NC network is available via the Dental Blue® News page at ***bluecrossnc.com/providers/dental-providers/dental-blue-news***.

We thank you for your participation in the Blue Cross NC dental network, as we continue our efforts to help our members improve the quality of their health and dental care.

1.2 The Blue Book Dental e-Manual available online

To access the e-manual online, please visit us on the web at ***bluecrossnc.com/providers/emanuals/dental-blue-book-emanual***. You must have Acrobat Reader on your computer to download the e-manual. If you are unable to download The Blue Book Dental e-Manual and you would like a copy, please contact your Blue Cross NC Provider Network representative.

1.3 Quick Reference Guide

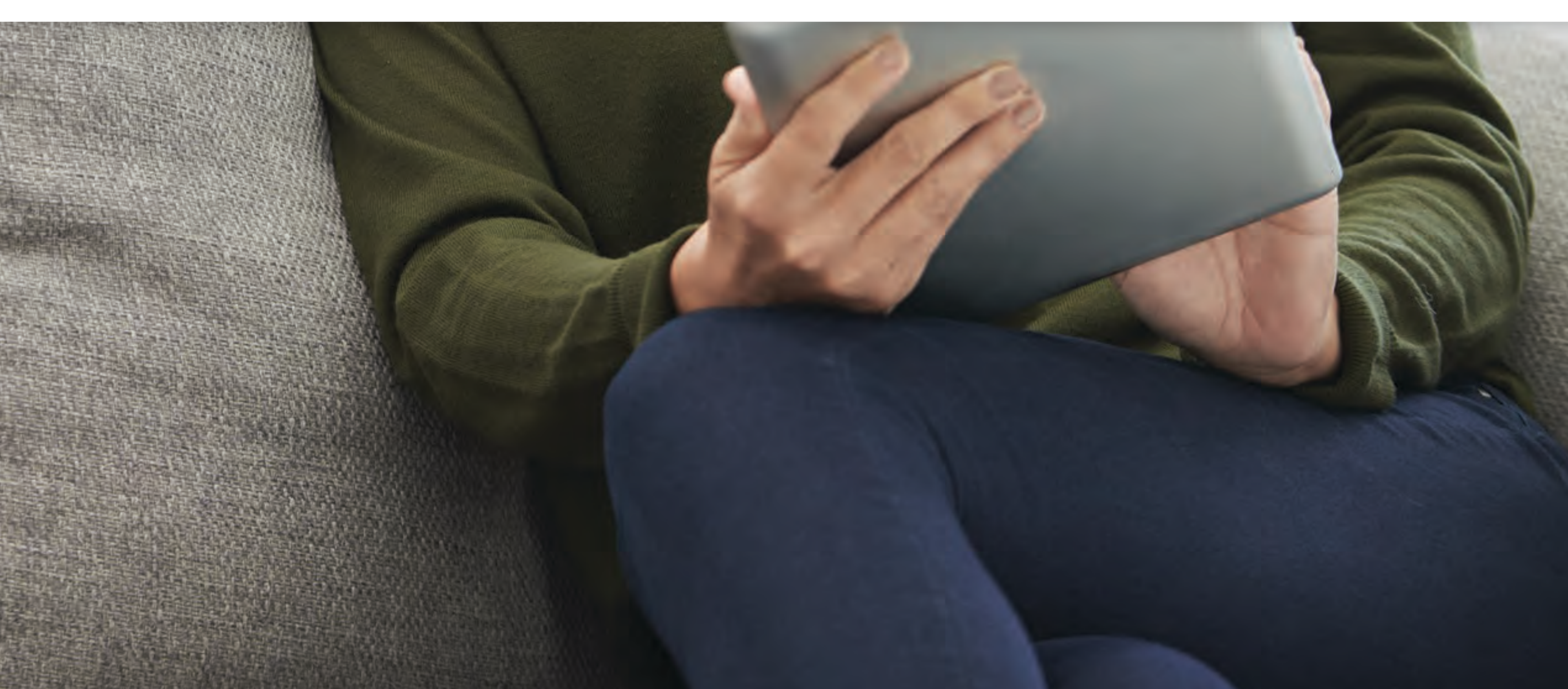
This e-manual is your main source of information for how to partner with us to administer Blue Cross NC dental products. If you cannot find specific information in this e-manual, the following additional resources are available to assist:

- Your Network Participation Agreement.
- Blue Cross NC's dental website (for dental providers) at ***bluecrossnc.com/provider-home#dentalproviders***.
- Blue Cross NC's website for providers (not exclusively dental) at ***bluecrossnc.com/provider-home***.
- Dental Blue News (Blue Cross NC's dental e-news service). Register to receive the latest news at ***bluecrossnc.com/dental-email-registry***. View the latest relevant news for dental providers in articles at ***bluecrossnc.com/providers/dental-providers/dental-blue-news***.
- Blue *e*SM at ***bluee.bcbsnc.com/providers/web/login***.
- For questions on dental policy claims, to verify benefits or membership call Dental Claim Provider Services at **1-800-305-6638**.
- Customer service at **1-800-214-4844**.
- Network Management at **1-800-777-1643, option 6**.

For additional contact information, please reference **Chapter 2** of this e-manual.

Thank you for your participation and for providing dental care to our Blue Cross NC members.

CHAPTER 2 Contact information and general administration

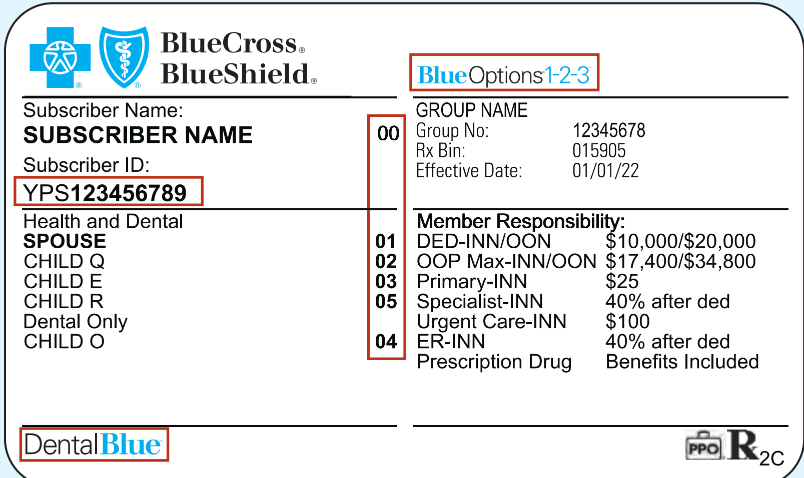


2.1 Contact and general claim information

Patients may arrive at your office and present varying types of Blue Cross NC member identification cards. This section provides examples of ID cards to better help you locate important information about the member, benefits and where to file claims.

Group dental plan

Sample identification card (front)

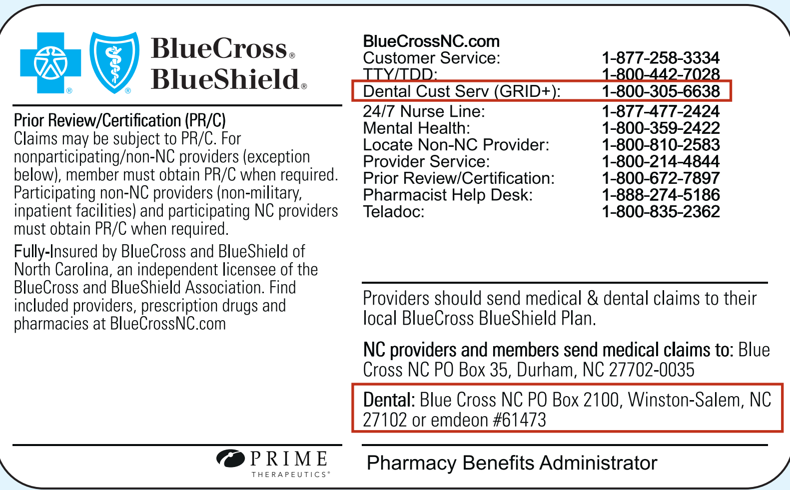


This card is an example of a member's identification card with both medical and dental benefits.

Always file claims for services with the patient's complete identification number, which includes both numbers and letters.

Example – **YPLW15950578 01**

Sample identification card (back)



Customer Service
1-800-305-6638

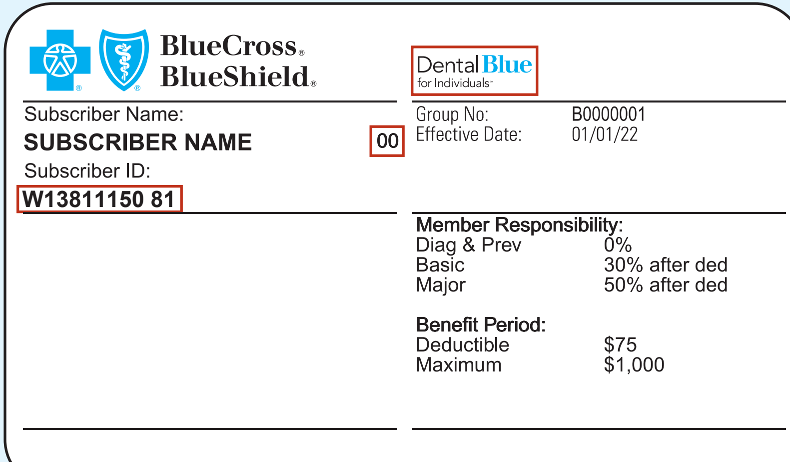
GRID+ logo identifies that a member is participating in the GRID+ dental network (see **Chapter 6** for additional information)

Paper Claims –
Mail to: **Blue Cross NC**
PO Box 2100, Winston-Salem, NC 27102

Electronic Filing
Emdeon Payer #61473

Customer Service 1-800-305-6638	
Claims **Electronically Filing** **Paper Filing**	**Emdeon Payer Number 61473** Mail to: **Blue Cross and Blue Shield of North Carolina** **PO Box 2100, Winston-Salem, NC 27102**
Website	***bluecrossnc.com/provider-home#dentalproviders***

Sample identification card (front)

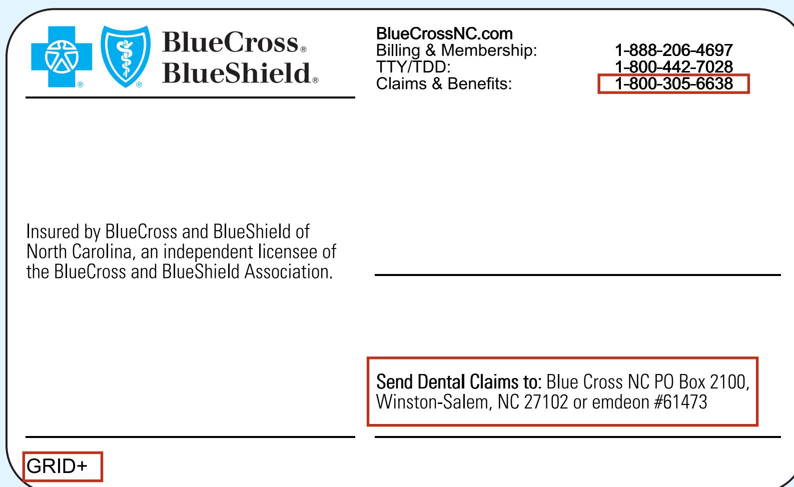


This card is of a Dental Blue for Individuals member's identification card.

Always file claims for services with the patient's complete identification number, which includes both numbers and letters.

Example – **W13811150 81**

Sample identification card (back)



Customer Service
1-800-305-6638

GRID+ logo identifies that a member is participating in the GRID+ dental network (see **Chapter 6** for additional information)

Paper Claims –
Mail to: **Blue Cross NC**
PO Box 2100, Winston-Salem, NC 27102

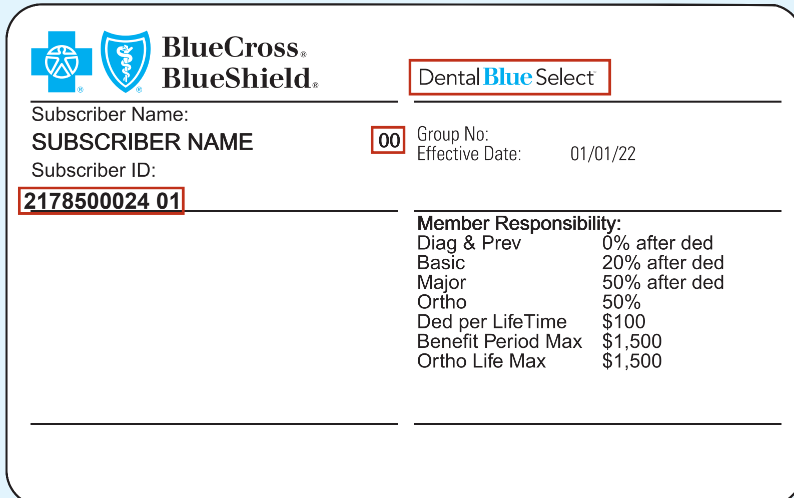
Electronic Filing
Emdeon Payer #61473

Customer Service 1-800-305-6638	
Claims **Electronically Filing** **Paper Filing**	**Emdeon Payer Number 61473** Mail to: **Blue Cross and Blue Shield of North Carolina** **PO Box 2100, Winston-Salem, NC 27102**
Website	***bluecrossnc.com/provider-home#dentalproviders***

Dental Blue Select℠

Group dental plan

Sample identification card (front)

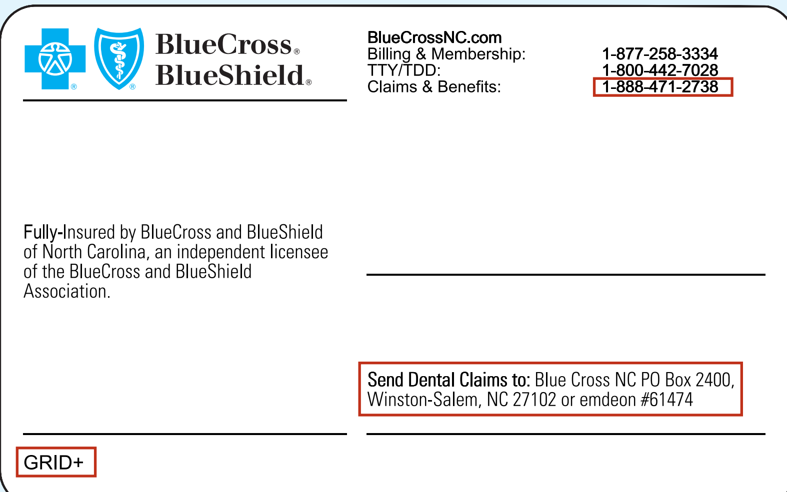


This card is of a Dental Blue Select identification card.

Always file claims for services with the patient's complete identification number, which includes both numbers and letters.

Example – **2178500024 01**

Sample identification card (back)



Customer Service
1-888-471-2738

GRID+ logo identifies that a member is participating in the GRID+ dental network (see **Chapter 6** for additional information)

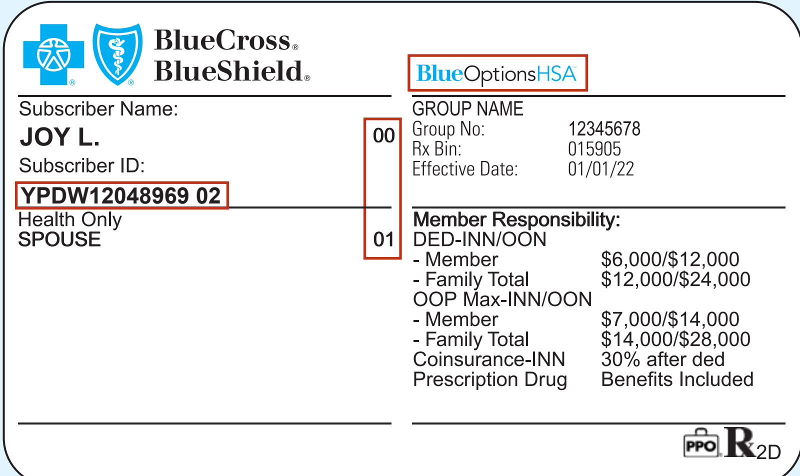
Paper Claims –
Mail to: **Blue Cross NC Claims Unit**
PO Box 2400, Winston-Salem, NC 27102

Electronic Filing
Emdeon Payer #61474

Customer Service 1-888-471-2738	
Claims **Electronically Filing** **Paper Filing**	**Emdeon Payer Number 61474** Mail to: **Blue Cross and Blue Shield of North Carolina** **PO Box 2400, Winston-Salem, NC 27102-2400**
Website	***bluecrossnc.com/provider-home#dentalproviders***

Dental services under Medical/Pediatric Oral Health

Sample identification card (front)

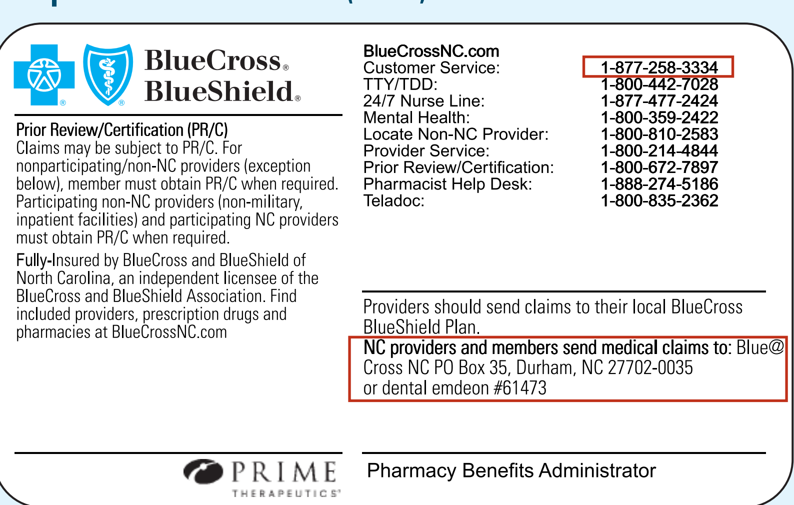


This is a sample ID card for a Blue Options member. Blue Options is one of the many health care products offered by Blue Cross NC.

Always file claims for services with the patient's complete identification number, which includes both numbers and letters.

For filing a claim for **Joy L**, use – **YPDW12048969 02**

Sample identification card (back)



PEDIATRIC DENTAL IS PART OF MEDICAL AND SHOULD BE BILLED TO MEDICAL VERSUS DENTAL USING THE MOST RECENT ADA CLAIM FORM

Customer Service
1-877-258-3334

Paper Claims –
Mail to: **Blue Cross NC**
PO Box 35, Durham, NC
27702-0035

Electronic Filing
Emdeon Payer #61473

Customer Service 1-877-258-3334	
Claims **Electronically Filing** **Paper Filing**	**Emdeon Payer Number 61473** Mail to: **Blue Cross and Blue Shield of North Carolina** **PO Box 35, Durham, NC 27702-0035**
Website	***bluecrossnc.com/provider-home#dentalproviders***

2.2 Eligibility, benefit verification and claim status

Dental providers and their staff can review eligibility and benefits for Blue Cross NC members enrolled in **Dental Blue for Groups, Dental Blue for Individuals**:

- **Website** – ***bluecrossnc.com/provider-home#dentalproviders*** includes the added feature of displaying benefit accumulator amounts, which provides what amounts have been applied to a member's dental deductible and coinsurance during the course of a benefit plan year.
- **IVR/Fax Back** – Blue Cross NC Dental Blue offers a faxback feature for providers seeking Verification of Benefits (VOBs). Providers may contact Blue Cross NC Dental Blue customer service to request VOBs. An unlimited amount of VOBs can be faxed to providers when requesting VOBs prior to rendering dental services. Call **1-800-305-6638** and select the faxback option to request VOBs.
- **Phone** – Providers who contact Dental Blue customer service at **1-800-305-6638** can receive a maximum of three (3) Verification of Benefits (VOB) at a time.

Verification of care eligibility and benefits for members enrolled in **medical policy plans with dental procedures, pediatric dental** and **FEP Dental** can be obtained in one (1) of the following ways:

- **Phone** – Providers may call to verify eligibility and benefits. Call the customer service number on the back of the member's ID card.
- **Provider Portal – Blue *e*** is a secure, internet-based application, for verification of membership and eligibility. Blue Cross NC offers this service free of charge to Blue Cross NC dental providers. Providers can easily register for **Blue *e*** online. **Blue *e*** can be used to find dental claim status for claims submitted for medical policies with the PO Box 35, Durham, NC filing address, listed on the patient's ID card.

Dental providers not currently registered to use **Blue *e*** can register online at ***bluecrossnc.com/provider-home#dentalproviders***. Providers with questions about enrolling as a Blue *e* user or how to use Blue *e* transactions can contact Blue Cross NC's eSolutions HelpDesk at **1-888-333-8594, option 1,** or you can email us at *Bluee.HelpDesk@bcbsnc.com*.

Additionally, to access information for members covered by dental policies (vs. medical policies), providers can access information via the LuminX Information Network portal, ***acsbluewww.ebixhealth.com/lin/faces/LinLogin.jsp***, a portal uniquely for those benefits covered under a Blue Cross NC dental insurance policy. Information includes eligibility, claims and pretreatment estimates.

2.3 Blue Cross NC dental customer service

For Dental Blue Group and Dental Blue Individual, the Blue Cross NC dental service office can be reached toll-free at **1-800-305-6638** during the hours of operation, Monday through Friday from 8:00 a.m. to 6:00 p.m., Eastern Time. Calls received outside these hours are handled by the Blue Cross NC Dental Blue integrated voice response (IVR) system. The IVR allows callers with a touch-tone phone to access benefit plan information via a series of voice prompts. When calling dental customer service, please use the customer service phone number assigned to the patient's dental coverage plan type. Customer service numbers are printed on the back of Blue Cross NC member's identification cards and are additionally located within this chapter.

Stay informed!

Blue Cross and Blue Shield of North Carolina is committed to informing dental providers participating in our dental network about recent dental-related updates, new dental products and programs and other relevant Blue Cross NC news.

Email updates

Join our email registry at *bluecrossnc.com/providers/forms-and-documentation/provider-email-registry* to get the latest dental news from Blue Cross NC delivered right to your inbox.

Dental Blue News

Visit our Dental Blue News page to stay up-to-date with the latest news and information for dental providers.

2.4 Blue Cross NC enhanced web-based services

Blue Cross NC offers web-based services to assist with the many administrative functions associated with arranging patient care and subsequent claim submission and reconciliation. Two provider portals are available depending on whether you are accessing information for benefits under a dental insurance policy or medical policy.

Dental Insurance Policy Provider Portal
acsbluewww.ebixhealth.com/lin/faces/LinLogin.jsp

Standard services include:

- Member eligibility check (dental policies only)
- Member claim history (claim history for dental services covered under a Blue Cross NC dental insurance policy that are provided by your practice to your patients)
- Pretreatment estimates (can be viewed like any other claim)

Website access requires registration. To register please access ***acsbluewww.ebixhealth.com/lin/faces/LinLogin.jsp***. Providers with questions about dental policy web-based services or having trouble should call dental policy customer service at **1-800-305-6638** and ask to speak with Provider Web Services.

Medical Insurance Policy Provider Portal
bluee.bcbsnc.com/providers/web/login

Standard services include:

- Member eligibility check (for both medical and dental policies)
- Copy of member ID card
- Claims information (status for dental services covered under a Blue Cross NC medical insurance policy that are provided by your practice to your patients)
- Prior authorization when required (entry, correction, status & approval)

Website access requires registration. To register, please access Blue *e* at ***bluee.bcbsnc.com/providers/web/login***. Providers with questions about Blue *e*, or having trouble, should call the Blue *e* Helpdesk at **1-888-333-8594, option 1**.

2.5 Electronic Attachments*

For dental services covered under dental policies, dental providers can send electronic attachments through NEA FastAttach™ (National Electronic Attachment Inc.) or Change Healthcare.

*Disclaimer: This applies to dental policies only.

2.6 Blue Cross NC Network Management

Network Management staff can be reached at **1-800-777-1643** and are available to assist your practice with the following:

- Enrollment/contracting with Blue Cross NC
- Questions regarding Blue Cross NC contracts, policies and procedures
- Changes to your organization including:
    - Opening/closing locations
    - Change in name or ownership
    - Change in tax ID number, address or phone
    - number Merging with another group
    - Adding or removing a provider

2.7 Blue Cross NC Network Management contact information

General Inquiries	
Phone **Fax** **Email**	**1-800-777-1643, Option 6** **919-765-4349** ***ProviderUpdates@BCBSNC.com***
Address	**PO Box 2291, Durham, NC 27702-2291**
On the web	***bluecrossnc.com*** ***bcbsnc.com/content/providers/dental-providers/join-network.htm*** ***bcbsnc.com/content/providers/dental/blue-book-dental.htm***

Dental Provider Enrollment	
Phone **Fax** **Email**	**1-800-777-1643, Option 6** **919-765-4349** ***ProviderUpdates@BCBSNC.com***
Address	Attention: **Dental Blue Contracting, PO Box 2291, Durham, NC 27702-2291**
On the web	***bcbsnc.com/content/providers/dental-providers/join-network.htm*** ***bcbsnc.com/content/providers/dental/blue-book-dental.htm***

Network Management staff is available to assist Monday through Friday, 8:00 a.m. to 5:00 p.m. EST.

CHAPTER 3 | Dental provider demographics

3.1 Dental provider demographics

Blue Cross NC maintains an online provider directory listing addresses, phone numbers and current rosters of providers at a participating practice so that our members can quickly locate dental care providers to schedule appointments. Our ability to successfully direct members to you for their dental care depends on the accuracy of the information we have on file for your dental practice. We encourage you to visit the "Find a Dentist" page located on the Blue Cross NC website at ***bluecrossnc.com*** to validate your dental practice business information.

If you find that your dental practice information needs to be updated, please let us know by contacting a Blue Cross NC Network Management representative or complete and return a provider demographic form that can be accessed from the "Dental Providers" tab on our website at ***bluecrossnc.com/provider-home#dentalproviders***. Providers can email the completed form to *ProviderUpdates@bcbsnc.com* or fax to Blue Cross NC at **1-919-287-8884**.

Please note that having accurate mailing information on file for your practice also ensures you receive claims payments and other important correspondence in a timely manner from Blue Cross NC.

Sample of the provider demographic form

Access the form at ***https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/Provider_Update.pdf***.

BlueCross BlueShield of North Carolina

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Demographic Change Form

Complete this form when updating the billing, practice, and contractual notice demographic information for a group or solo provider. Email the completed form to ***Provider.AddressUpdts@bcbsnc.com*** or fax to **919.287.8884**.

Effective Date of Change: ____
This date should not be greater than 60 days from the submission of this form.

Legal Name: ____

Tax Identification Number (TIN): ____

National Provider Identifier (NPI): Individual NPI (Type I) ________________ **Group NPI (Type II)** ________________

Does group accept new Blue Medicare Patients? ◯ **Y** ◯ **N** **Does group accept new Blue Cross NC Patients?** ◯ **Y** ◯ **N**

Required for Blue Medicare
Medicare Provider # ________________________ **CLIA # (if applicable)** ________________________
(Please attach most recent copy)

Billing Address:
Address where provider receives checks, billing information and general correspondence

____

____

Blue Medicare Mailing/Correspondence Address:
Address where provider receives general mail specific to Blue Medicare including but not limited to membership and claims

____

____

FPO

Phone Number: ____

Practice Address is the same as Billing? ◯ **Y** ◯ **N**
If not, please complete below:

Practice Address: ☐ **Additional Satellite Location** ☐ **Replacement Address**
Street address of facility/office where services are rendered

____

____

Appointment Phone Number: ____

Fax Number for Blue Cross NC and/or Blue Medicare Use: ____

If the above address is a replacement address, please advise what address it is replacing:

____

____

Appointment Phone Number: ____

Fax Number for Blue Cross NC and/or Blue Medicare Use: ____

Contractual Notice Address: ☐ **No Change** ☐ **Same as Billing Address** ☐ **Same as Billing Address**
Address where contractual notices and other communications regarding the provider agreement with Blue Cross NC must be sent

____

____

Contractual Notice Recipient: ____
Name of authorized person who may receive contractual notices and other communications regarding the provider agreement with Blue Cross NC

Practice E-Mail Address: ____
Allows us to quickly disseminate important information to provider practices

____ ________________
Signature of Physician, Practice Manager, or Authorized Representative **Date**

The back of this sample form is continued on the following page.

Sample of the provider demographic form

Access the form at ***https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/Provider_Update.pdf***.

General Updates:

Practice Manager/Physician may download this form and e-mail to Blue Cross NC at ***ProviderUpdates@bcbsnc.com*** or fax to Blue Cross NC **919-287-8884**.

Contractual Notice Updates:

Only persons authorized to update or amend your provider agreement with us may update the Notice Contact address, as this is a contractual requirement. Please email contractual notice updates to ***ProviderUpdates@bcbsnc.com*** or fax to Network Management Operations **919-765-4349**.

===

Provider Demographic Form

It is a participating provider's/group's contractual obligation to notify Blue Cross and Blue Shield of North Carolina (Blue Cross NC) of any change in demographic information. It is a participating provider's/group's contractual obligation to notify Blue Cross NC of any change in demographic information, including billing, practice and contractual notice demographic updates. This is critical to ensure Blue Cross NC and Blue Medicare HMO and Blue Medicare PPO members can access care through your practice by displaying the correct demographic information in the Provider Directory.

Blue Medicare Mailing/Correspondence Address

It is imperative that your practice specify where you would like to receive mailings specific to Blue Medicare. Blue Medicare correspondence can include information regarding membership and claim adjustments/requirements; information that may have a great impact on your relationship with our members.

Notice Contact – What is it? **For non-Medicare provider agreements,** the Notice Contact is the name or title and address that you and Blue Cross NC are required to use to send certain notices regarding your provider agreement. This address is the "Notice Contact" listed in your agreement with us. Your Commercial agreement with us must contain a "Notice Contact" provision listing the name or title and address of the person to whom contractual notices and other communications regarding our agreement shall be sent.

Some notices must be sent in writing. Other notices may be sent electronically. See your provider agreement and the provider manual for more details. The "Notice Contact" may be different from your billing address and physical address. It is a participating provider's/group's contractual obligation to notify Blue Cross NC of any change to the Notice Contact.

You may update the Notice Contact identified in your agreement with us by filling out this form and sending it to us. We accept e-mails, faxes, or hard copies. Only persons authorized to update or amend your provider agreement with us may complete this form, as this is a contractual requirement.

The back of this sample form is continued on the following page.

CHAPTER 4 Dental versus medical benefit plans

4.1 Identifying dental versus medical plans

Blue Cross NC offers a variety of dental benefits for individuals and groups, including:

- Dental Blue® for Individuals℠ and Dental Blue for Individuals PPO Preventive plan – consumer driven dental plans for individuals and their eligible dependents.
- Dental Blue® and Dental Blue® Preferred℠ (PPO) for Group – offers employers the freedom to choose a plan to meet the needs of employees, selecting plans from a choice of available benefit options.
- Dental Blue® Select℠ – employers have a choice of Standard, Complete or Enhanced dental plans.
- Dental Blue® for Federal Employees – a Blue Cross NC product offering flexibility and choice, intended to complement the policy offered to federal employees and retirees of the federal government. See Chapter 5, Section 5.6, for additional information about this product.

In addition to the dental benefit plans for groups and individuals, Blue Cross NC medical plans may offer limited dental benefits where applicable. Pediatric Oral Health benefits were also added to certain Blue Cross NC health plans as mandated under the Affordable Care Act. Please reference Section 4.3 of this e-manual for additional information regarding Pediatric Dental services covered under Blue Cross NC medical plans.

4.2 Member identification cards

Blue Cross NC members enrolled with dental coverage receive identification cards from Blue Cross NC that display the name of the subscriber, as well as the names of his or her eligible dependents. Providers are responsible for verifying that members are eligible for benefit coverage at the time services are rendered.

It's important to note that an identification card does not guarantee that a person is currently enrolled in a Blue Cross NC dental plan. Whether from speaking with Blue Cross NC customer service, obtaining member information using Blue *e* or from the website ***bluecrossnc.com/members/dental-blue-members***, information about benefits and eligibility is accurate at the time it's provided.

Coverage and payment decisions pertaining to eligibility are made according to the member's policy and current eligibility information when a claim is received, as of the date services were rendered. Eligibility responses provided by customer service, Blue *e* and/or the website ***bluecrossnc.com/members/dental-blue-members*** do not guarantee coverage, eligibility or payment. Sample member identification card images can be found in **Chapter 2**.

Blue Cross NC **strongly** recommends that a patient's chart be updated with a photocopy of the patient's most current member identification card, each time a patient is seen in your office. The updated copy of the member's card will help ensure that the needed member identifying information is accurately recorded for reporting on the next claim submission.

4.3 Pediatric Dental benefits within medical benefits

Blue Cross NC medical plans offer limited Pediatric Dental benefits where applicable. In 2014, Pediatric Oral Health benefits were added to Blue Cross NC health plans as mandated under the Affordable Care Act (ACA). The ACA mandate made Pediatric Oral Health (Pediatric Dental) **benefits available to children up to age nineteen (19)**. Pediatric Dental benefits are essential health benefits for all Blue Cross NC ACA compliant plans.

Pediatric Dental benefits offer a full range of dental services including preventive, basic, major and medically necessary orthodontia services covered under certain qualified medical plans with Blue Cross NC. Prior approval is required for medically necessary orthodontia.

Members covered under Blue Cross NC medical plans with Pediatric Dental benefits may visit a dental network provider or an out-of-network provider for dental services. If members choose to visit a participating dentist, they will save on their out-of-pocket cost.

A participating dentist rendering dental care to a member with Pediatric Dental benefits must submit claims using the most recent ADA claim form to Blue Cross NC medical plan first for reimbursement. The member's medical plan is considered primary. Once the claim is processed and payment issued, the provider or member may submit a claim to the member's dental carrier for reimbursement. Blue Cross NC's dental plan will always be considered secondary to the member's medical plan for Pediatric Dental services.

4.3.1 Member eligibility, benefits and claim status

Dental providers should always verify a member's eligibility and benefits prior to providing dental care services. To verify eligibility, benefits and claim status for Pediatric Dental services, please call the medical customer service number listed on the back of the member's ID card. Providers may also verify benefits by visiting the Blue *e* website.

Dental providers can identify a member under age nineteen (19) with Pediatric Dental by viewing the back of the member's medical ID card.

Blue Cross and Blue Shield of North Carolina
PO Box 35
Durham, NC 27702-0035

4.4 Benefit exclusions and limitations

Below is a partial list of exclusions/limitations for dental services covered under most medical and/or standalone dental policies. Additionally, the member booklet can be referenced for final determination of exclusions/limitations. Providers are reminded to **always verify a member's benefits and eligibility prior to rendering a service**.

- Services, supplies and drugs that are typically not covered under a member's dental benefit coverage unless written into a policy by an employer group.
- Not clinically necessary.
- Investigational in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment.
- Procedures that are considered to be experimental, including pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
- Drugs or medications, obtainable with or without a prescription unless they are dispensed and utilized in the dental office during the patient visit.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Not prescribed or performed by or upon the direction of a dentist or other provider.
- For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement.
- Received prior to the member's effective date.
- Received on or after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination.
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining dental records and late payment charges.
- Incurred more than eighteen (18) months prior to the member's submission of a claim to Blue Cross NC, except in the absence of legal capacity of the member.
- For any services that would not be necessary if a non-covered service had not been received, except for emergency services in the case of an emergency.
- For benefits that are provided by any governmental unit except as required by law.
- For services that are ordered by a court that are otherwise excluded from benefits under this dental benefit plan.

Continued on the following page.

- For care that the provider cannot legally provide or change or is outside the scope of license or certification.
- Provided and billed by a licensed dental care professional who is in training.
- Available to a member without charge.
- For care given to a member by a provider who is in a member's immediate family.
- For any condition suffered as a result of any act of war or while on active or reserve military duty.
- In excess of the allowed amount.
- For oral orthotic devices, palatal expanders and orthodontics except as specifically covered by a member's dental benefit plan.
- Dental services provided in a hospital, except when a hazardous condition exists at the same time or covered oral surgery services are required at the same time as a result of a bodily injury.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- Hypnosis except when used for control of acute or chronic pain.
- Acupuncture and acupressure.
- Surgery for psychological or emotional reasons.
- Travel, whether or not recommended or prescribed by a doctor or other licensed dental care professional, except as specifically covered by a member's dental benefit plan.
- Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control.
- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators and ramps.
- For services primarily for educational purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, web or computer programs, individual or group instruction and counseling, except as specifically covered by your dental benefit plan.
- For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law.
- For conditions that federal, state or local law requires to be treated in a public facility.

Continued on the following page.

- For vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind.
- Dental procedures performed solely for cosmetic or aesthetic reasons, except when dental procedures are performed in order to restore normal function to minor children with congenital defects and anomalies.
- Dental procedures not directly associated with dental disease.
- Procedures not performed in a dental setting.
- Treatment of malignant or benign neoplasms, cysts or other pathology, except excisional removal.
- Treatment of congenital malformations or hard or soft tissue, including excision. Hard or soft tissue biopsies of neoplasms, cysts or hard or soft tissue growth or unknown cellular makeup are not excluded.
- Replacement of complete or partial dentures, fixed bridgework or crowns within eight (8) years of initial or supplemental placement. This includes retainers, habit appliances and any fixed or removable interceptive orthodontic appliances.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral.
- Expenses for dental procedures begun prior to the member's eligibility with the plan.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct Vertical Dimension or Occlusion (VDO).
- Denture relines for complete or partial conventional dentures are not covered for six (6) months following the insertion of prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures are not covered for six (6) months after insertion of the full or partial denture. After the specified waiting period, relines are covered once every twelve (12) months.
- One hard tissue periodontal surgery and one soft tissue periodontal surgery per surgical area are covered within a three (3) year period. This includes gingivectory, gingivoplasty, gingival curettage (with or without flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
- Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement, are covered once every thirty-six (36) months per quadrant or surgical site.
- Clinical situations that can be effectively treated by a more cost-effective, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.
- Services for incision and drainage if the involved abscessed tooth is removed on the same date of service.
- Full mouth debridement is limited to once every five (5) years.
- Occlusal guards for any purpose other than control of habitual grinding.
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
- Implants (except as specifically covered).
- Orthodontia services (except as specifically covered).
- Any dental services not specifically listed as a covered service.

Note: This is a partial list of exclusions/limitations.

CHAPTER 5 Federal plans with dental benefits

5.1 Federal Employees Health Benefit Plan (FEHBP)

The Blue Cross and Blue Shield Association (BCBSA) contracts with the United States Office of Personnel Management on behalf of the independent Blue Cross and Blue Shield Plans to provide health care coverage (including certain dental services) to federal employees, postal employees and retirees who choose to enroll in one of two service benefits plan options – standard option and basic option.

5.2 Eligibility

Benefits are available to federal employees who have elected coverage, retirees and their surviving spouses, family members, former spouses, federal employee reservists who are on leave and certain members qualifying for temporary continuation of coverage. Please visit the United States Office of Personnel Management website for detailed descriptions about eligibility requirements: *www.opm.gov*.

5.3 Benefits

Verification of benefits can be obtained by calling the customer service number on the back of the member's ID card. Additionally, contact information can be found in **Chapter 2** of this e-manual. Dental providers should always verify a member's benefits and eligibility prior to providing any dental care services.

5.4 Additional online information

The service benefit plan handbook can be accessed on the web at *fepblue.org/benefitplans*.

To learn more about the Federal Employee Program®, dental providers can visit the following websites:

- Blue Cross NC Federal Employee Program: ***bcbsnc.com/content/fep/index.htm***
- Federal Employee Program: *fepbluedental.com*
- U.S. Office of Personnel Management: *www.opm.gov/insure*

5.5 FEP Blue Dental®

Blue Cross NC participates in the Federal Employee Dental and Vision Insurance Program (FEDVIP) offering dental benefits. Blue Cross NC is one of many carriers available to federal employees and retirees. Enrollees of the FEDVIP dental plan have a full range of dental benefits, including preventive, basic, major and orthodontia services. The FEDVIP dental plan, known as Blue Cross Blue Shield FEP Dental, offers a choice of two (2) plan options (high plan and standard plan). Blue Cross Blue Shield FEP Dental is a dental benefit program sanctioned by the federal government for federal employees and retirees. Dental providers should always verify a member's benefits and eligibility prior to providing any dental care services.

Blue Cross Blue Shield FEP Dental	
Customer Service	**1-855-504-BLUE (2583)**
Blue Cross NC FEP Dental	**PO Box 75, Minneapolis, MN 55440-0075**
Website	***fepbluedental.com***

5.5.1 Exclusions and limitations

The exclusions list applies to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care or treatment of a covered condition. Please reference Section 7.35 of this e-manual for important information regarding non-covered services.**

The following services are not covered:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.
- Services and treatment which are experimental or investigational.
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation.
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.
- Services and treatment performed prior to your effective date of coverage.
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated.
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
- Services and treatment resulting from your failure to comply with professionally prescribed treatment.
- Any charges for failure to keep a scheduled appointment.
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD).
- Services or treatment provided as a result of intentionally self-inflicted injury or illness.
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
- Office infection control charges.

- Charges for copies of your records, charts or X-rays, or any costs associated with forwarding/mailing copies of your records, charts or X-rays.
- State or territorial taxes on dental services performed.
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist.
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
- Those which are for specialized procedures and techniques.
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
- Duplicate, provisional and temporary devices, appliances and services.
- Plaque control programs, oral hygiene instruction and dietary instructions.
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
- Gold foil restorations.
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
- Charges by the provider for completing dental forms.
- Adjustment of a denture or bridgework which is made within six (6) months after installation by the same dentist who installed it.
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners.
- Cone Beam Imaging and Cone Beam MRI procedures.
- Sealants for teeth other than permanent molars.
- Precision attachments, personalization, precious metal bases and other specialized techniques.
- Replacement of dentures that have been lost, stolen or misplaced.
- Orthodontic services provided to a member who has not met the twelve (12) month waiting period requirement.

- Repair of damaged orthodontic appliances.
- Replacement of lost or missing appliances.
- Fabrication of athletic mouth guard.
- Internal and external bleaching.
- Nitrous oxide.
- Oral sedation.
- Topical medicament center.
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non-eligible implants.
- When two (2) or more services are submitted and the services are considered part of the same service to one another the plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by FEP Blue Dental.
- When two (2) or more services are submitted on the same day and the services are considered mutually exclusive (when one [1] service contradicts the need for the other service), the plan will pay for the service that represents the final treatment as determined by this plan.
- All out-of-network services listed in **Chapter 5** are subject to the maximum allowable amount as defined by FEP Blue Dental. The member is responsible for all remaining charges that exceed the allowable maximum.

CHAPTER 6 National GRID+ Dental Network

6.1 Your participation in our national network

The National GRID+ Dental Network, administered by the GRID Dental Corporation (GDC)*, is a national dental network and includes many of the nation's Blue plans. In addition, the GRID+ coordinates access to networks wherever local Blue plans do not participate.

6.2 Our participating partner Blue plans

The following applies to dental providers participating with Blue Cross NC dental network.

- Providers participating with the Blue Cross NC dental network are automatically included as a participating provider in the GRID+ network.
- When members of other Blue plans are in North Carolina and searching for a participating dental provider, your practice will appear in the provider directory. This may assist you in growing your practice should those members choose you as their dental provider.
- In order to verify that a member of an out-of-state Blue plan qualifies as a "member" under your agreement, look for a "GRID+" indicator on the member's Blue Cross and/or Blue Shield branded card or on the notification of payment. Claims processing, benefits and customer service for these members will be handled by the out-of-state Blue plan that issued the card to the applicable member. Providers should reference the information on the back of the identification card.

Continued on the following page.

Sample identification card (front)

FIRST_NAME LAST_NAME

I.D. XXXXXXXXX

DENTAL
DEPENDENTS

Employer:
EMPLOYER_NAME

Group Number	000000-0000
Effective Date	00/00/00
Provider	PROVIDER_NAME

Dental Program
COMPLETE

Sample identification card (back)

www.anthem.com/ca/mydental

For GRID+ Customer Service call:
877-567-1804

Present this card at each visit. This card is for identification only and is not a guarantee of benefits, or eligibility. For claims submission purposes, use the subscriber's identification number.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association and provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Forward claims to:
Anthem Dental Claims
P.O. Box 1115
Minneapolis, MN 55440-1115

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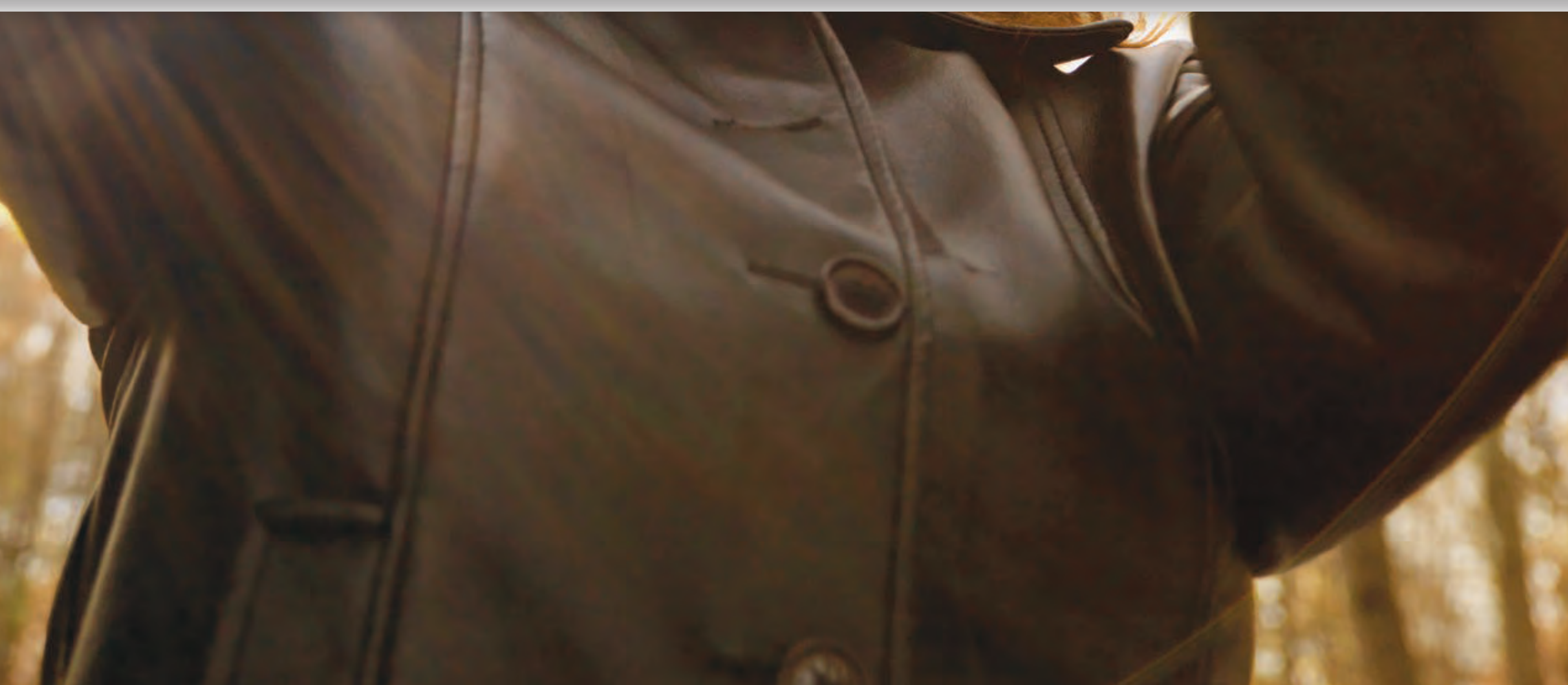
Identifying that a member is participating in the GRID+ Dental Network.

6.3 Reimbursement

As a North Carolina participating provider, regardless of whether the patient is a Blue Cross NC member or a member of another participating plan, the fee schedule contracted under the Blue Cross NC agreement applies unless contracted with a separate Blue plan owned affiliate network.

*GRID Dental Corporation is a separate company that provides access to dental networks and services on behalf of Blue Cross NC.

CHAPTER 7 | Claims administration, billing and reimbursement



7.1 Administration of dental claims

With the implementation of the ACA mandated Pediatric Dental benefits, the processing of dental claims has become more complex. The following is a general guideline for dental claims processing:

- Dental services such as preventive, basic or major care are typically covered under a member's dental benefit. Blue Cross NC utilizes the services of ACS Benefit Services, Inc. for the administration of claims for services covered under a member's supplemental dental policy.
- Services such as Pediatric Dental services, medically necessary orthodontia or medically necessary dental reconstructive services are typically covered under the member's Blue Cross NC medical benefit. Blue Cross NC administers benefits for dental services covered under a member's medical plan.
- Dental services covered under the Federal Employee Benefit Health Plan are handled through Blue Cross NC.

Note: Claims administration for the Federal Employee Program is handled through Blue Cross NC for both dental and medical services.

7.1.2 Dental claims for services covered under a medical benefit/ Pediatric Dental benefit

Effective January 1, 2014, dental provider contracts apply to medical services. Blue Cross NC, under our health benefit plans, provides benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

- Accidental injury of the sound teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- Congenital deformity, including cleft lip and cleft palate
- Removal of tumors, cysts which are not related to teeth or associate dental procedures
- Excision of tumors, cysts or exostosis for reasons other than for preparation for dentures

In addition, ACA mandated "Pediatric Dental benefits" such as diagnostic and preventive, basic, major and medically necessary orthodontia are covered under the medical plan for certain members. If the patient does not have a Blue Cross NC medical benefit plan, submit Pediatric Dental electronic claims to Emdeon payer #61473.

Blue Cross NC administers these benefits through our advanced claims payment system. Blue Cross NC rules and guidelines will supersede this e-manual. Providers are encouraged to access the Blue Cross NC website ***bluecrossnc.com*** to obtain copies of the procedures, policies and guidelines.

7.1.3 Medical vs. dental

The table below provides further clarification regarding dental services covered under a member's Blue Cross NC supplemental dental policy and dental services covered under a member's Blue Cross NC medical policy.

Dental	Medical	Pediatric Dental
Dental procedures must be submitted using the most recent ADA dental claim form.	Medical procedures should be submitted using an ADA claim form.	Providers can submit an ADA claim form or HCFA-1500 medical claim form.
Contact the customer service number on the back of the member's dental ID card for questions relating to dental benefits.	Contact the customer service number on the back of the member's medical ID card for questions relating to medical benefits.	Contact the customer service number on the back of the ID card for medical benefits.

Important Note: Providers should always verify a member's individual benefits and coverage prior to rendering any dental service. The presentation of Blue Cross NC identification cards should not serve as a method for verifying a member's status or eligibility to receive dental benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

7.2 Blue Cross NC dental claims submission

Blue Cross NC accepts dental claims in the following formats: EDI (electronic data interchange) submissions via the Emdeon clearinghouse and paper claims.

Emdeon is the preferred and most efficient method.

An interactive paper claim form is available online. Using the ***bcbsnc-dental.com*** site, register and log in as a provider. (Refer to **Chapter 2** for instructions on registration.) You will then have access to the appropriate dental claim form for each of the dental products which include the correct mailing address.

7.3 National Provider Identifiers

Blue Cross NC requires that all electronically transmitted claims include billing and rendering NPI (national provider identifier) numbers. Providers with a group NPI should list the group NPI in box 49 of the claim form and the individual NPI in box 54 (rendering provider). The individual NPI will apply to box 49 and 54 for solo providers.

7.4 Electronic Claim Filing

Dental providers are encouraged to submit their claims via Emdeon. Claims are received by Blue Cross NC through separate Emdeon payer numbers that identify product lines. Submitting claims using an incorrect payer ID number will delay processing. Always refer to the member's Blue Cross NC ID card to properly identify the correct plan and the correct Emdeon payer ID number:

- 61472 – Federal employees/Pediatric Oral Health/medical-dental claims
- 61473 – Blue Cross NC Dental Blue for Group/Individual and Dental Blue for federal employees
- 61474 – Blue Cross NC Dental Blue Select

7.5 Attachments

The chart below shows methods for how to file claims that require attachments.

Dental Claims Attachment Options		
Dental Plans	**Summary**	**Details**
Paper Claim Filing	Submit attachments/medical records as a paper claim to the Dental Plan mailing address shown on the back of the member ID card.	Digital X-rays, narratives, periodontal chartings and chart notes should be submitted via paper along with the claim.
Electronic Claim Filing	Options include NEA/Fast Attach or Change Healthcare.	
Medical Plans	**Summary**	**Details**
Paper Claim Filing	Submit attachments/medical records as a paper claim to the Dental Plan mailing address shown on the back of the member ID card.	Digital X-rays, narratives, periodontal chartings and chart notes should be submitted via paper along with the claim.
Electronic Claim Filing	N/A	We do not have electronical file attachment options as this time. Please follow the paper claim filing option described above.

Please note that costs and/or fees can be associated with the use of FastAttach and/or the FastLook systems. Dental providers enrolling for use of any vendor-offered applications assume all associated expenses. See **Chapter 11** for specific details.

7.6 Paper claims

Claims for dental services must be submitted on the most current version of the American Dental Association (ADA) claim form. ADA claim forms may be purchased from a vendor or directly from the ADA by calling **1-800-947-4746** or visiting ADA on the web at *www.ada.org*. Additionally, dental providers may download copies of the current pre-addressed and approved ADA forms from ***bluecrossnc.com/provider-home#dentalproviders***.

7.7 Claim form completion

Dental claim forms must be submitted with all required fields complete, using acceptable data and coding sets needed to complete processing of a claim (please note that additional information may be requested). Claim submissions should report all rendered services and include procedure codes from the most current ADA Current Dental Terminology (CDT) user's manual.

All participating dental providers must submit claims within one hundred and eighty (180) days from the date of completion of the dental treatment. Below is a summary (not all-inclusive) of what's needed to comply with claims submission requirements:

- Use of the most current version of the American Dental Association (ADA) claim form is required. Complete by following the ADA claim form instructions.
- Essential data elements must be completed (essential data elements include, but are not limited to, place of service codes and procedure codes).
- Claims must be completed using the ADA standard code set. Claims missing an essential data element or listing inappropriate code sets, or are otherwise illegible, will be returned.
- Include necessary supporting documentation (i.e., X-rays and dental provider notes).
- Claim forms must include the member's name and ID number (including alpha prefix and suffix) and patient's date of birth.
- The dental provider's identifying information and the location where service was provided must be clearly identified on the claim form.
- A date of service must be provided on the claim form for each service line submitted.
- Each separate (individual calendar date) of service must be submitted as a single claim. Individual claims may not span dates of service with the exception of certain orthodontia services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, and fillings). Failure to provide tooth and surface identification codes can result in the delay or denial of claims payment.

7.8 Sample ADA claim form and completion instructions

Visit the American Dental Association website at: *ada.org/en/publications/cdt/ada-dental-claim-form* for comprehensive completion instructions for the ADA claim form.

ADA American Dental Association® **Dental Claim Form**

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

DENTAL BENEFIT PLAN INFORMATION

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

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 ☐U | 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

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 ☐U | 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 ☐U | 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) (Primary diagnosis in "**A**") A ______ B ______ C ______ 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

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

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

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

SAMPLE

©2019 American Dental Association
J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

The back of this sample form is continued on the following page

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35).

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information 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. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

SAMPLE

7.9 Claim form – common errors

Always remember to verify member's current eligibility and benefits prior to providing any dental services.

1

Box 3	Company/Plan Name, Address, City, State and Zip Code:	This box is always completed. Enter the information for the insurance company or dental benefit plan. If the patient is covered by more than one plan, enter the primary insurance company information here for the initial claim submission. • If the patient is covered by more than one plan, enter the primary insurance company information here for the initial claim submission. • When submitting a separate claim to the secondary carrier, place the secondary carrier's company/plan name and address information here.

Dental Blue for GROUPS and INDIVIDUALS

Blue Cross and Blue Shield of North Carolina
Dental Blue Claims Unit
PO Box 2100
Winston-Salem, NC 27102-2400

Dental Blue SELECT:

Blue Cross and Blue Shield of North Carolina
Dental Blue Select Claims Unit
PO Box 2400
Winston-Salem, NC 27102-2400

Federal Employee Health Benefit Plan (medical coverage including limited dental benefits) or Pediatric Dental or Dental Services under Medical

Blue Cross and Blue Shield of North Carolina
PO Box 35
Durham, NC 27702-0035

FEP Blue Dental®

FEP Blue Dental Claims
PO Box 75
Minneapolis, MN 55440-0075

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Box 4	Other Dental or Medical Coverage?	Mark the box after "Dental?" or "Medical?" whenever a patient has coverage under any other dental or medical plan, without regard to whether the dentist or the patient will be submitting a claim to collect benefits under the other coverage. • Leave blank when the dentist is not aware of any other coverage(s). • When either box is marked, complete Items 5 through 11 in the "Other Coverage" section for the applicable benefit plan. • If both Dental and Medical are marked, enter information about the dental benefit plan in Items 5 through 11.
Box 5	Name of Policyholder/ Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix):	If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.

Box 6	Date of Birth (MM/DD/CCYY):	Enter the date of birth of the person listed in Box #5. The date must be entered with 2 digits each for the month and day, and 4 digits for the year of birth.
Box 7	Gender:	Mark the gender of the person who is listed in Box #5. Mark "M" for Male, "F" for Female or "U" for Unknown as applicable.
Box 8	Policyholder/ Subscriber Identifier (SSN or ID#):	Enter the social security number or the identifier number of the person who is listed in Box #5. The identifier number is a number assigned by the payer/insurance company to this individual.
Box 9	Plan/Group Number:	Enter the group plan or policy number of the person identified in Box #5.
Box 10	Patient's Relationship to Person Named in Box #5:	Mark the patient's relationship to the other insured named in Box #5.
Box 11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code:	Enter the complete information of the additional payer, benefit plan or entity for the insured named in Box #5.

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Box 12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:	Enter the complete name, address and ZIP Code of the policyholder/ subscriber with coverage from the company/plan named in Box #3.
Box 13	Date of Birth (MM/DD/CCYY):	A total of 8 digits are required in this field: 2 for the month, 2 for the day of the month, and 4 for the year.
Box 14	Gender:	This applies to the primary insured, which may or may not be the patient. Mark "M" for Male, "F" for Female or "U" for Unknown.
Box 15	Policyholder/Subscriber Identifier (SSN or ID#):	Enter the unique identifying number assigned to the person named in Box #12, EXCEPT when the patient is a spouse, dependent child or other. In this case you will enter the prefix (letters), numbers including the last 2 digits of the spouse, dependent child or other: • For example: ***YPLW11595057801-01 (dependent child or spouse) YPLW11595057801-02 (another dependent child).*** This information is on their identification card.
Box 16	Plan/Group Number:	Enter the policyholder/subscriber's group plan/policy number.
Box 17	Employer Name:	If applicable, enter the name of the policyholder/subscriber's employer.

Continued on the following page.

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Box	Field	Instructions
Box 18	Relationship to Policyholder/Subscriber in #12 Above:	Mark the relationship of the patient to the person identified in Box #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. **If the patient is also the primary insured, mark the box titled "Self" and skip to Box #23.**
Box 19	Reserved for Future Use:	Leave blank and skip to Box #20. (Box #19 was previously used to report "Student Status.")
Box 20	Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:	Enter the complete name, address and ZIP Code of the patient.
Box 21	Date of Birth (MM/DD/CCYY):	A total of 8 digits are required in this field: 2 for the month, 2 for the day of the month, and 4 for the year of birth of the patient.
Box 22	Gender:	This applies to the patient. Mark "M" for Male, "F" for Female or "U" for Unknown.
Box 23	Patient ID/Account #:	Enter if the dentist's office has assigned a number to identify the patient.

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Box	Field	Instructions
Box 39	Enclosures? (Y or N):	Enter a **"Y"** or **"N"** to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models)
Box 40	Is Treatment for Orthodontics?	**If no, skip to Box #43.** If yes, answer Boxes 41 and 42.
Box 41	Date Appliance Placed (MM/DD/CCYY):	Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.
Box 42	Months of Treatment:	Enter the total number of months required to complete the orthodontic treatment. (Note: This is the total number of months from the beginning to the end of the treatment plan. Some versions of the paper claim form incorrectly include the word "Remaining" at the end of this data element's name).
Box 43	Replacement of Prosthesis?	This box applies to crowns and all fixed removable prostheses (e.g., bridges and dentures). Please review the following three situations in order to determine how to complete this item. **a** If the claim does not involve a prosthetic restoration mark "NO" and proceed to Box 45. **b** If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, mark "NO" and proceed to Box 45. **c** If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark the "YES" field and complete Box 44.

Continued on the following page.

Box 44	Date of Prior Placement (MM/DD/CCYY):	Complete if the answer to Box #43 was "YES".
Box 45	Treatment Resulting From:	If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box in this item, and proceed to Boxes #46 and #47. **If the services you are providing are not the result of an accident, this Box does not apply; skip to Box #48.**
Box 46	Date of Accident (MM/DD/CCYY):	Enter the date on which the accident noted in Box #45 occurred. Otherwise, leave blank.
Box 47	Auto Accident State:	Enter the state in which the accident noted in Box #45 occurred. Otherwise, leave blank.

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	The "Billing Dentist" or "Dental Entity" section provides information on the individual dentist's name, the name of the practitioner providing care within the scope of their state licensure, or the name of the group practice/corporation that is responsible for billing and other pertinent information. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist.

Box 48	Name, Address, City, State, ZIP Code:	Enter the name and complete address of a dentist or the dental entity (corporation, group, etc.).

Box 49	NPI (National Provider Identifier):	Enter the appropriate NPI type for the billing entity. A Type 2 NPI is entered when the claim is being submitted by an incorporated individual, group practice or similar legally recognized entity. Unincorporated practices may enter the individual practitioners Type 1 NPI.

***NOTE:* The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer, or applicable state law/regulation.**

An NPI is unique to an individual dentist or dental entity and has no intrinsic meaning. There are 2 types of NPIs available to dentists and dental practices:

- **Type 1 Individual Provider – All individual dentists are eligible to apply for Type 1 NPIs, regardless of whether they are covered by HIPAA.**
- **Type 2 Organization Provider – A health care provider that is an organization, such as a group practice or corporation. Individual dentists who are incorporated may enumerate as Type 2 providers, in addition to being enumerated as a Type 1. All incorporated dental practices and group practices are eligible for enumeration as Type 2 providers.**

Continued on the following page.

#	Box	Field	Description
8	**Box 53**	Certification:	**Signature of the treating or rendering dentist** and the date the form is signed. This is the dentist who performed, or is in the process of performing, procedures, indicated by date, for the patient. If the claim form is being used to obtain a pre-estimate or pre-authorization, it is not necessary for the dentist to sign the form. ***Claim forms prepared by the dentist's practice management software may insert the treating dentist's printed name in this item.***
9	**Box 54**	NPI (National Provider Identifier):	Enter the treating dentist's Type 1 – Individual Provider NPI in Box # 54. (See Box #49 for more NPI information.)

ADA American Dental Association® Dental Claim Form

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

DENTAL BENEFIT PLAN INFORMATION (1)

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

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.) (2)

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 ☐U | 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

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3) (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 ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION (4)

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 ☐U | 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) (Primary diagnosis in "**A**") A ________ B ________ C ________ 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 (5)

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

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.) (6)

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

49. NPI (7) | 50. License Number | 51. SSN or TIN

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION (8)

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 (9) | 55. License Number

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

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

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SAMPLE

7.10 Required identifying information

- Member's name, Blue Cross NC identification number (including alpha prefix and suffix) and date of birth must be listed on all claims submitted. If the member's identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting provider's office, causing a delay in payment. The member's ID is located on the member's Blue Cross NC identification card. (Do not use "nick names" when submitting claims.)
- **The rendering and billing office must be clearly identified on the claim.** Please include a dentist (practice) name, NPI and tax identification number for both the rendering provider and the billing entity. The provider name, tax ID and billing address must match the provider's contract with Blue Cross NC.
  Note: Providers with a Group NPI number should list the Group NPI number in field forty-nine (49) and the individual NPI number in box fifty-four (54) (rendering provider). The individual NPI will apply to box forty-nine (49) and fifty-four (54) for solo providers.
- The date of service must be provided on the claim form for each service line submitted.
- Use approved ADA dental codes as published in the current CDT book.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Failure to provide tooth and surface identification codes can result in the delay or denial of claim payment.

7.11 Documentation, treatment plans, charting and X-rays

Please send only copies of X-rays or readable images. X-rays will not be returned.

Options for dental providers to submit electronic attachments to our dental plans include:

- FastAttach
- Change Health Care

7.12 Timely filing of claims

To be eligible for payment, claims must be received no later than one hundred and eighty (180) days from the date of service. Participating dental providers may not collect, or attempt to collect payment from Blue Cross NC members for any claim that was not submitted within the one hundred and eighty (180) day time period.

7.13 Dental coding terminology, dental procedures and nomenclature

Dental providers should report services using codes found in the most current edition of the Current Dental Terminology (CDT) manual. The CDT manual is published by the American Dental Association (ADA) for reporting services for treatment. The existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract. The CDT manual can be purchased directly from the ADA by calling 1-800-947-4746 or by accessing their website at *www.ada.org*.

7.13.1 Deletion and addition of ADA codes

Once the ADA deletes codes, we will no longer accept the codes as of the effective date of the deletion. Submitted claims will be rejected or returned to the provider's office. All new ADA codes added will be considered at 80% of charge until adequate data is obtained for fair pricing.

7.14 Dental claims processing

In an effort to process claims accurately and consistently, our claims processing administrator has developed processing standards that represent current community standards of dental care and are derived through consultation with dental practices, academic communities and current scientific literature. These standards are supported by system edits designed to adjudicate claims efficiently and accurately based on the member's contract. These edits use the most cost-effective, clinically appropriate claim reimbursement, based on clinical standards and contractual limitations.

7.15 Follow-up care

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member's condition. Treatment rendered for the following is not eligible for benefits:

- Cosmetic reasons
- Member convenience
- Services not meeting standards of care

Additionally, the following limitations and exclusions apply for post-operative visits for periodontal and oral surgery:

Description	Limitations and Exclusions
Oral evaluations	No coverage if evidence that a post-op for periodontal or oral surgery is being billed as an oral evaluation
Office visit for observation	No coverage if evidence that a post-op for periodontal or oral surgery is being billed as an oral evaluation

Note: This list, while meant to be comprehensive, may not list every procedure.

7.16 General criteria

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member's condition. Treatment rendered for cosmetic reasons, member convenience or services that do not meet standards of care are not eligible for benefits.

7.17 Accident related dental services

Oral surgery services that are not covered under the dental plan can be submitted to the member's medical plan using a CMS-1500 claim form.

7.18 Anesthesia under medical benefits

The administration of local anesthesia or for anesthesia administered by the operating surgeon, surgical assistant or dentist is considered incidental to the surgical or dental procedure. This includes sedation given during a procedure or surgery. Separate reimbursement is not provided for incidental services. Anesthesia may be considered medically necessary for the safe and effective administration of dental procedures when the following apply:

- For children below the age of 9
- Persons with serious mental or physical conditions
- Persons with significant behavioral problems
- Under the ACA dental plans, sedation is covered as a separate benefit for ACA pediatric dental plans only when billed with specific periodontal service codes D4200-D4276 or specific oral surgery codes D7220-D7999.

See medical policy titled Anesthesia Services at ***bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy***.

7.19 Dental-medical claims CPT/HCPCS

Claims for "dental-medical" (dental related services that fall under a patient's medical benefit), such as cyst and tumor removal, excision of lesions, biopsies and/or TMJ services, should be filed to Blue Cross NC (or the patient's medical benefit carrier) using the most current version of the CMS-1500 claim form. Essential data elements must be completed.

Essential data elements include, but are not limited to, place of service codes and procedure codes (including modifiers if applicable). Claims must be completed using CPT and/or HCPCS standard code sets. Claims missing an essential data element or that use an inappropriate code or are otherwise illegible will be returned.

Blue Cross NC accepts medical service claims when filed using the CMS-1500 paper claim form and when filed electronically. If sending a paper claim form to Blue Cross NC, please submit to the medical claims address listed on the member's Blue Cross NC identification card. Providers electing to transmit claims electronically for medical services can obtain resources and required forms on the Blue Cross NC electronic solutions website located at ***bluecrossnc.com/ providers/providers-forms-and-documentation***.

Please note that all electronic senders of claims for medical services will need to sign and submit a Blue Cross NC trading partner agreement and an electronic connectivity request form or a **Blue *e*** SM interactive network agreement available from the Blue Cross NC website located at *https://acsbluewww.ebixhealth.com/lin/faces/LinLogin.jsp*.

If you are signed up for **Blue *e*** and need to add users to your account, visit us at ***bluecrossnc.com/providers/ providers-forms-and-documentation***.

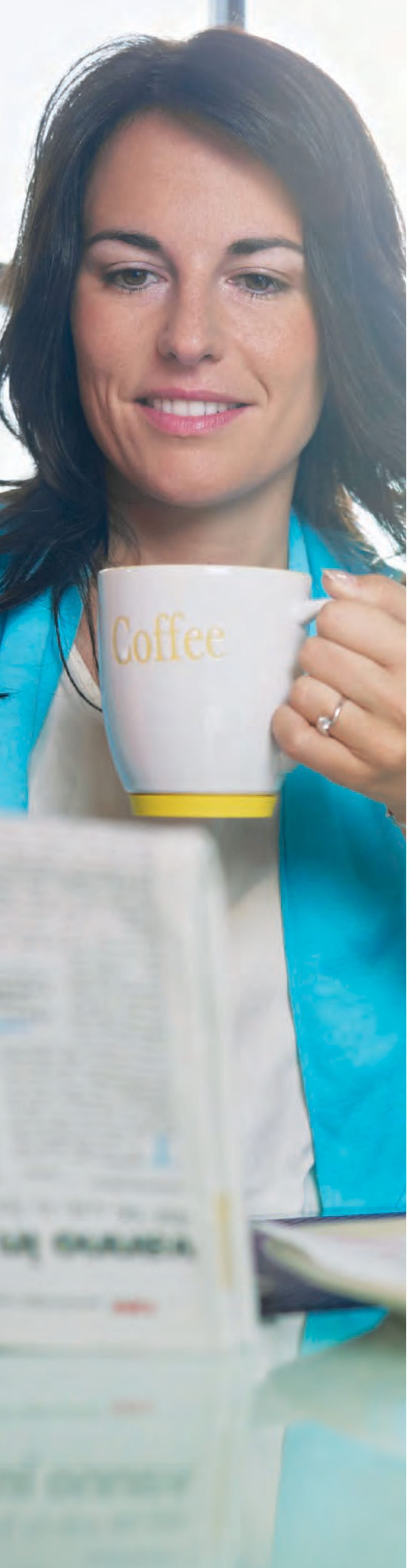
7.20 Accidental injuries, Pediatric Dental benefits and dental-medical for out-of-state members

Blue Cross NC can accept claims for Blue Cross and/or Blue Shield member's having medical benefits coverage from a Blue Cross and/or Blue Shield plan other than Blue Cross NC, when services are provided for accidental injuries or other services that qualify under the out-of-state member's medical benefit plan.

- Send claims for "dental-medical" services provided to out-of-state Blue Cross and/or Blue Shield Plan members to:
  Blue Cross Blue Shield of North Carolina
  PO Box 35
  Durham, NC 27702
  Questions about claims filed for out-of-state members should be placed by calling **1-800-487-5522**. Dental providers can also verify an out-of-state Blue Cross and/or Blue Shield plan member's medical eligibility or benefits by calling **1-800-676-BLUE (2583)**.
- The Pediatric Dental benefit process dictates that claims are processed by the specific plan and does not flow through the current IPP process.

7.21 Payment guidelines

Providers are notified of payment determination via messages contained on the notification of benefit (NOB). For example, a message will appear when services that are considered incidental to the primary service are not eligible for separate reimbursement.



7.22 Payment for covered services only

Participating dental providers are eligible for payment, only when the services provided are clinically necessary and covered as part of the member's benefit plan. The issuance of the member's benefit payment amount is considered payment in full, with the exception of any applicable deductible, coinsurance and/or copayment amounts.

7.23 Appeals and review of benefit determinations

Please contact Blue Cross NC Dental Blue® customer service for assistance with making a request for appeal or benefit determination review. Please use the call center appropriate for the member's benefit coverage type as outlined in **Chapter 2** of this e-manual.

7.24 Billing Blue Cross NC members

Participating providers agree not to bill members for services until after receipt of the Blue Cross NC issued notification of benefits (NOB), except for member's copayments. Member's copayment amounts, when applicable, are listed on the member's Blue Cross NC identification card. **However, dental providers may bill Blue Cross NC members prior to the receipt of the NOB for services verified in advance as non-covered.** Any amounts that both you and the member agree were collected erroneously for any reason must be refunded to the member within forty-five (45) days of the receipt of the NOB or your discovery of the error.

7.25 Payment options

Enrollment in payments for dental and for medical plan payments is different. Please see the tables below for details regarding payment options.

Blue Cross NC Dental Payment Options		
Dental Plans	**Summary**	**Details**
Paper Check	Your office receives paper checks and Explanation of Payments	Blue Cross NC dental payments default to paper checks, unless you have an existing arrangement with Zelis™ Payments. To sign up for one of the ePayments options below, please visit *ZelisPayments.com*, email membership@zelispayments.com or call Zelis Payments Membership Department at **1-877-828-8834**.
Electronic (EFT/ACH)	VRA™ (Virtual Reimbursement Account)	VRA is a direct deposit into your bank account via ACH payment delivery. It is CAQH CORE®-certified, which ensures compliance with ACA standards and HIPAA.
Electronic (credit card)	Select (virtual credit card)	Select payments utilize a reloadable, virtual payment card which can be faxed or downloaded.
Medical Plans	**Summary**	**Details**
Electronic (EFT)	Electronic Funds Transfer (EFT) through **Blue *e***	Providers must register for **Blue *e***. Visit ***bluecrossnc.com/providers***, click on the **Blue *e*** Login button to register. Once registered, go to the **Blue *e*** Guide for EFT Set-up.

Important note: Blue Cross NC may choose to pay non-contracted providers. Non-contracted providers will be paid via paper check only.

Once providers are registered for **Blue *e***, go to the **Blue *e*** Guide for EFT Set-up.

7.26 Amounts billable to members

Providers may collect any applicable copayments at the time service is rendered. Any applicable coinsurance and/or deductible amounts may be collected from Blue Cross NC members only after receipt of the notification of benefits. **Amounts for non-covered services may only be collected if they meet the criteria outlined in the instructions for the hold harmless provision as contained in Section 7.37 of this e-manual.** Any amounts collected erroneously by a dental care provider, from a member, for any reason, shall be refunded to the member within forty-five (45) days of the error being identified.

7.27 Amounts not billable to members

Participating providers may not collect any payments from members for covered services, except for any applicable copayment, coinsurance and deductible amounts. Participating providers may not balance bill Blue Cross NC members for the difference between billed charges and the amount allowed on the notification of benefits for a processed claim. Any differences between a dental provider's charges and the allowed amount are considered contractual adjustments and are not billable to members. Participating providers may not seek payment from either members or Blue Cross NC if a proper claim has not been submitted to Blue Cross NC within one hundred and eighty (180) days from the date of service. Participating providers charging fees for administrative services, such as paper work completion or furnishing clinical records may not bill Blue Cross NC members for these fees.

7.28 Billing members for non-covered services

Sometimes a dental provider may be asked by a member to provide services that are not covered by the member's benefit plan. Only under the following conditions may the provider bill the member for such services:

- The provider must inform the member in advance of providing the service, in a written notification, that the specific service might not be covered.
- The member signs a written acknowledgment that he/she received such notification prior to receiving the specific service at issue. That notification must inform the member that the treatment may not be covered.
- The member also acknowledges in advance and in writing that he/she has chosen to have the treatment and if it is indeed not covered, the member is responsible for the expense and will pay the dental provider directly.
- The waiver must be specific and provide the member name, exact treatment of care being rendered, the date of service, dental and/or CPT codes and the total cost of the treatment. If a payment plan is agreed upon between the provider and member, please outline the payment terms. It is not acceptable to use a generic release form with a general statement regarding member's obligations to pay for non-covered services.

7.29 Coordination of benefits

When a member is covered by more than one (1) coverage plan, one plan must be designated as primary and the other as secondary. Coordination of benefits (COB) logic is used to determine which plan pays first on the claim.

If Blue Cross NC is primary and another insurance plan is secondary, use the following guidelines:

- Any prior approval and/or certification requirements must be followed according to the member's Blue Cross NC plan.
- File a claim first with Blue Cross NC. The secondary plan may be billed any copayment, coinsurance and/or deductible amounts and for services not covered under the Blue Cross NC member's benefit plan.

If Blue Cross NC is secondary, use the following guidelines:

- Any prior approval and/or certification requirements must be followed according to the member's Blue Cross NC plan.
- File a claim with the primary plan first, after the primary plan pays its benefits, then file the secondary claim along with the primary payment information to Blue Cross NC.

Blue Cross NC and our member's combined liability are limited to the Blue Cross NC contractual allowed amount. The contract between the provider and Blue Cross NC allows that benefits will be coordinated up to the contractual allowance. Disallowed amounts and/or services cannot be billed to the member.

Pediatric Oral Health benefits covered under the health plan will always be considered primary. Stand-alone dental will be considered secondary. Coordination of benefits rules will apply.

7.30 Hold harmless provision

Providers agree not to bill or otherwise hold members, Blue Cross NC or any third party responsible for payment for services and/or supplies provided to members, which are determined not to be clinically necessary and/or not eligible under the member's benefit plan, except when the following conditions have been met:

The dental provider obtained prior authorization or certification in advance of providing the specific services and/or supplies to the member – and/or – the dental provider gave specific written notification to the member in advance of providing the non-medically necessary services or other non-covered services, explaining that such service might not be covered under the member's benefit plan; and the member signed a written authorization stating that:

- The member received from the provider notification that the specific services and/or supplies may not be covered by his or her benefit plan.
- The member received the notification prior to receiving the specific services and/or supplies.
- The notification informed the member that the particular services and/or supplies, if not covered by member's benefit plan, are provided at the member's own expense, if the member elects to receive the specific services and/or supplies.
- The provider obtained the member's written authorization prior to rendering the specific services and/or supplies.
- The member's authorization includes that such services and/or supplies may not be covered by his or her benefit plan and the member agrees to pay for such services and/or supplies apart from his or her benefit plan.
- The member's authorization specifies that the member elects to receive such services and/or supplies at the member's own expense and the provider has obtained the member's written authorization.
- The notification given by the provider and the authorization signed by the member, as outlined in the provider agreement, will be given stating the specific treatment provided to the member and not as a general or standard procedure.

Dental providers agree to provide Blue Cross NC and/or ACS with a copy of any and all such written authorizations upon request. Please refer to your dental care practice's contractual agreement with Blue Cross NC to review the hold harmless provision and how the provision applies. If you have questions regarding the hold harmless provision, please contact Blue Cross NC Network Management at **1-800-777-1643**.

CHAPTER 8 Pre-treatment estimates

8.1 Pre-treatment estimate of benefits under dental plans

Under dental plans only, a pre-estimate of benefits is a request made prior to a procedure being performed to verify benefits and clinical appropriateness of a procedure. This allows both the dental care provider and the patient to make an informed decision of potential coverage for a given procedure in advance.

When the charges from a dentist for a proposed course of treatment are expected to be over $250, a pre-treatment estimate of benefits is **strongly recommended** before any services are performed. The member or the dentist can make a request for a pre-treatment estimate of benefits (certain procedural and dental necessity information will most often be needed from the dental provider rendering care). Once received, the information will be reviewed and a pre-treatment estimate of benefits will be provided.

When requesting a pre-estimate of benefits, please send a written request along with any supporting documentation to the claims mailing address that's listed on the member's identification card, or use the claims mailing information located in **Chapter 2** of this e-manual.

Pre-treatment requests for a specific diagnosis or procedure must be submitted in writing. This chart provides information regarding required documentation needed before a pre-treatment estimate of benefits can be determined:

Description	Information Required for Claims Processing
Single Unit Fixed Restorations	
Crowns **Build-ups** **Post and cores**	Pre-operative X-rays
Periodontics	
All periodontic services	Pre-operative X-rays Periodontal charting
Multiple Unit Fixed Restorations	
Abutments **Pontics**	Pre-operative X-rays (full arch)
Endodontics	
All endodontic services	Pre- and post-operative X-rays
Oral Surgery	
Surgical extractions **Impactions**	Pre-operative X-rays
Anesthesia	
General anesthesia	Reason, type, duration of agent

Please review the prior plan approval code list available online at ***bluecrossnc.com/provider-home***. It is important to review this list once every quarter for procedures related to medical/dental procedures such as, but not limited to, oral and reconstructive surgeries, bone grafts, TMJ, pediatric orthodontic treatment. This list is subject to change quarterly.

8.2 Prior plan approval

Prior plan approval may be also referred to as prior review or prior authorization. This is the process in which Blue Cross NC reviews the dental-medical criteria for certain services paid under a member's medical benefit, such as TMJ, splint therapy or medically necessary orthodontia covered under Pediatric Dental benefit.

Reviews are performed to confirm the following:

- Member eligibility
- Benefit coverage
- Compliance with Blue Cross NC corporate medical policy regarding medical necessity
- Appropriateness of setting
- Requirements for utilization of in-network and out-of-network facilities and/or providers

It's important for in-network providers to remember that hold harmless is a contractual agreement between Blue Cross NC and participating providers. The agreement states that the provider may not balance bill a member for services or supplies that were not prior authorized or certified in advance by Blue Cross NC and/or deemed not medically necessary by Blue Cross NC. Members are not to be held responsible for any failure to obtain PPA.

If a request for PPA is submitted and not approved for medical necessity and the member elects to continue with the service, then you would need to have the member sign a waiver that they are aware of the denial of services and responsible for the cost. The waiver must include the member's name, ID number, a description of the treatment, dental and or medical codes, date of service, amount member agrees to pay out of pocket and payment plan if applicable.

When a Blue Cross NC member seeks care from a dental provider that is nonparticipating with Blue Cross NC, the care will be reimbursed at the lower benefit level, with the member having liability for a higher out-of-pocket expense. The member is responsible for making sure that the PPA is obtained.

8.2.1 Submitting a request

Requests for PPA for Medical Dental can be submitted to Blue Cross NC's Care Management and Operations department in one (1) of the following ways:

- **Call 1-800-672-7897** Monday – Friday, 8:00 am – 5:00 pm
- **Fax** clinical information to: **1-800-571-7942**
- **Mail** clinical information to:
  Blue Cross and Blue Shield of North Carolina
  Attention: Care Management and Operations
  PO Box 2291
  Durham, NC 27702-2291

Include the following information when submitting a request:

- Practice name and Blue Cross NC provider number
- Contact name, phone number and fax number
- Patient's name, Blue Cross NC member ID number and date of birth
- Attending physician's name, Blue Cross NC provider number and phone number
- Treatment setting – i.e., physician's/provider's office
- Expected dates of service
- Description of diagnosis and diagnosis codes
- Description of procedure and applicable codes
- Clinical information, including history and physical, treatment plan and orthodontic contract

If all clinical information is submitted with the request, then Blue Cross NC has three (3) business days to return a decision. If the nurses or medical directors need additional information, the process can take up to fifteen (15) calendar days. A letter will be faxed to you with the determination.

The Blue Cross NC corporate medical policy for Pediatric Orthodontics includes documentation requirements, along with guidelines for coverage. Dental providers can access the policy at ***bluecrossnc.com/providers/policies-guidelines-codes/medical-policies***.

8.2.2 Peer-to-peer review

Blue Cross NC medical directors are available to discuss clinical problems and benefit issues with network providers, particularly where there are issues that complicate the management of the patient's condition. If you have questions about a certification request, you may request to speak directly to a medical director by calling **1-800-672-7897**, extension **51019**. The purpose of the peer-to-peer discussion is to give the requesting physicians an opportunity to discuss the clinical details of a requested service. A peer-to-peer review may also be requested by a Blue Cross NC medical director in order to obtain more clinical information from an attending physician before making a final determination.

8.2.3 Reconsideration review

Blue Cross NC offers a provider courtesy review for denied services. This is separate from the appeals process and is done if there is relevant information that was not previously submitted. This must be requested within one hundred and eighty (180) days from the date of the adverse benefit determination letter. Dental providers can submit this information by calling or faxing to the same numbers for Care Management and Operations (see **Section 8.2.1, Submitting a request**).

8.2.4 Appeals for medical necessity denials

Appeals for cases that are deemed not medically necessary by Blue Cross NC and are pre-service, are member appeals. Member appeals must be initiated by the member. Providers can initiate an appeal on the member's behalf only with a signed member consent form. Member benefit notification letters will include instructions for members on how to file an appeal for medical necessity denials. Post-service appeals are provider appeals and can continue to be submitted by providers. To find out more about Blue Cross NC appeals and grievance procedures, please refer to **Chapter 12** of this e-manual.

CHAPTER 9 Orthodontic care

9.1 Orthodontic care

When applicable, benefits for a comprehensive orthodontic treatment are covered for all eligible members through age eighteen (18), or for all members with no age limit. The following are covered services and are typically considered part of the comprehensive orthodontic care if the group has elected a plan with orthodontia coverage:

- Diagnosis, including the examination, study models, radiographs and other aids needed to define a specific condition.
- Appliances or devices worn during the course of treatment. Coverage includes the design, making, placement and adjustment of the device. Benefits are not provided to repair or replace an appliance.

9.2 Medically necessary orthodontia

The ACA requires that ten (10) essential health benefits are included on every qualified health plan. One (1) of those essential benefits is Pediatric Dental coverage. Included in the Pediatric Dental essential health benefit is the coverage of orthodontia when it is medically necessary. Blue Cross NC will administer this benefit as follows:

- Covered members under the age of nineteen (19) – the benefit ends on the last day of the month of the member's nineteenth (19th) birthday.
- Codes (D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8210, D8220, D8660, D8670, D8680 and D8999) are included in Blue Cross NC's prior plan approval list, which can be found at ***https://www.bluecrossnc.com/providers/prior-authorization***. Please reference **Chapter 8** for additional information related to prior plan approval.

9.2.1 Claims

Since medically necessary orthodontia is a medical benefit, claims should be filed as follows:

- Please use the most current ADA claim form with the appropriate CDT codes.
- Include the diagnosis code(s) for the patient on the ADA claim form.

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

- Payment is based on the orthodontic contract so please include a copy of the completed orthodontic contract/treatment plan with the claim.
- Address for Pediatric Dental claims:
  Blue Cross and Blue Shield of North Carolina
  PO Box 35
  Durham, NC 27702-0035
- Emdeon Number for medical claims: 61473
- After your PPA is approved, you will need to submit a claim each time service is rendered in order to be reimbursed. You will not be receiving a payment in total upfront.

9.3 Notes on orthodontic care

- The dental provider must submit a complete treatment plan.
- Initial fee/down payment (date appliances are placed).
- Number of treatment months.
- Monthly fee.
- File orthodontic claims on a monthly basis.
- Phase I treatment is minor orthodontic treatment and can be paid in one total fee when treatment begins. Phase II treatment is comprehensive orthodontics and is divided into multiple payments. The first benefit payment is 50% of your initial payment, but no more than half of the **lifetime maximum** for orthodontics. This is followed by monthly coinsurance payments based on the existing treatment plan, up to the **lifetime maximum** for orthodontics. In order for benefits to continue throughout the treatment plan, this dental benefit plan must remain in effect, the **member** must remain enrolled in the plan, and the **member's** orthodontic **lifetime maximum** must not be met.
- Liability for orthodontic treatments should be assumed with the effective date of coverage, even if the appliances were in place prior to coverage. Coverage is available from the effective date forward but only for the remaining time and fees (even if only a part of a member's lifetime orthodontic benefits are used).

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CHAPTER 10 Provider certification

10.1 Provider certification

Blue Cross NC electronically submits annual payment information to the IRS. An IRS form W-9 is required to be submitted as requested for the registration process, or when you file your first claim with Blue Cross NC, or as the result of an IRS action due to a CP2100 report. Failure to provide a W-9 or certified W-9 when requested may result in an IRS required withhold of payment. Dental providers may also find it necessary to re-file an IRS form W-9 to reflect changes in a practice as recommended by a tax accountant. Blue Cross NC participates in the IRS tax identification number (TIN) matching service to verify provider certification.

A description of the matching services is available on the web at *www.irs.gov*. Blue Cross NC utilizes the matching service to validate IRS forms W-9 submitted by dental providers. The tax name and TIN, either an employer identification number (EIN) or social security number (SSN), submitted on the IRS form W-9 must match the IRS records.

10.2 Credentialing and re-credentialing

Blue Cross NC credentials all practitioners of care applying for membership in the network(s) and re-credentials any applicable contracted practitioner within three (3) years. Practitioners of care that are required to be credentialed and re-credentialed include both doctors of dental surgery (DDS) and doctors of dental medicine (DMD). Guidelines are followed for all providers applying for participation in the Blue Cross NC networks. These guidelines have been adopted by Blue Cross NC and adhere to the guidelines established by the National Committee for Quality Assurance (NCQA) and the North Carolina Department of Insurance (NCDOI). NCQA is responsible for accrediting managed care organizations (MCOs) using specific standards for credentialing, quality management, utilization management, member rights and responsibilities, preventive care and medical records. The NCDOI is the regulatory body for Centers for Medicare and Medicaid Services and the Affordable Care Act.

Blue Cross NC makes best efforts to process and initially credential practitioners within sixty (60) days of receipt of a completed application. Blue Cross NC makes best efforts to process and recredential practitioners by their recredentialing due date. For further information about the credentialing and/or re-credentialing process and to download forms and applications, please visit the "Providers Applying for Credentialing" page located at ***bcbsnc.com/content/providers/dental-providers/join-network.htm***.

Please see below additional forms that are required when enrolling in the Blue Cross NC network:

- Individual enrollment application and/or group enrollment application
- Substitute W-9 form*

*Available for download at ***bluecrossnc.com/providers/dental-providers/dental-enrollment-and-credentialing***.

CHAPTER 11 Appeal and grievance procedures

11.1 Member appeal and grievance process

In accordance with state law and in response to heightened concerns about member privacy and the confidentiality of medical information, Blue Cross NC requires the **member's written authorization** in order for a third party, including the member's provider, to pursue an appeal or grievance on the member's behalf. The appeal and grievance processes are available to address member concerns about:

- Adverse medical necessity decisions (non-certifications)
- Blue Cross NC decisions related to the availability, delivery or quality of dental care
- Claims payment, handling or reimbursement
- The relationship between Blue Cross NC and the member

Member appeals must be requested within one hundred and eighty (180) days of the adverse benefit determination letter. Member appeals have a thirty (30) day turnaround time once they are received by Blue Cross NC. There are expedited processes if a situation is urgent. Benefit notification letters will have instructions for how members can file an appeal. In order for you, the provider, to represent the member in a level I member appeal, a **written authorization** must be obtained from the member. The member may obtain the member appeal representation authorization form by calling the customer service phone number located on the back of their ID card or the member can download a copy at ***bcbsnc.com***. A copy of the member representation authorization form is included in this section of the Dental e-Manual. Requests for review should also include all pertinent dental records information, not previously supplied to Blue Cross NC. Member authorization must be received by Blue Cross NC for a specific issue. A blanket authorization statement for appeal cannot be used. A signed authorization will remain valid until the particular issue is resolved or until authorization is rescinded by the member. Providers should submit documents for a level I appeal along with the appeal representation form to the following address:

Blue Cross and Blue Shield of North Carolina
Level I – Dental Member Appeals
PO Box 2100
Winston-Salem, NC 27102-2100

11.2 Member grievance policy

Occasionally, Blue Cross NC receives complaints from members about a provider or their staff regarding quality of care issues. In order to appropriately respond to our members, Blue Cross NC may ask you to review and provide a written response to such cases. You are required to cooperate with Blue Cross NC member grievance policies and must respond to Blue Cross NC direct inquiries within the timeframe specified in each request. This will ensure the best service to our mutual customer, our member/your patient.

11.2.1 Level I provider appeals

Level I provider appeals consist of retrospective reviews and do not require a member signed authorization. A post-service level I provider appeals of claims is performed based on your belief that a claim has been denied or adjudicated incorrectly. The provider appeal process is separate from Blue Cross NC's member rights and appeals process. If at any time the member files an appeal during a provider appeal, the member's appeal supersedes the provider appeal. Providers may not appeal items related to member benefit or contractual issues. If you believe a claim has been denied or adjudicated incorrectly, you may initiate a request for review by submitting a written request for appeal. To request a claim review regarding a processed claim related to:

- Coding, bundling or fees
- Medical necessity

Providers will have ninety (90) calendar days from the adjudication date to submit the level I billing/coding dispute. Providers will have ninety (90) calendar days from the adjudication date to submit the level I clinical necessity provider appeal.

Blue Cross and Blue Shield of North Carolina
Level I – Dental Member Appeals
PO Box 2100
Winston-Salem, NC 27102-2100

11.3 Provider resources

The provider website contains a form for requesting provider appeal reviews regarding coding, bundling, fees and clinical necessity. This form is located at ***bcbsnc.com/assets/providers/public/pdfs/level_one_provider_appeal_form.pdf***. Blue Cross NC provides resources that are readily available which may provide immediate resolution to questions for how a particular claim was considered. Your Blue Cross NC notification of payment (NOP) and explanation of payment (EOP) provide a detailed summary of how a claim was adjudicated. The secured website ***bcbsnc-dental.com***, accessed via the internet, allows you to search from your desktop: status of submitted claims, including payment amounts, member responsibility and deductible amounts.

11.3.1 Sample member appeal representative authorization (members under 65)

BlueCross BlueShield of North Carolina

Date:

Name
Address
City, State, Zip

Patient:

Date of Birth:

Date(s) of Service:

Provider:

Reference Inquiry:

Regarding:

I have given my permission for ______________________________ to represent me, and act on my behalf

regarding the above-referenced denial for the following services:________________________________ .

I authorize Blue Cross and Blue Shield of North Carolina (Blue Cross NC) to release any of my protected health information (PHI) to my representative named above for the purpose of resolving my appeal.

I understand that I may revoke this authorization at any time by mailing a written notice to Blue Cross NC at the address below. I understand that revoking this authorization will not affect my action that Blue Cross NC has taken prior to receiving my notice of revocation.

I further understand that Blue Cross NC will not condition the provision of my health plan benefits because of this authorization.

I further understand that the person(s) that I have given permission to receive my PHI may not be subject to federal health information privacy laws and that they may disclose my information and it may no longer be protected by federal health information privacy laws.

This authorization will expire upon resolution of this appeal.

Thank you,

Member Signature Date

CHAPTER 12 Glossary

The following abbreviated glossary of terms contains common terminology used in the descriptions of Blue Cross NC products and procedures.

Terminology specific to dental procedures can be referenced by accessing the ADA Glossary of Dental Terms available on the American Dental Association's website located at: *www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-terms*.

Allowable charge/amount – the maximum amount to be reimbursed to a provider as negotiated.

Allowed amount – the charge that Blue Cross NC (or contracted vendor) determines is reasonable for covered services provided to a member. This may be established in accordance with an agreement between the dental provider and Blue Cross NC.

Alpha prefix – a letter code that precedes a member's identification number.

BCBS – Blue Cross and Blue Shield (BCBS) is used to refer to national association programs.

Beneficiary – a person who is eligible to receive insurance benefits (includes member, dependent and subscriber).

Benefit booklet – the document that contains a general explanation of the member's benefits.

Benefit period – the period of time, usually twelve (12) months as stated in the group or individual contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by Blue Cross NC (or our vendor).

Billed charge – the amount a dental provider bills a patient for a particular dental service or procedure. This is referred to as actual charge or public charge.

Billing – (a) an itemized account of subscriber dues owed to the plan by a group or subscriber; (b) an itemized account of services rendered by a dental provider or supplier.

Claim – a request for retrospective payment by a member or, on his/ her behalf, by the provider for services or supplies rendered. Each document or request for payment should be counted as one claim.

Coinsurance – the sharing of charges by Blue Cross NC and the member for covered services received by a member, usually stated as a percentage of the allowed amount.

Copayment – the fixed-dollar amount which is due and payable by the member at the time a covered service is provided.

Coordination of benefits (COB) – a method of determining the primary payment source when a person is covered under more than one (1) program.

Coverage – benefits available to eligible members.

Covered service(s) – a service, drug, supply or equipment specified in a member's benefit booklet for which members are entitled to benefits in accordance with the terms and conditions of their dental benefit plan.

Dependent – a member other than the subscriber, who is eligible for dental insurance through a spouse's, parent's or other family member's policy.

Dependent child(ren) – the covered child(ren) of a subscriber, spouse or domestic partner up to the maximum dependent age, as specified in the subscriber's policy.

Exclusions – specific conditions or services listed in the dental benefit plan for which benefits are not available.

Explanation of benefits (EOB) – a statement to the subscriber that explains the action taken on each claim.

Family deductible – a deductible that is satisfied by either the combined expenses of all family members or a certain number of family members.

Group – an employer or other entity that has entered into a contract for dental care and/or administration of benefits for its eligible members.

Group contract – the agreement between Blue Cross NC and the group. It includes the master group contract, the benefit booklet(s) and any exhibits or endorsements, the group enrollment application and dental questionnaire when applicable.

Dental benefit plan – the evidence of coverage issued to a group or individual by us or other Blue Cross and/or Blue Shield plans that describes the scope of covered services and establishes the level of benefits payable, on an insured or administered basis, for such services rendered to members.

HIPAA – Health Insurance Portability and Accountability Act – calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans and employer groups.

Hold harmless – a contract provision whereby providers agree not to charge members more than the allowable charges for covered services and not to charge members for non-covered services. The subscriber's only liability would be the deductible, coinsurance and/or copayment.

In-network – refers to participating dental providers.

Inquiry – a request for information, action or a document from a subscriber, provider, account, another plan or the general public. Inquiries may be received in any area within a plan office.

Investigational (experimental) – the use of a service or supply, including but not limited to treatment, procedure, equipment, drug or device that Blue Cross NC does not recognize as standard dental or medical care of the condition, disease, illness or injury being treated. The following criteria are the basis for Blue Cross NC's determination that a service or supply is investigational:

- Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) for final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
- There is insufficient or inconclusive scientific evidence in peer-reviewed medical or dental literature to permit Blue Cross NC's evaluation of the therapeutic value of the service or supply.
- There is inconclusive evidence that the service or supply has a beneficial effect on dental health outcomes.
- The service or supply under consideration is not as beneficial as other established alternatives.
- There is insufficient information or inconclusive scientific evidence that, when utilized in a noninvestigational setting, the service or supply has a beneficial effect on dental health outcomes and is as beneficial as any established alternatives.

Lifetime maximum – the maximum amount of covered services that will be provided to a member while they have coverage under a dental benefit plan or any prior dental benefit plan sponsored by the group in any member's lifetime.

Medical dental – dental services covered under medical plans.

Medical necessity – medical services or procedures that are considered reasonable, appropriate and necessary based on clinical standards of care.

Member – a subscriber or dependent, whose enrollment application and change form has been accepted and approved by Blue Cross NC as eligible for coverage benefits.

Notification of benefits (NOB) – a statement to the provider that explains the action taken on each claim.

Primary payer – when a member is covered by more than one (1) insurance carrier, the primary payer is the carrier responsible for providing benefits before any other insurer makes payment.

Retrospective review – a manner of judging dental necessity and appropriate billing practices for services that have already been rendered.

Secondary payer – when a member is covered by more than one (1) insurance carrier, the secondary payer is the carrier responsible for providing benefits after the primary payer has provided benefits.

Subrogation – the substitution of one person for another who has a legal claim or right.

Underwriting – the process by which an insurer determines if, and on what basis, an application for insurance will be accepted.

IVR – the IVR system is a voice response front end application that allows callers to access member's benefits information and check eligibility, claims and payment status for individual accounts.

Workers' compensation – insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured on the job, and to pay benefits to dependents of employees killed in the course of or in circumstances arising from their employment.

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