Dental Manual

A Dental Administrative Guide

2025

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

This publication is subject to periodical revisions and additions. Future inserts will be sent to you if necessary. For questions about these materials, please contact your Provider Network Representative.

Arkansas
BlueCross BlueShield
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Dear Dentist:

We are excited to provide you with the Arkansas Blue Cross and Blue Shield Dental Manual, an administrative guide to assist you and your staff in servicing our members—your patients.

This Dental Manual, along with the CDT Dental Procedure Guidelines that follow it, provide a comprehensive, single reference source for many of the policies and procedures necessary to support your practice when doing business with us. (Other applicable Arkansas Blue Cross coding or claims filing policies and procedures may be published from time to time on our website or in the *Dental Bulletin* or may be sent to you by special notice via regular mail). The Dental Manual is an accompaniment to your Preferred Payment Plan Provider Participation Agreement, which provides comprehensive details regarding the terms of your Agreement.

The enclosed CDT Guide lists all ADA codes and their applicable claim guidelines as they relate to our Benefit Plans, including covered and non-covered codes, any criteria that must be met for coverage, and any coverage limitations. You may use the CDT Guide immediately.

Your dedicated Dental Network Manager is available to assist you with any questions you have relating to your Agreement, the Dental Manual, or the CDT Guide. You can find your Manager's contact information along with a map of assigned territories in Section 2 of this Dental Manual.

Thank you for the role you and your staff play in providing a positive experience for our members who are seeking solutions for their dental health. From time to time, you can expect to see updates to this Dental Manual to keep you apprised of changes and additional information as it becomes available. Please note that updates to the Dental Manual may be published on the Arkansas Blue Cross website, in the *Dental Bulletin*, or in special notices sent to you via regular mail. If you have any suggestions for what you would like to see included in the Dental Manual, please contact your Dental Network Manager.

We appreciate the quality service you provide to our members and look forward to continuing our mutually beneficial relationship with you and your staff.

Sincerely,

Christy Hockaday

Vice President Provider Networks

Updated: January 2025

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Section 1: Definitions

The definitions of capitalized terms that are not otherwise defined in the body of the Agreement are set forth in this section of the Dental Manual.

Account	An employer, union, association, or other group that has entered into an insurance policy or agreement with Arkansas Blue Cross and Blue Shield or a Network Plan to provide Covered Services to Members of that Account.
ACA	The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act, is a United States federal statute signed into law on March 23, 2010.
Agreement	The "Participating Dentist Agreement" between a Network Dentist and Arkansas Blue Cross, as Administrator for LSV's dental plans.
Applicable Laws	Any statutes, regulations, or other legal requirements applicable to the matter being referenced in the Agreement.
Allowable Expense	The maximum amount of payment allowed by Arkansas Blue Cross for Dental Benefits covered under the applicable Insured's Dental Program.
Administrator	LSV performs administrator services for Responsible Payors in accordance with the terms of its contracts with such Responsible Payors and the Agreement.
Application	The form that a Dentist has completed setting forth requested information concerning his or her professional qualifications, experience, and other relevant credentialing information.
Appeal	The process used to have an adverse Benefit determinationreviewed. The process may also be known as a request for Reconsideration of an Adverse Organization Determination.
Benefit Plan	The written agreement entered by a Responsible Payor with an Account or an individual which specifies the terms, conditions, limitations and exclusions applicable to the Member's Covered Services.
Billed Charges	The amount you bill for a specific dental service or procedures.
Centers for Medicare and Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for administration of Medicare. CMS language may be different than conventional insurance contracts.
Clean Claim	A claim for Covered Services that is submitted for adjudication in accordance with applicable terms and conditions of this Dental Manual. A claim is considered to be clean when it requires no further information, adjustment or alteration in order to be processed and paid by the Responsible Payor.
Co-insurance	The sharing of expenses of Dental Benefits between the insured and Arkansas Blue Cross. The amount of any such expense is set forth in the applicable Dental Program.
Conditions of Participation	The minimum qualifications and standards required to be credentialed to participate in a Provider Networks, including: 1. Any information set forth or referenced in the Dentist's Application, which is incorporated into the Agreement by reference, shall be true, accurate and correct in all material respects throughout the term of the Agreement, and 2. The Dentist shall notify LSV in a timely manner of any material changes in that information.

Confidential Information	Any and all data, reports, interpretations, forecasts, documents, records and other information fixed in a tangible medium, which contain information concerning a party that: 1. Is marked, otherwise identified as, or legally entitled to protection as confidential, proprietary, privileged or trade secret information; and 2. Is disclosed by or on behalf of a party (the "Disclosing Party") to the other party (the "Receiving Party") Confidential Information does not include information that: 1. Is based on documents in the Receiving Party's possession prior to disclosure of Information that was not acquired directly or indirectly from the Disclosing Party; or 2. Was in the public domain at the time of disclosure or subsequently became part of the public domain through no fault of the Receiving Party; or 3. Was legally received on a non-confidential basis from a third party, who is not known to be bound by a confidentiality agreement preventing the disclosure of such information; or 4. Was independently developed by the Receiving Party without reliance on or knowledge of the Disclosing Party's Confidential Information.
Coordination of Benefits (COB)	The determination of which Payors have primary and secondary responsibilities for paying for Covered Services in accordance with the rules set forth in the Member's Benefit Plan when that Member is eligible for Covered Services from more than one Payor, including from a governmental or self-funded Payor.
Copayment	A fixed-dollar amount that a Network Dentist must collect directly from a Member as a portion of the Maximum Allowable Charge for Covered Services.
Cost Sharing	Any and all charges that a Dentist may collect directly from a Memberin accordance with the terms of the Member's Benefit Plan; which includes Copayments, Deductibles or Coinsurance.
Covered Services	Necessary and Appropriate dental care services and supplies rendered to Members in accordance with the terms of the Member's Benefit Plan, the applicable Dental Manual and the Agreement.
Deductible	The aggregate dollar amount that a Member must pay in accordance with the Member's Benefit Plan before the Responsible Payor is required to pay for Covered Services. The Member must pay 100% of the Dentist's Maximum Allowable Charges for Covered Services until the Member satisfies the applicable Deductible.
Denied	Dental services that are not covered under the applicable Arkansas Blue Cross Plan will be denied. If a claim is denied, you can bill and collect your billed charge from the member, if the member hasagreed to pay for the service(s).
Dental Benefits	Those covered dental services and supplies, together with exclusions and limitations, as set forth in the applicable Dental Program.
Dental Manual	This document which sets forth the policies, procedures, and requirements applicable to Network Dentists providing dental services to Members.
Dental Program	The dental benefit program under which the Insured is covered by, or through (e.g., under a reciprocity or other agreement with Arkansas Blue Cross for the provision of Dental Benefits) Arkansas Blue Cross, and which specifies the covered Dental Benefits.
Dependent	A Member who is eligible and enrolled in a Benefit Plan based upon his or her relationship with a Subscriber.

Emergency Dental Care	Dental services necessary to treat a sudden onset and severity of adental condition that leads to an immediate dental procedure to relieve pain or eliminate infection.
Exchange or Health Insurance Marketplace	A governmental agency or non-profit entity that meets the applicable standards of 45 C.F.R. § 155 subpart D and makes QHP available to individuals and employers. This term includes bothstate and Federally-Facilitated Exchanges.
Governing Body	The person(s) who have authority over a business entity.
GRID	The National Dental GRID and The National Dental GRID+ links the dental networks from most of the nation's Blue plans.
Grievance	Dissatisfaction from or on the behalf of an Enrollee or DentalService provider about any action taken by Arkansas Blue Cross.
HCR	Health Care Reform. See "ACA".
HIPAA	The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.
Insured	Each individual covered under a Dental Program.
Late Claim	The submission of a claim for covered services to Arkansas Blue Cross, as the Administrator for the Responsible Payor, more than 180 days (six months) from the date of service or the completion of a course of treatment. Arkansas Blue Cross may deny a late claim unless it determines, at its discretion, that there was good cause for the delay in submitting that claim.
LSV	Life and Specialty Ventures, LLC.
Maximum Allowable Charge Schedule	The amount that Arkansas Blue Cross has determined to be the maximum amount payable for a covered service rendered to a member as set forth in the applicable maximum allowable charge schedule.
Medicare Advantage Plan	Arkansas Blue Cross and Blue Shield, a Medicare Advantage Organization offering Medicare Advantage Programs through an MA Contract.
Member	A person eligible to receive covered services under a benefit plan.
Member Payments	Any and all charges that a dentist may collect directly from a member in accordance with the terms of the member's benefit plan; which include copayments, deductibles or co-insurance.
National Provider Identifier (NPI)	The government-issued, 10-digit identification number for individual healthcare providers and entities.
Necessary and Appropriate	Dental services and supplies that are: 1. Rendered consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic and related diseases); 2. Furnished in accordance with standards of good dental practice; 3. Provided in the most appropriate site and at the most appropriate level of service based upon the Member's condition; 4. Not provided solely to improve a Member's condition beyond normal variation in individual development and aging, including improving physical appearance that is within normal individual variation; 5. As beneficial as any established alternative; and

	6. Not rendered solely for the Dentist's, Member's or a third party's convenience.
Network Dentists	Dentists who participate in the Provider Network.
Network Plan	United Concordia and Arkansas Blue Cross have a network access arrangement that permits members of United Concordia to access care rendered by the Arkansas Blue Cross provider network. As an Arkansas Blue Cross network provider, you are also considered in-network for United Concordia members in Arkansas and contiguous counties.
Non-Covered Services	Services and supplies that are not covered by or limited in coverage pursuant to the Member's Benefit Plan.
Non-Reimbursable Services	Services that would have been Covered Services but for the fact that the Dentist: 1. Rendered services that were not Necessary and Appropriate, or 2. Failed to comply with applicable requirements of the Dental Manual in connection with the provision of such Services, or 3. Failed to submit a claim for such services within the submission deadlines established by the applicable Dental Manual.
Participating Agreement	The document that defines the contractual rights and obligations between you as a participating Dentist and Arkansas Blue Cross for your participation in the Preferred Participating Provider (PPP) network which is made up of your standard contract.
Participating Dentist	A duly licensed dentist who has contracted with Arkansas Blue Cross to participate in its Dental Program(s).
PPO	Preferred Provider Organization
PPP	Preferred Payment Plan
Provider Network	The group of Dentists who contract with Arkansas Blue Cross to render Covered Services to Members.
Plan	An Arkansas Blue Cross dental plan.
Pre-authorization	A dentist's submission of information to the responsible payor prior to rendering services, for advanced written approval for planned services for medically necessary treatment. Preauthorization is subject to: • the accuracy and completeness of the Dentist'ssubmission of information, • Medical Necessity • the Member's eligibility at the time services are rendered, • the Responsible Payor's allowed payment for such services,and • the terms of the Member's Benefit Plan at the time servicesare rendered
Predetermination of Benefits	A Dentist's submission of information to the Responsible Payor prior to rendering services, to request that the Responsible Payor inform the Dentist if services may be Covered Services and what Allowable Charge, Copayment, Co-insurance and Deductible amounts may apply. A Predetermination of Benefits is not a commitment and does not create any obligation to pay any amount for services rendered. A Predetermination is subject to: 1. the accuracy and completeness of the Dentist's submission of information, such services being Necessary and Appropriate, 2. the Member's eligibility at the time services are rendered, 3. the Responsible Payor's allowed payment for such services, and

	4. the terms of the Member's Benefit Plan at the time services are rendered
Responsible Payor	The Plan responsible for paying benefits for Covered Services rendered to a Member.
State	The State of Arkansas
Subscriber	A Member who is eligible and enrolled in a Benefit Plan as an individual or as an employee or member of an Account.
Unbundling of Procedures	The "unbundling" of charges has been recognized on a national level as a contributing factor to the increasing cost of healthcare. Examples of unbundling include the use of more than one procedure code to bill for a procedure that can be adequately described by a lesser number of codes, filing for services that are an integral part of a procedure, and filing for procedures (such as "sterilization", services, or supplies) that are required in rendering dental services. When these and other unbundled claims are identified, partial denials of payment or refund request will result.
Utilization Management Program	The review process used to evaluate if services rendered to Members are Necessary and Appropriate.

Section 2: Contact Information

At Arkansas Blue Cross, one of our most important goals is to nurture a relationship with you defined by mutual respect and responsiveness. Please do not hesitate to contact us with any questions.

Claims and Customer Service Contact Information

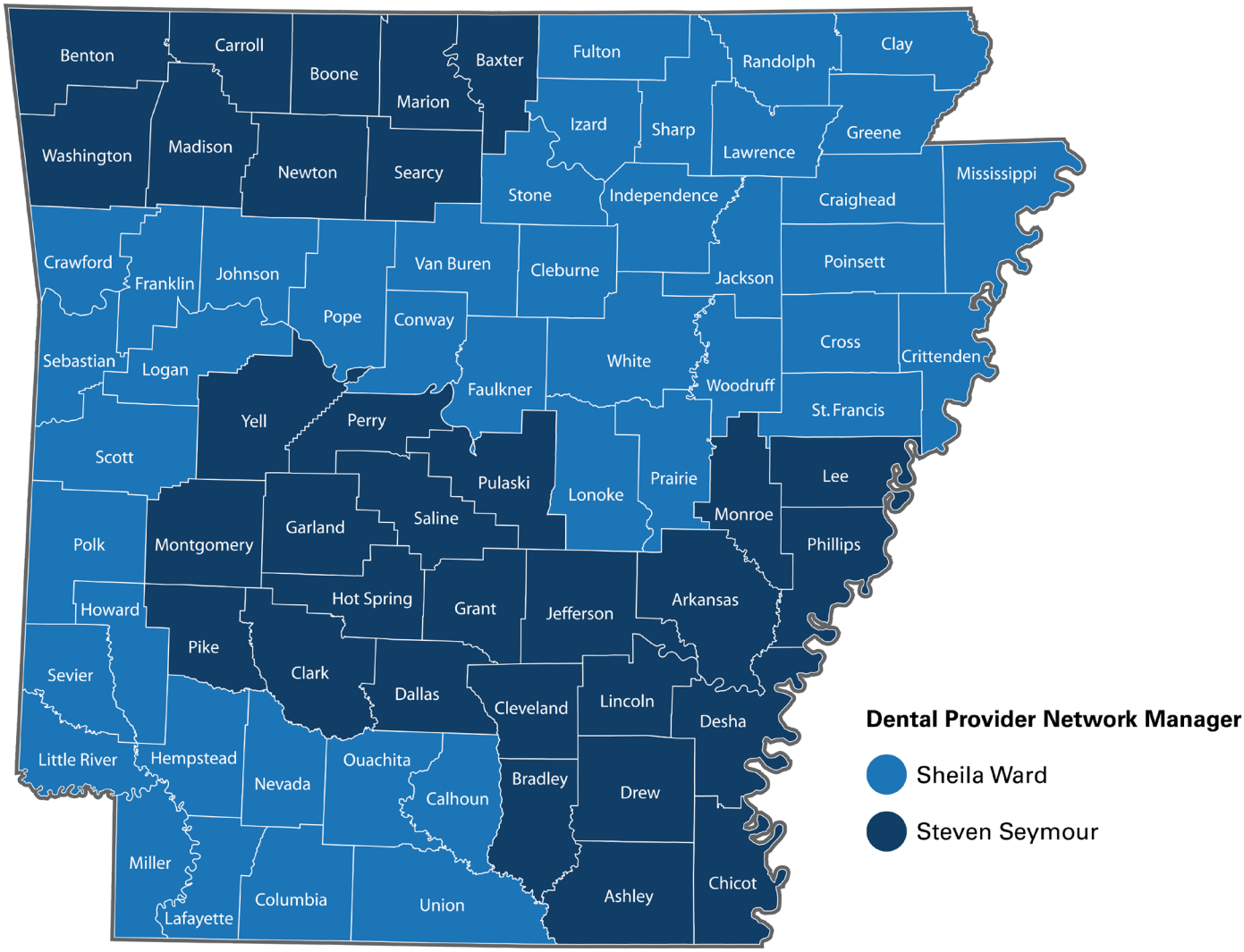
Plan	Schedule of Allowances	Customer Service	Claims Address	Electronic Claims Payor ID
DentalBlue (Fully insured group and individual plans)	PPP Fee Schedule PPO Select Plus Fee Schedule PPO Select Fee Schedule	(888) 224-5213	Dental Claims Administrator P.O. Box 69436 Harrisburg, PA 17106-9436	TLY26
DentalBlue (Self-insured plans offered through BlueAdvantage Administrators of Arkansas)	PPP Fee Schedule	(888) 224-5213	Dental Claims Administrator P.O. Box 69436 Harrisburg, PA 17106-9436	TLY26
Medicare Advantage	Medicare Advantage Fee Schedule	(888) 224-5213	Dental Claims Administrator P.O. Box 69436 Harrisburg, PA 17106-9436	TLY26
Federal Employee Program	FEP Fee Schedule	(800) 482-6655	Arkansas Blue Cross FEP– Dental P.O. Box 2181 Little Rock, AR 72203	00520
Postal Service Health Benefits (PSHB) Program	FEP Fee Schedule	(855) 493-3302	Arkansas Blue Cross FEP– Dental P.O. Box 2181 Little Rock, AR 72203	00520

Dental Provider Network Representative Contact Information

Steven Seymour and Sheila Ward are here to answer any questions you have about working with Arkansas Blue Cross. Please refer to the territory map below to determine which one acts as your Provider Network Representative.

Contact Information

Sheila Ward sheila.ward@usablelife.com	**Steven J. Seymour** steven.seymour@usablelife.com
General email dentalproviderrelations@usablelife.com **Provider website** arkansasbluecross.com/providers/dental-providers	**USAble Life** Attn: Dental Provider Relations P.O. Box 1650 Little Rock, Ark. 72203 dentalproviderrelations@usablelife.com Fax: 501-208-8302



Section 3: Your Relationship with Arkansas Blue Cross

Dentist's Responsibilities

As a participating Dentist, you are solely responsible for making treatment recommendations and decisions for your patients. You are also responsible for ensuring that all claims you submit are accurate, complete and adhere to the claims filing and coding policies of Arkansas Blue Cross.

Arkansas Blue Cross' Responsibilities

Arkansas Blue Cross will not interfere with your judgment with respect to a patient's treatment or the Dentist/Patient relationship. However, we do reserve the authority to make eligibility and coverage determinations and to make claims-processing decisions that may include re-bundling or down-coding. You can find additional information on claim edits in the CDT Guide at the end of this Dental Manual.

Role of Third Party Administrator Engaged By Arkansas Blue Cross

In an effort to promote quality and efficiency of services to members, as well as enhance the claims filing, reimbursement and network management experiences of participating dentists, Arkansas Blue Cross has contracted with several third parties for the provision of certain services associated with the dental networks and dental products of Arkansas Blue Cross. As of the issue date for this version of the Dental Manual, these third parties consist of the following entities:

(1) Life and Specialty Ventures, LLC (shortened for purposes of convenience to "LSV") an affiliate company of Arkansas Blue Cross, which has been engaged to assist , either directly or via one of its subsidiary companies, in coordinating with United Concordia Companies, Inc. with respect to dental claims administration, and in providing certain dental network management services to Arkansas Blue Cross. It is anticipated that LSV may form a subsidiary to be known as "LSV Dental Management, Inc.," or "LSVDM" for short. You should expect to be contacted from time to time by LSV or one of its subsidiaries such as LSVDM. Your cooperation with LSV and its subsidiaries is required as a Condition of Participation in the Arkansas Blue Cross dental networks, to the extent that LSV and its subsidiaries contact you acting on our behalf.

(2) United Concordia Companies, Inc. (shortened to "UCCI") has been engaged to perform the day-to-day administration of dental claims for Arkansas Blue Cross dental products. Routine inquiries or contacts concerning Member eligibility, claims filing, claims status, and any related reimbursement questions or issues should be directed to UCCI at the Dental Claims Administrator addresses and associated customer service numbers listed elsewhere in this Dental Manual.

PLEASE NOTE: Arkansas Blue Cross reserves the right to change any third party administrator at any time in its sole discretion. Should such a change occur, you will be notified by Arkansas Blue Cross and will be required to cooperate with any new or replacement third party administrator.

Section 4: Working with Arkansas Blue Cross

What We Offer You

At Arkansas Blue Cross, we are committed to helping you provide the best care to your patients and manage a successful business practice. We have built a reputation based on trust and excellent customer service, the same qualities you deliver to your patients. We offer:

- Fast, reliable and direct electronic claims-processing
- Dedicated provider network representatives
- Competitive reimbursement rates driven by the market
- On-line dental manual to assist providers with basic questions.
- The Arkansas Blue Cross Preferred Payment Plan (PPP) network, Arkansas Blue Cross Preferred Provider Organization (PPO) network and the Arkansas Blue Medicare network.
- A listing in our online Provider Directory, which members can use to search for providers by location, specialty, gender or language. They can even print a map with directions to your office. Visit the directory at www.arkansasbluecross.com.

Section 5: Conditions of Participation in Our Networks

Conditions of Participation

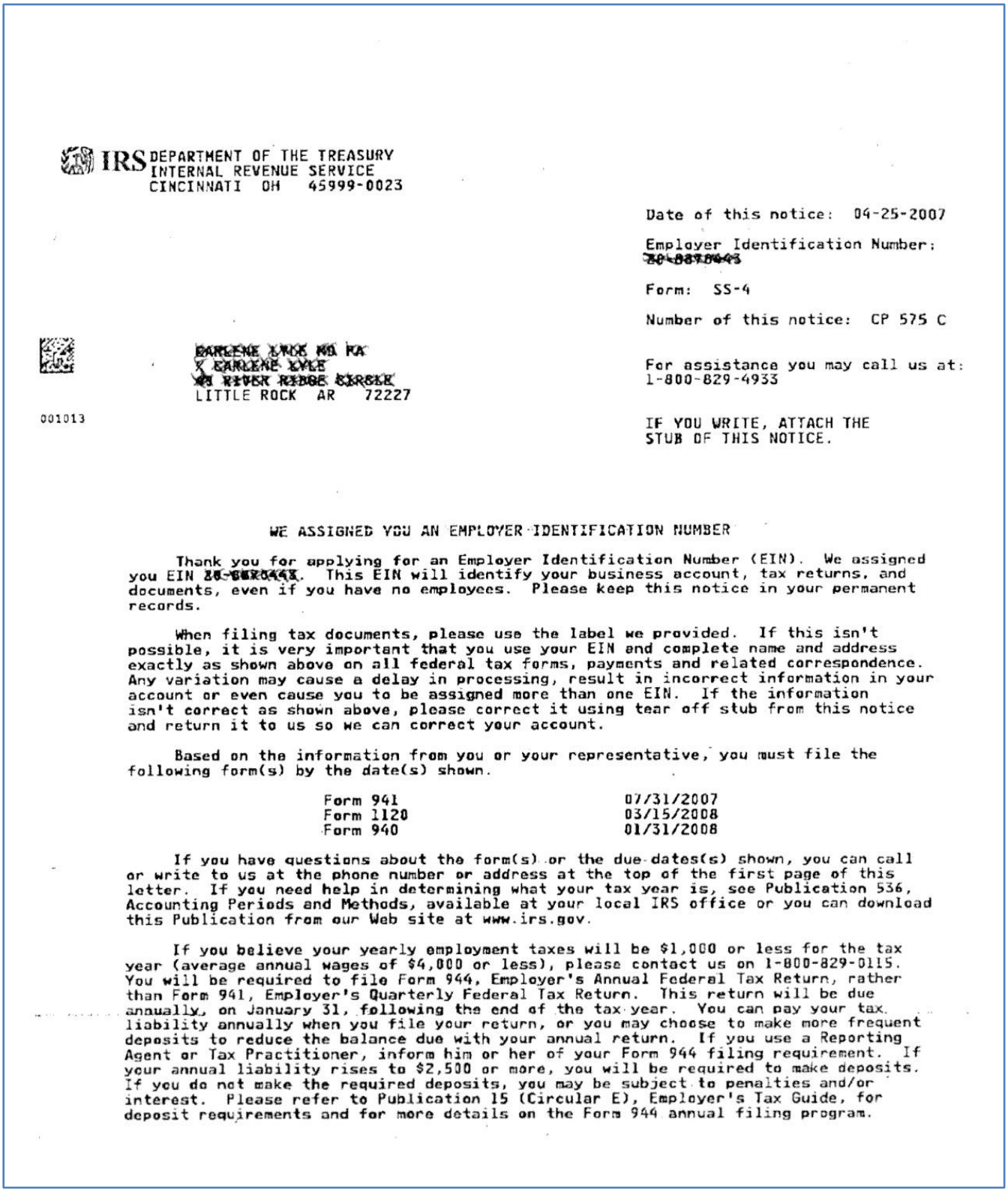
To participate in the Arkansas Blue Cross Dental networks, each dentist must meet the Standards, Requirements, and Contractual Conditions described below:

General Conditions	• You must complete a Provider Application with associated attachments. • Sign the Agreement and continuously comply with all its terms and conditions. • You must cooperate with any third party claims administrator or network administrator engaged by Arkansas Blue Cross. As of the issue date of this version of the Dental Manual, this includes United Concordia Companies, Inc. and Life and Specialty Ventures, Inc. ("LSV") as well as any subsidiary of LSV working on behalf of Arkansas Blue Cross.
Standards	• You must be licensed in Arkansas. If you practice in a state other than Arkansas, you must comply with the license requirements of the state where you are located and where services are rendered to members. • You must maintain individual liability insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in aggregate to insure you against any claim for damages arising by reason of personal injury or death caused directly or indirectly by you. • DEA (Drug Enforcement Administration) and CDS (Controlled Dangerous Substances) eligible dentist who do not have an active DEA certificate will provide a DEA waiver indicating the reason for the waiver and provide a designated practitioner to write on their behalf. The alternate prescriber may be an individual or a practice but must be identified by name and NPI. • The Arkansas Providers who hold an Arkansas DEA must be registered with the Arkansas Prescription Drug Monitoring Program. Prescription Drug Monitoring Program (AR PDMP) is an electronic database of all the controlled prescriptions dispensed at Arkansas pharmacies, mail-order pharmacies delivered into Arkansas, and other dispensaries such at a veterinary or medical clinic. Under the law, a prescriber may designate someone in the facility to be that prescriber's delegate for checking the Prescription Drug Monitoring Program database once that delegate has also registered. Arkansas Blue Cross requires contracted providers in Arkansas to register and encourages use of the Arkansas Prescription Drug Monitoring Program.
Requirements	• You must achieve a satisfactory review from the Arkansas State Board of Dental Examiners.
Contractual Conditions	• You shall notify Arkansas Blue Cross of your intent to terminate, extend or alter your participation. Furthermore, any individual provider wishing to join an existing group practice shall notify Arkansas Blue Cross. • To the extent that services that otherwise meet the requirement of the Agreement are rendered by a dentist not located in Arkansas, the statutory and regulatory requirements of that state that are equivalent to these Contractual Conditions shall be complied with to the satisfaction of Arkansas Blue Cross. • Excluded Persons. Dentist represents and certifies that neither it, nor its Affiliated Parties or Downstream Entities have been suspended or excluded from participation in the Medicare program or any other federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)). Dentist shall check appropriate databases regularly, but no less than monthly and upon hiring and subcontracting, to determine whether any Affiliated Party or Downstream Entity has been suspended or excluded from participation in the Medicare

	program or any other federal health care program. Databases include the U.S. Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals/Entities (http://exclusions.oig.hhs.gov) and the General Services Administration's System for Award Management (http://www.sam.gov/portal). Dentist shall notify Arkansas Blue Cross immediately in writing if Dentist, an Affiliated Party, or any Downstream Entity is suspended or excluded from the Medicare program, or any other federal program monitored as described in this Section. Dentist shall prohibit any Affiliated Party or Downstream Entity that appears on any of the above-listed databases or who has opted out of Medicare from doing any work directly or indirectly related to the delivery or administration of Covered Services to Medicare Advantage Members. Arkansas Blue Cross reserves the right to require Dentist to demonstrate compliance with this provision upon reasonable request. • If a party received Confidential Information from another party, the receiving party would not disclose the Confidential Information to third parties, in whole or in part, except with prior written consent of the disclosing party, as required by Applicable Laws or as permitted by the Arkansas Blue Cross Participating Dentist Agreement. The receiving party and its representatives shall utilize confidential information disclosed pursuant to the Agreement as is reasonably necessary to accomplish the objectives of the Agreement and in accordance with Applicable Laws, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations and the Heath Information Technology for Economic and Clinical Health Act and its implementing regulation. The receiving party and its representative shall not utilize Confidential Information for any other purpose including, without limitation, using that confidential Information for its own benefit or for the benefit of third parties, except with the prior written consent of the disclosing party. The Dentist acknowledges and agrees that LSV may disclose Confidential Information received from or on behalf of the Dentist, including fee, claims and encounter information, to affiliates, reciprocity plans, regulators, accreditation agencies, Administrators, and auditors after informing those third parties of the confidential nature of the disclosed information.

Example of IRS Tax Letter

For verification, Arkansas Blue Cross will accept a tax coupon or letter from the Department of Treasury (IRS) CP 575C. See the following example of an IRS letter:



IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice: 04-25-2007

Employer Identification Number:
[redacted]

Form: SS-4

Number of this notice: CP 575 C

[redacted]
LITTLE ROCK AR 72227

001013

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [redacted]. This EIN will identify your business account, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, please use the label we provided. If this isn't possible, it is very important that you use your EIN and complete name and address exactly as shown above on all federal tax forms, payments and related correspondence. Any variation may cause a delay in processing, result in incorrect information in your account or even cause you to be assigned more than one EIN. If the information isn't correct as shown above, please correct it using tear off stub from this notice and return it to us so we can correct your account.

Based on the information from you or your representative, you must file the following form(s) by the date(s) shown.

Form 941	07/31/2007
Form 1120	03/15/2008
Form 940	01/31/2008

If you have questions about the form(s) or the due dates(s) shown, you can call or write to us at the phone number or address at the top of the first page of this letter. If you need help in determining what your tax year is, see Publication 536, Accounting Periods and Methods, available at your local IRS office or you can download this Publication from our Web site at www.irs.gov.

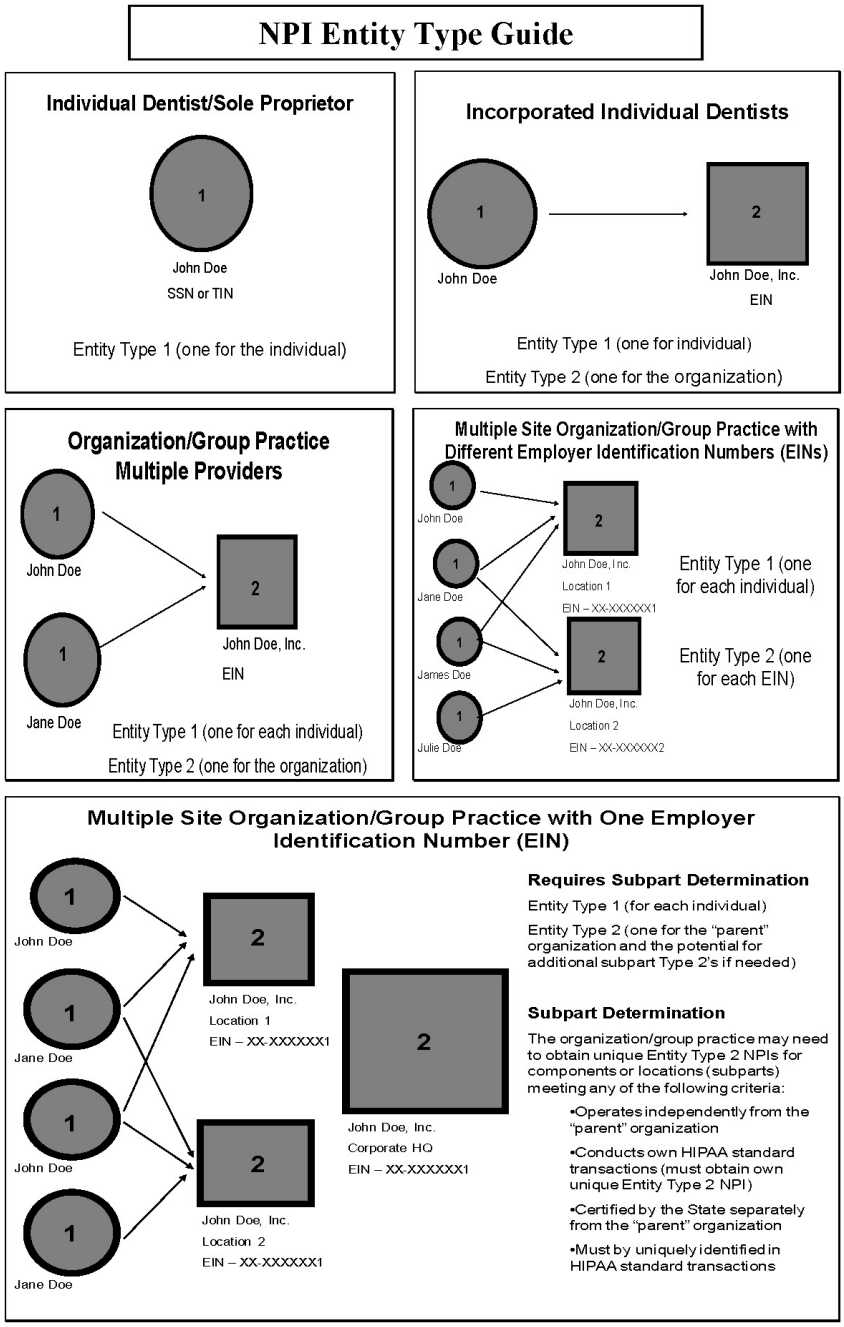
If you believe your yearly employment taxes will be $1,000 or less for the tax year (average annual wages of $4,000 or less), please contact us on 1-800-829-0115. You will be required to file Form 944, Employer's Annual Federal Tax Return, rather than Form 941, Employer's Quarterly Federal Tax Return. This return will be due annually, on January 31, following the end of the tax year. You can pay your tax liability annually when you file your return, or you may choose to make more frequent deposits to reduce the balance due with your annual return. If you use a Reporting Agent or Tax Practitioner, inform him or her of your Form 944 filing requirement. If your annual liability rises to $2,500 or more, you will be required to make deposits. If you do not make the required deposits, you may be subject to penalties and/or interest. Please refer to Publication 15 (Circular E), Employer's Tax Guide, for deposit requirements and for more details on the Form 944 annual filing program.

Section 6: National Provider Identifier (NPI)

Overview

The National Provider Identifier (NPI) is a government-issued, 10-digit identification number for individual healthcare providers and organizations. The numbers are randomly assigned and contain no coded information about the individual or organization. The NPI will never expire, and your individual NPI will remain the same even if you change jobs or locations.

All dentists are required by federal law to obtain an NPI. Arkansas Blue Cross requires each participating dentist to have an NPI regardless of whether the dentist submits claims electronically. We encourage you to obtain an NPI as soon as possible; getting your NPI now will help eliminate issues with claims administration.



How to Apply for and Use an NPI

You can apply for an NPI at no charge through CMS' National Plan and Provider Enumeration System website at https://nppes.cms.hhs.gov.

You can choose to either

1) Apply online and receive your NPI via email in one to five business days or

2) Download a printable application and submit by mail; processing takes about 20 business days.

Once you have received an NPI, fax a copy of your confirmation to our Dental Provider Relations department at **(501) 208-8302** and we will update your provider record. If you have questions about NPI email us at **dentalproviderrelations@usablelife.com**.

Section 7: Filing Provider or Practice Changes

Occasionally, you may need to submit changes to us concerning relocation, adding or changing an Employer Identification Number (EIN) or Tax Identification Number (TIN), adding or terminating an associate or closing a plan panel. For guidance on how to notify us, please contact your Provider Network Representative. Contact information can be found in section 2: Contact Information of this manual.

Changes Requiring Notification

Changes to your practice that require a notification include:

- Adding dentists to your practice
- Additional offices
- Change of practice name
- Changes to telephone and fax numbers
- Relocation
- Retirement/Death of Provider
- Transfer of ownership (TIN change)

Changes to your status that require a notification include:

- Accreditation
- Certification
- License to practice dentistry suspended or revoked
- Malpractice or an act of professional misconduct as found by a court or arbitrator.
- Participation
- Professional liability or malpractice insurance changed or revoked
- Qualification

Submitting Changes

Occasionally, you may need to submit changes to us concerning relocation, adding or changing an Employer Identification Number (EIN) or Tax Identification Number (TIN), adding or terminating an associate. For guidance on how to notify us, please consult the table below:

Type of Change	Method of Submission
Relocation, contact information (telephone, fax, etc.), adding additional practice locations	Adding or changing par provider or practice form https://www.arkansasbluecross.com/providers/dental-providers/dental-provider-forms
Employer Identification Number (EIN) or Taxpayer Identification Number (TIN)	NPI or TIN change form https://www.arkansasbluecross.com/providers/dental-providers/dental-provider-forms Copy of letter from the IRS (CP 575) or your tax coupon receipt
Associate dentist/orthodontist who has left your practice	Termination request form https://www.arkansasbluecross.com/providers/dental-providers/dental-provider-forms
Add a new associate dentist/orthodontist to your practice	New provider application https://www.arkansasbluecross.com/providers/dental-providers/dental-provider-forms Contact your dental provider representative.
Terminate participation in the networks	Termination request form or a letter of termination https://www.arkansasbluecross.com/providers/dental-providers/dental-provider-forms

Section 8: Dental Plans and Benefits

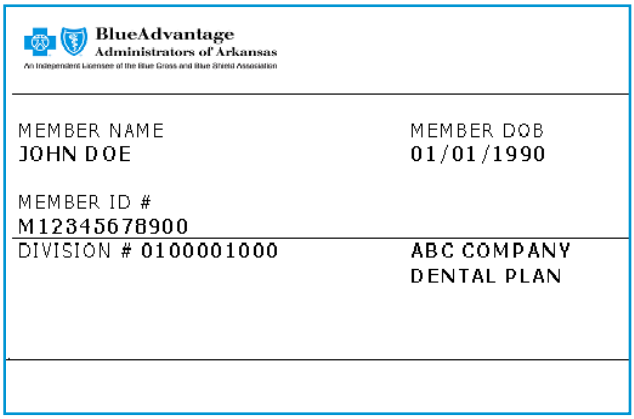
Arkansas Blue Cross and Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. The following is an overview of the dental plans offered by or administered by Arkansas Blue Cross.

Dental Plans Offered or Administered by Arkansas Blue Cross

Plan/ Program	Responsible Payor	Claim Type	Payment Supported by	Customer Service Provider	Contact for Network Participation
DentalBlue	Arkansas Blue Cross or BlueAdvantage Administrators of Arkansas	Dental	Arkansas Blue Cross or BlueAdvantage Administrators of Arkansas	Dental Claims Administrator	Steven Seymour Fax: (501) 208-8299 steven.seymour@usablelife.com Sheila Ward Fax: (501) 208-8298 sheila.ward@usablelife.com
Medicare Advantage	Arkansas Blue Cross or BlueAdvantage Administrators of Arkansas	Dental	Arkansas Blue Cross or BlueAdvantage Administrators of Arkansas	Dental Claims Administrator	
FEP Dental	Arkansas Blue Cross	Dental	Arkansas Blue Cross FEP program	FEP customer service	
BlueCare (no longer available; grandfathered policies only	Arkansas Blue Cross	Dental	Arkansas Blue Cross	Dental Claims Administrator	

BlueAdvantage Administrators of Arkansas

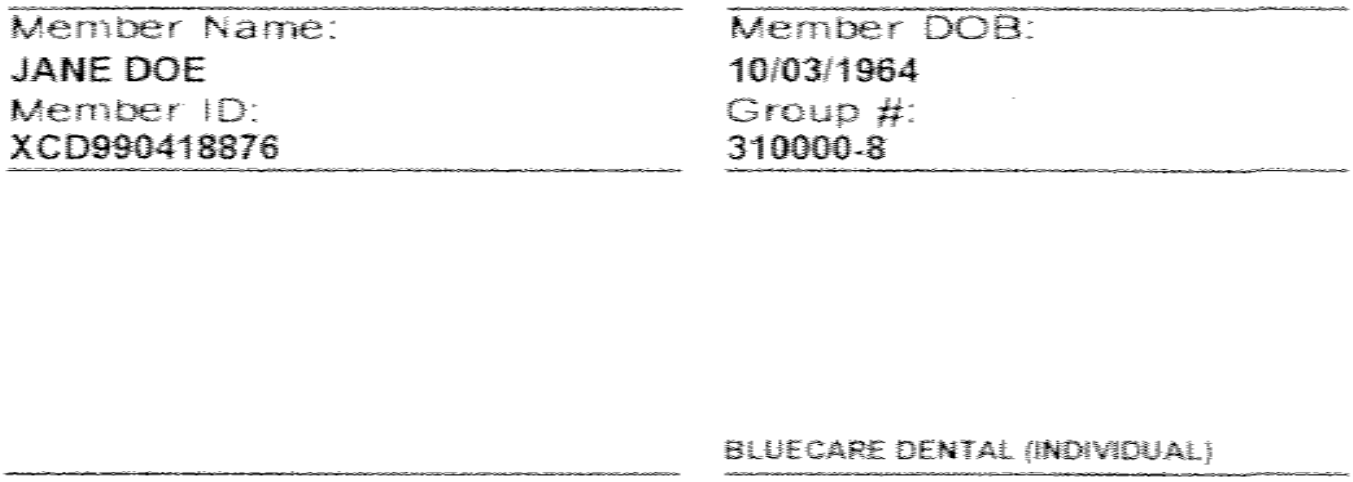
BlueAdvantage Administrators of Arkansas, a division of Arkansas Blue Cross, is Arkansas' largest third-party administrator, administering employer dental-plan benefits for self-funded groups. Sample Card



BlueCare

BlueCare is an individual dental product previously offered to individuals and their families under the age of 65. This product is no longer being marketed but will remain in effect for current policy-holders.

Sample Card



DentalBlue Silver, Gold and Platinum: Comparison of Benefits

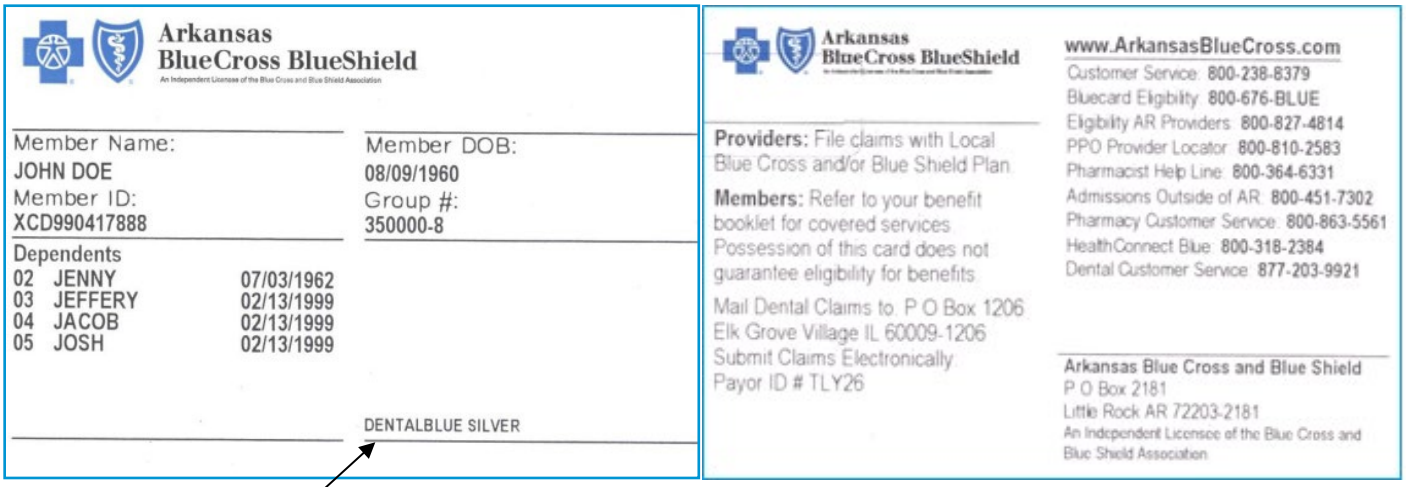
Arkansas Blue Cross offers an integrated approach to dental care, and the cornerstone is our Dental Blue plans, all of which offer preventive services.

DentalBlue Comparison of Benefits					
	SILVER	**GOLD**	**PLATINUM**	**PLATINUM PREMIUM**	**PEDIATRIC**
Individual Deductible	$50	$35	$20	$20	$20
Calendar-Year Maximum	$1,000	$1,000	$1,500	$2,500	Not applicable
Annual Maximum Rollover	No	Yes	Yes	Yes	Not applicable
Preventive & Diagnostic	90%	100%	100%	100%	100%
Minor Restorative Services	75%	80%	80%	80%	80%
Major Restorative Services	50%	50%	50%	50%	50%
Implants	Not covered	50%	50%	50%	Not covered
Minor Restorative Services	6 months	6 months	6 months	6 months	Not applicable
Major Restorative Services	Not applicable	6 months	6 months	6 months	Not applicable
Total Per Covered Child Under Age 19	$400	$400	$400	$425	$400
Total For All Covered Children Under Age 19	$800	$800	$800	$800	$800

BRONZE	**DentalBlue Bronze℠** offers basic, preventive care, including initial and periodic exams, prophylaxis (teeth cleaning), fluoride treatments, X-rays and sealants. ***This plan is no longer marketed.**
SILVER	**DentalBlue Silver℠** covers the preventive services listed above, plus the minor restorative services of fillings, endodontics, oral surgery, extractions and periodontics.
GOLD	**DentalBlue Gold℠** covers preventive services and minor restorative services, along with major restorative services including inlays and onlays, crowns, bridges, partials, dentures, and implants with no exclusion for missing teeth. DentalBlue Gold also includes the annual maximum rollover benefit, which allows members to "roll over" a portion of their unused benefit-year maximum to the next year. Members may roll over $350 to the next benefit year, as long as they submit at least one claim during the year and total claims do not exceed $500 for that benefit year. The rollover benefit is available to each member on a subscriber's dental policy and can accumulate from one benefit year to the next, up to a maximum of $1,000. This means you can potentially have a $2,000 annual maximum per member, which can provide even more protection for unexpected dental bills.

PLATINUM	**DentalBlue Platinum℠** covers preventive services and minor restorative services, along with major restorative services including inlays and onlays, crowns, bridges, partials, dentures, and implants with no exclusion for missing teeth. DentalBlue Platinum also includes the annual maximum rollover benefit, which allows members to "roll over" a portion of their unused benefit-year maximum to the next year. Members may roll over $350 to the next benefit year, as long as they submit at least one claim during the year and total claims do not exceed $500 for that benefit year.
PLATINUM PREMIUM	**DentalBlue Platinum Premium℠** covers preventive services and minor restorative services, along with major restorative services including inlays and onlays, crowns, bridges, partials, dentures, and implants with no exclusion for missing teeth. DentalBlue Platinum Premium also includes the annual maximum rollover benefit, which allows members to "roll over" a portion of their unused benefit-year maximum to the next year. Members may roll over $900 to the next benefit year, as long as they submit at least one claim during the year and total claims do not exceed $1,500 for that benefit year.
PEDIATRIC	**DentalBlue Pediatric℠** covers preventive services and minor restorative services, along with major restorative services including crowns and dentures. DentalBlue Pediatric also includes In-Network Out-of-Pocket Maximum, meaning each calendar year; a Covered Person must pay the In-Network Coinsurance for covered services up to the In-Network Out-of-Pocket Maximum specified in the Schedule of Benefits. If the Plan provides family coverage, any number of Covered Persons in the family must collectively pay the cost of covered services equal to the In-Network Out-of-Pocket Maximum specified in the Schedule of Benefits. For example, if the Plan covers one Covered Person, the In-Network Out-of-Pocket Maximum will be satisfied when In-Network Coinsurance payments for that Covered Person equal $375. If the Plan covers more than one Covered Person, the In-Network Out-of-Pocket Maximum will be satisfied when In-Network Coinsurance payments for all Covered Persons equal $750. After such payments are made, no further In-Network Coinsurance will be required for the balance of the calendar year, regardless of which Covered Person incurs a claim.

DentalBlue Silver, Gold, Platinum and Platinum Premium: Sample Cards



Denotes plan type; DentalBlue Silver, Gold, Platinum or Platinum Premium

Important Note: We use assigned subscriber identification numbers in place of Social Security numbers. Be sure to use the member's current identification number when submitting claims to avoid delays in payment.

DentalBlue: Optional Benefit Riders

DentalBlue gives employers the option to add certain benefit riders. These include:

- Implant Coverage: Benefits for single-tooth endosteal dental implants, single-tooth abutments and single tooth implant/abutment-supported crowns are available only to members of fully insured groups and individuals enrolled in DentalBlue Gold.
- Maximum Rollover: This benefit is offered to members of fully insured groups and individuals enrolled in DentalBlue Gold. The benefit rewards members who practice good dental care by allowing them to roll over a portion of their unused benefits from year to year. To be eligible, members must:
  - Have received at least one covered service during the benefit period,
  - Have been an active member of the plan on the last day of the benefit period, and
  - Have not exceeded their dental plan's maximum.

  We recommend that you submit a predetermination of benefits for Arkansas Blue Cross members to determine if they have this benefit, as it may change the remaining total amount of members' annual maximum and reduce their out-of-pocket expenses.
- Other benefits: Employers may choose to add coverage for composite resin restorations of posterior teeth.

DentalBlue: Policies and Conditions

Dependent Care Coverage**	Dependent children aged 26 or younger as of the effective date of the policy—including divorced dependents—may continue their coverage by completing a new DentalBlue application within 30 days of becoming ineligible for coverage under their existing policy. At that time, the policyholder will be credited for any met waiting periods and will begin a new benefit year; however, credit will not be given for a met deductible.
Waiting Periods**	DentalBlue plans contain waiting periods prior to certain services being covered. Once the waiting period is satisfied, those services are payable, subject to all other terms, conditions, exclusions and limitations of the policy.
Benefits and Services Not Included**	Orthodontic services; services, procedures or supplies not dentally necessary; services or procedures not prescribed or rendered by a dentist; services or supplies collectible under Workers' Compensation or any law providing benefits for dependents of military personnel; services for conditions for which treatment is provided by federal or state government or are provided without cost; intentional self-inflicted injuries; accidental injuries; injuries or diseases caused by war; cosmetic services; prescription drugs; local or block anesthesia when billed separately; experimental or investigational services; services provided by an immediate relative.
General Coverage Limitations**	Routine exams, prophylaxis, (fluoride treatments, bitewing X–rays for dependent children through age 18) are limited to two per benefit year; bitewing X–rays, one occurrence of two, four or eight vertical bitewings for adults over age 18, are limited to one per benefit year; comprehensive evaluations are limited to one per covered person every 24 months; fixed space maintainers through age 18; rebasing/relining of full or partial dentures, and sealants for dependents through age 15 on permanent first and second molars are limited to one per each three-year period; full mouth radiographs, inlays and onlays for treatment of decay, single crowns, crown buildups including pins, removable prosthetics, resin-bonded retainers, and post and core buildups are limited to one per each five-year period; stainless steel, prefabricated resin or composite resin crowns; root canal therapy, crown lengthening, and guided tissue regeneration are limited to one per tooth per lifetime.
**Special Note: The preceding is a summary only and is NOT intended to substitute for the terms of any Member's applicable Health Plan or insurance policy. All coverage and payment is subject to the precise, full terms of the Member's applicable Health Plan or insurance policy which controls over any contrary or inconsistent provisions of this Dental Manual.	

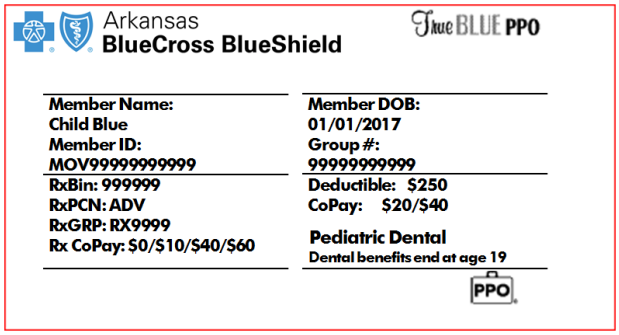
Workers' Compensation

Arkansas Blue Cross contracts with various workers' compensation Payors who refer injured workers to our network of participating providers. Under Arkansas Workers' Compensation Regulations and Rules, employers have the right to make the initial choice of physicians for injured workers, except in emergency treatment. If an injured worker approaches you seeking dental treatment for a worker's compensation injury, please contact that worker's employer (generally via its human resources department) to determine if the injury is compensable and to ensure the employer is aware you will be providing treatment and/or services.

The actual Payor may be the employer, but in most instances will be the employer's workers' compensation insurer who will assign a claims adjuster to coordinate and provide reimbursement for the treatment or service. Under Arkansas Workers' Compensation Rules, health care providers shall be paid the lesser of (1) the provider's usual charge, or (2) the maximum fee established by the AR State Fee Schedule, or (3) the provider's contracted price. When the contracted price for a procedure is the "lesser of," that amount is considered payment in full. Employers, insurers, employees and providers may access the current list of participating dental providers at www.USAbleMCO.com.

Arkansas Blue Cross and Blue Shield Group Members with Pediatric Dental Coverage

Claims must be filed with the correct ID number, including the alpha prefix.
Sample New ID Card with Pediatric Dental Coverage



Dental Xtra

The oral health of your patients can have a big impact on their overall health, especially if they've been diagnosed with certain medical conditions. For members with medical and dental plans with Arkansas Blue Cross, we're able to review their medical claims to identify and automatically enroll those with qualifying health conditions (listed in the grid below) that benefit from additional dental care. We conduct outreach and education to make sure our members are aware of the positive impacts preventive and/ or periodontal dental services have on their total well-being.

Your Partnership with Arkansas Blue Cross

Our Dental Xtra program allows us to combine expertise in all disciplines of comprehensive care. By partnering with Arkansas Blue Cross, you can help your patients who have medical conditions that might benefit the most from preventive dental care. Through Dental Xtra, you can:

- Help your patients achieve better overall health
- Easily identify patients eligible to enroll, or already enrolled, in the program, so they can take advantage of enhanced dental benefits
- Increase your revenue by providing additional services

Effective 1/1/2025

D4355 full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit will be covered once every 24 months at 100% when enrolled in the program (applicable to all covered conditions).

D0120 Periodic oral evaluation (oral health screening) is covered four time per calendar year if member is enrolled in the program for oral, head and neck cancers or Sjögren syndrome.

Eligible medical conditions	Two additional cleanings or periodontal maintenance visits, plus:		
	Periodontal scaling covered 100%	Enhanced cleaning to remove excess plaque buildup	Oral health screenings; fluoride treatments
Chronic obstructive pulmonary disease	✓	✓	
Coronary artery disease	✓	✓	
Diabetes	✓	✓	
End-stage renal disease	✓	✓	
Metabolic syndrome	✓	✓	
Oral, head, and neck cancers		✓	✓
Pregnancy	✓	✓	
Sjögren's syndrome		✓	✓
Stroke	✓	✓	

Note: Chronic obstructive pulmonary disease (COPD), End-stage renal disease (ESRD) and Metabolic syndrome (MetS) are not covered conditions for Medicare Advantage.

Enhanced dental benefits at no additional cost

We've made it easier financially for your patients to take advantage of the program:

- Services do not count toward the annual maximum
- There are no deductibles, copayments or coinsurance (when seen by a participating provider), and waiting periods do not apply
- The benefits are worth more than $1,000 for each enrolled member – additional revenue for your practice

How do my patients enroll?

Members who have medical and dental plans through Arkansas Blue Cross and a qualifying medical condition are auto-enrolled in the program. Members who have only a dental policy with Arkansas Blue Cross or are pregnant must self-enroll. If your patient qualifies and needs to self-enroll, they can do so at https://www.arkansasbluecross.com/members/dental-xtra/enroll.Once you have identified members who are enrolled, we encourage setting up their four prophy recalls.

For more information about the impact oral health has on the qualifying conditions, please visit:

https://www.arkansasbluecross.com/members/dental-xtra

Section 9: Medicare Advantage Plans

Effective January 1, 2025 Arkansas Blue Medicare will be offering the following plans for its Medicare Advantage members to choose from during the open enrollment period.

2025 Medicare Advantage Plans

PPO	PFFS	HMO	EGWP
BlueMedicare Saver Choice BlueMedicare Premier Choice BlueMedicare Freedom Giveback	BlueMedicare Preferred BlueMedicare Value	BlueMedicare Premier BlueMedicare Independence BlueMedicare Classic Plus	Blue Medicare Premier Choice

Providers who participate in Arkansas Medicare Advantage dental network may have access to members with these Medicare Advantage plans.

These Medicare Advantage plans cover a limited number of dental services, but those procedures that are covered have a $0 member copayment in network, with the balance of the allowable charge payable by Arkansas Blue Medicare. Select plans have 30%-50% member copayment. Any dental service not covered by the member's plan may be billed at your usual and customary charge. This does not include procedures that would otherwise be covered but are denied due to frequency limitations having been met. **For dental services not covered by the plan, please notify the members in writing before services are rendered.**

Please be sure to verify eligibility and benefits for all Medicare Advantage members before rendering services, frequencies and limitations vary plan to plan. The diagram below is an **example** of covered procedures, copayments and limitations on one of the various Arkansas Blue Medicare plans.

For Arkansas Blue Medicare eligibility, benefits and claims information please visit our website at https://www.mydentalcoverage.com/shared/login.shtml to access online services on MyDentalCoverage or contact customer service at 1-888-224-5213.

Claims can be files electronically using payor ID TLY26 or mail claims to the address listed below.

Dental Claims Administrator
P. O. Box 69436
Harrisburg, PA 17106-9436

Below are samples of ID Cards.

Arkansas Blue Medicare HMO Member Sample Cards

Arkansas Blue Medicare PPO Member Sample Card

Arkansas Blue Medicare PFFS Member Sample Cards

Arkansas Blue Medicare EGWP Member Sample Cards

Effective January 1, 2025, Medicare Advantage members will no longer have access to the Dental Xtra program or benefits.

Section 10: Member Information

Verifying Member Eligibility, Benefits and Claim Status

You can obtain patient eligibility, benefits, claims status, maximums, deductibles, service history, allowance information, procedure code information, and orthodontic information via:

- **The Dental Information Center:** Reach us at **1-888-224-5213**. Please have the patient's name, ID number, and date of birth ready when you call.
- **Interactive Voice Response (IVR) System:** Our Customer Service IVR System offers dentists and most subscribers access to information stored in records and the capability of finalizing predeterminations for payment via the telephone. This automated system requires a touch-tone telephone and provides an immediate response. **You can choose to listen to the information or, in most instances, request the information by fax**. The IVR system is available to respond to your inquiries 24 hours a day, 7 days a week, except when our databases are undergoing scheduled maintenance.
- **Our website:** Providers can access member information on United Concordia's website by registering for **MyDentalCoverage** to obtain immediate, up-to-the-minute access to member information 24 hours a day, 7 days a week.
- **Federal Employee Program:** For FEP members, call **1-800-482-6655**.

Confidentiality of Patient Information

The Privacy Rule enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has strengthened the protections already in place at Arkansas Blue Cross to safeguard our members' protected health information (PHI). Since the Privacy Rule applies to Payors and providers, Arkansas Blue Cross shares with you the responsibility of protecting privacy. Please see Section IV of your Agreement for reference to your commitments regarding Member records and PHI confidentiality.

The HIPAA Privacy Rule allows for Arkansas Blue Cross to share PHI with other parties without members' authorization under certain circumstances, including when we have a business relationship with the third party and to the extent we need to share the information to support treatment, payment or health care operations, as defined by the Privacy Rule. If you have questions about the Privacy Rule, seek advice from your attorney or business counselor.

We are sensitive to concerns about confidentiality and will take every precaution to protect the privacy of your patients' dental records, including validating your provider information when you call us. As your Agreement with Arkansas Blue Cross states, we may require access to or copies of members' dental records. Our members' Health Plans and insurance policies advise members of our right to assess and handle their records to support treatment, payment and healthcare operations.

Section 11: Predeterminations and Claims

Predeterminations

Overview

Download the most current ADA claim form at www.adacatalog.org. To order a hard copy, contact your dental office supplier or software administrator or call the ADA at 1-800-947-4746.

A predetermination is a written request by a provider for verification of benefits prior to rendering services. This request helps us determine how we will process a claim based on a member's benefits. A predetermination is not a guarantee of payment, but is designed to determine:

- If a service is covered under the member's plan
- If the procedure meets our utilization review guidelines and dental policy
- If any time limitations apply on a procedure
- The projected estimated payment for the procedure

Some plans require a predetermination for services. Please verify with Customer Service if a predetermination is needed. We recommend you submit a predetermination for prosthetics and crowns, inlay/onlay restorations, and periodontal services totaling more than $300 in allowable expenses.

We process a predetermination as if it were an actual claim and respond via a pre-treatment estimate. You and the member will be notified of all approvals and denials.

How to Submit a Predetermination

Complete the most current version of the *ADA Dental Claim Form* as if you were submitting an actual claim for services. Do not enter a date of service on the claim. Remember to:

- Enter an X in Box 1 of the claim form next to "Request for Predetermination/ Preauthorization."
- List only the services to be included in the predetermination.
- Send the predetermination electronically, if possible.
- For Arkansas Blue Cross plans, paper requests may be sent to:

  Dental Claims Administrator
  P.O. Box 69436
  Harrisburg, PA 17106-9436

Pre-Authorizations

As of April 1, 2022, Health Advantage fully insured and Arkansas Blue Cross and Blue Shield fully insured medical policies will require prior approval of prosthodontics services. Contact your members medical policy for more information.

How to Submit a Clean Claim

Sample Form and Instructions

Completing a Dental Claim Form

Please follow the instructions below to complete the most current *ADA Dental Claim Form*, which you can find on the ADA website or in the most current ADA Practical Guide to Dental Procedure Codes. *A sample form follows these instructions.*

Header Information (blocks 1 and 2)

- 1: Enter an X in the appropriate box to indicate if this claim is a pre-treatment estimate or a claim for actual services rendered.
- 2: Predetermination/Preauthorization Number is not required.

Insurance Company/Dental Benefit Plan Information (block 3)

For Arkansas Blue Cross plans: Dental Claims Administrator P.O. Box 69436 Harrisburg, PA 17106-9436	*For Federal Employee Program:* Arkansas Blue Cross and Blue Shield FEP– Dental P.O. Box 2181 Little Rock, AR 72203

Other Coverage (blocks 4-11) refers to the possible existence of other medical or dental insurance policies, relevant for coordination of benefits.

Policyholder/Subscriber Information (blocks 12-17) documents information about the insured person (subscriber), who may or may not be the patient.

Patient Information (blocks 18-23) refers to the patient receiving services or treatment.

Record of Services Provided (blocks 24-35) regards the treatment performed or proposed. For a predetermination of benefits, complete this area in the same way as for an actual service, but omit the date of service. Ten lines are available for reporting.

Authorizations (blocks 36 and 37) are where the patient or subscriber signs to provide consent for treatment and authorization for direct payment.

Ancillary Claim/Treatment Information (blocks 38-47) asks for additional information regarding the claim and the member's prior dental history. Some of these questions may be left blank if the service is not orthodontic or prosthetic.

Billing Dentist or Dental Entity (blocks 48-52A) provides information on the dentist or group/corporation responsible for billing and receiving payment, which may or may not be the treating dentist. *Block 49 is specific to reporting the associated National Provider Identifier (NPI).*

Treating Dentist and Treatment Location Information (blocks 53-56A) asks for information specific to the provider. Block 54 asks for the treating dentist's NPI. To obtain an NPI, visit the Centers for Medicare & Medicaid Services' National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/NPPES/Welcome.do. *You must submit all claims with your NPI information.*

Billing with a National Provider Identifier (NPI)

If you have a Type 1 NPI (Sole Proprietor), submit your claim using the Type 1 NPI in blocks 49 and 54.
If you have a Type 2 NPI (Professional Corporation, Limited Liability Corporation or Incorporated—PA, PC, LLC or INC), submit your claim using the Type 2 NPI in block 49 and the rendering provider's NPI (Type 1) in block 54.

Sample Claim Form

Dental Claim Form

Arkansas BlueCross BlueShield

Send Completed Claim Form To:
Dental Claims Administrator
P.O. Box 69436
Harrisburg, PA 17110-9436

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

INSURANCE COMPANY/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 | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved for Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

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-9 = B; 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 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

J430D/12

HOW TO FILE A CLAIM

1. Complete boxes 1 – 23.
2. Please ensure box 15 contains your member number as it appears on your ID card.
3. Be sure to sign the authorization to release information in box 36.
4. If you wish to have your benefits paid directly to your dentist, sign box 37.
5. Ask your dentist to complete boxes 24 – 58, or attach an original itemized billing from the dentist on his/her letterhead or approved ADA claim form that includes all information requested in boxes 24-58.
6. Attach all related Explanation of Benefits statements for other coverage if applicable.
7. PLEASE KEEP COPIES OF YOUR BILLS PRIOR TO SENDING THE ORIGINALS WITH THIS CLAIM. SERVICES THAT ARE DENIED FOR PAYMENT WILL BE NOTED ON YOUR EXPLANATION OF BENEFITS. NO BILLS ARE RETURNED TO YOU EVEN IF THEY ARE DENIED FOR PAYMENT.
8. Send completed claim form to:

   Dental Claims Administrator
   PO Box 69436
   Harrisburg, PA 17110-9436

NOTE: Subscriber submitted claim forms must be submitted within two years of the date of service. Claims which cannot be identified due to incomplete subscriber information will be returned.

HOW TO REACH US

Phone:
- Members - (888) 223-4999
- Providers - (888) 224-5213

Write:
Dental Customer Service
PO Box 69437
Harrisburg, PA 17110-9436

Section 12: Coordination of Benefits (COB)

Determining the Primary Payor

The first of the following rules applicable shall be used by Arkansas Blue Cross to determine the primary payor.

1. The plan that covers the person as an employee or member, other than as a dependent, is determined to be primary before the dental plan that covers the person as a dependent.

   However, if the person is also a Medicare beneficiary, Medicare is secondary to the dental plan covering the person as a dependent of an active employee. The order in which dental benefits are payable will be determined as follows:

   a. dental benefits of a plan that covers a person as an employee, member or subscriber
   b. dental benefits of a plan of an active employee that covers a person as a dependent
   c. Medicare benefits
2. When two or more dental plans cover the same child as a dependent of different parents:
   a. The dental benefits of the plan of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the dental plan of the parent whose birthday, excluding the year of birth, falls later in the year; but
   b. If both parents have the same birthday, the dental benefits of the plan that has covered the parent for the longest are determined before those of the plan that has covered the parent for the shorter period of time.

      However, if one of the plans does not have a provision that is based on the birthday of the parent, but instead on the gender, this results in each plan determining its benefits before the other, the plan that does not have a provision based on a birthday will determine the order of dental benefits.
3. If two or more dental plans cover a dependent child of divorced or separated parents, dental benefits for the child are determined in this order:
   a. the plan of the parent with custody of the child
   b. the plan of the spouse of the parent with custody of the child
   c. the plan of the parent not having custody of the child

      However, if the specific terms of a court decree make one parent financially responsible for the dental care expenses of the child, and if the entity obliged to pay or provide the dental benefits of the dental plan of that parent has actual knowledge of those terms, the dental benefits of that plan are determined first. This does not apply with respect to any claim determination period or dental plan year during which any dental benefits are actually paid or provided before that entity has the actual knowledge.
4. The dental benefits of a dental plan that covers a person as an employee other than as a laid-off or retired employee, or as a dependent of such a person, are determined before those of a dental plan that covers that person as a laid off or retired employee or as a dependent of such a person. If the other dental plan is not subject to this rule, and if, as a result, the dental plans do not agree on the order of dental benefits, this paragraph shall not apply.
5. If an individual is covered under a COBRA continuation plan and also under another group dental plan, the following order of benefits applies:
   a. The dental plan which covers the person as an employee or as the employee's dependent
   b. The coverage purchased under the dental plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA

If none of the above rules determines the order of dental benefits, the dental benefits of the plan that has covered the employee, member or insured the longest period of time are determined before those of the other dental plan.

Coordination of Benefits shall not be permitted against the following types of policies:

1. Indemnity
2. Excess insurance
3. Specified illness or accident
4. Medicare supplement

Determining Your Patient's Liability in a COB Situation

If Arkansas Blue Cross Plan is the Secondary Plan in accordance with the order of benefits determination rules outlined above, the benefits of the Plan will be reduced when the sum of:

1. The benefits that would be payable for the allowable expense under the Arkansas Blue Cross Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those Allowable Expenses in a claim determination period. In that case, the benefits of the Arkansas Blue Cross Plan will be reduced so that its benefits and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of the Arkansas Blue Cross Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Plan.

Helpful Tips

In situations where you believe your patient may be covered by more than one Payor, the following hints may help you manage the claim more efficiently:

- Determine your patient's primary Payor and submit the claim to that Payor first.
- Submit the primary Payor's Explanation of Benefits (EOB) to the secondary Payor (even if both Payors are Blue Cross Blue Shield plans).
- Always calculate your patient's liability by claim line rather than by using the total claim payment amount, waiting until all insurance payments have been made.
- Remember that the secondary Payor's EOB may not correctly reflect the patient's balance and that your patient's liability may be affected by contracts that you hold with the primary carrier.

Section 13: Reimbursement

Overview

Arkansas Blue Cross (or its designated third party claims administrator, such as UCCI) will always reimburse claim payments for covered members directly to the participating provider. If an unassigned claim is submitted on behalf of the member, we will still pay the claim directly to the participating dentist.

Services That Are Not Covered

In accordance with the Arkansas Blue Cross Dental PPP and PPO Fee Schedules, participating dentists agree to accept as payment in full the lesser of either their Usual Charge or the Allowance for dental services provided under the applicable dental program, less any applicable member cost-share, such as a deductible, co-insurance or copayments. You may not bill your patient for the difference between our allowed amount and your actual charge, except in these instances:

- ***The procedure is non-covered*.** If a service is not considered an eligible service under the member's benefit plan (i.e., it is not listed on the Schedule of Allowances), you can collect your fees. You should verify with your patients that services are covered; for any that are non-covered, please inform the patients that they will be responsible for your actual charge. (Please note that your Agreement imposes other conditions on billing of Members for any services that are not Medically Necessary or which are Experimental/Investigational, including the requirement to first obtain a written waiver from the Member – See Section II (C) of the Agreement).
- ***A member has exhausted their annual maximum benefit and any roll-over benefit, if applicable*.** In this instance, you can collect your full fee (subject only to the Agreement's preconditions for billing of any services that are not Dentally Necessary or Experimental/Investigational). Please verify that the patient has exhausted all benefits and inform them of their responsibility for your actual charge.
- ***The service was an Alternate Treatment (per the Member's Certificate)*.**

Here is an example of how we calculate the member's cost-share for a non-covered service:

Procedure Code	Your Charge	Coverage Level	Allowed Amount	Member Cost-share
D0460	$50	0%	$0	$50

Co-insurance

Co-insurance is a type of member cost-share representing a percentage of the allowed amount for covered services. If the member's dental plan covers a procedure at less than 100%, the member is responsible for the difference between what we pay and the allowed amount, as shown in this example:

Procedure Code	Benefit Type	Coverage Level	Allowed Amount	Member's Co-insurance
D2150	Basic	80%	$100	$100 x 20% = $20

The member's co-insurance is based on a percentage of your Arkansas Blue Cross applicable Schedule of Allowances and the member's benefit structure. The member is responsible for all non-covered services (with exceptions as noted above – See Section II (C) of your Agreement). You can collect the member's co-insurance at the time of the visit or bill the member after you receive payment from us.

Deductibles

Covered services may be subject to a deductible, a specified amount of money the member must pay before coverage begins. Generally, the deductible applies annually with a per-member amount that cannot exceed a family total maximum for the benefit period. Any member cost-share that applies toward the deductible shall be based upon the provider's Usual Charge or the Allowance, whichever is less, as shown in this example:

Member's Yearly Deductible	Your Charge	Allowed Amount	Member Cost-share Applied Toward Deductible
$50	$30	$25	$25

Common Reasons for Non-Payment

To familiarize yourself with Arkansas Blue Cross reimbursement requirements, please refer to the list below of messages commonly found on dental remittances to explain non-payment:

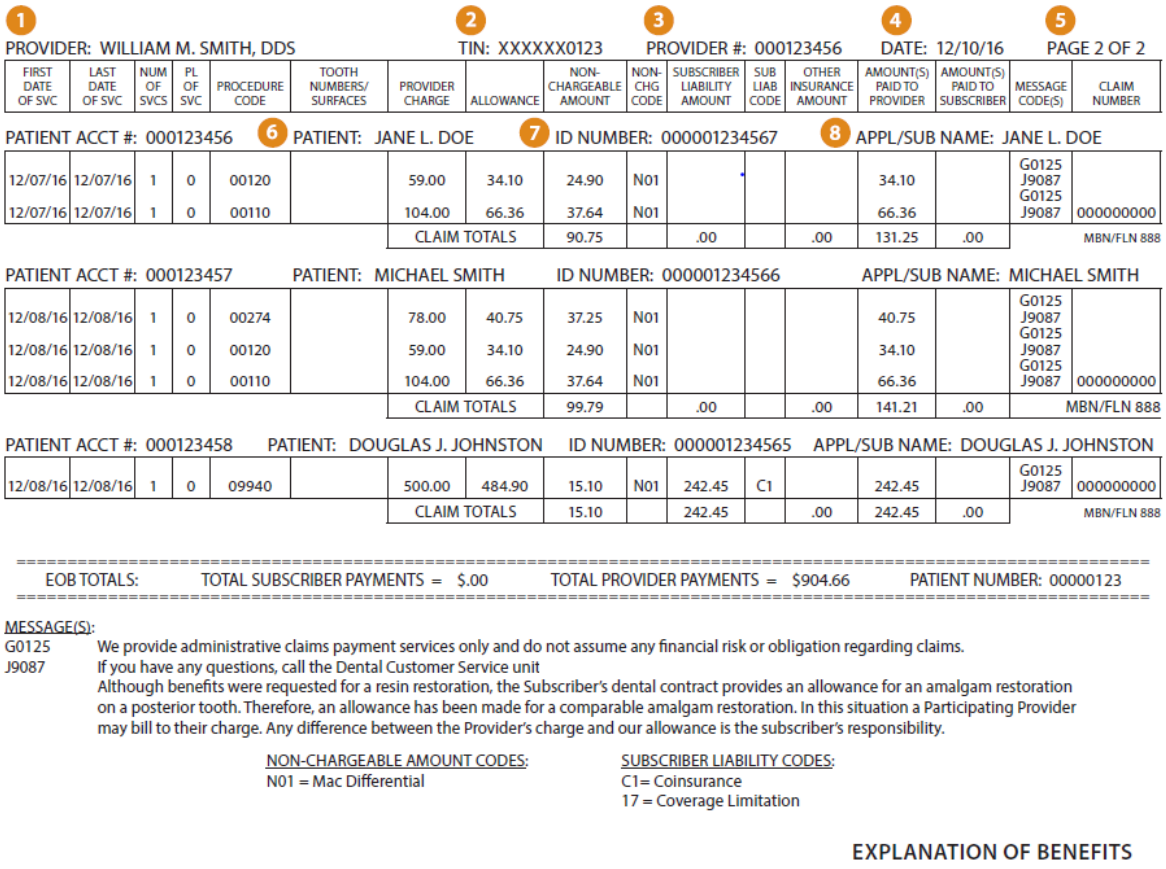
- No payment can be made. The reported procedure is covered once in a 3-year period. Benefits have been provided previously for a similar service within this time period.
- No payment can be made. The patient's coverage does not provide for this service.
- No payment can be made. The reported service is covered twice in a contract year period.
- No payment can be made. The maximum benefit amount available under the patient's coverage has been paid. **IF THIS HAS OCCURRED, YOU MAY BALANCE BILL THE MEMBER.**
- No payment can be made. An incomplete dental claim has been received in our office. Please submit a dental claim form with the tooth number(s) for the procedure(s) reported, include x-ray(s), periodontal charting and any narrative if required.
- This patient cannot be identified from the identification number reported above. Please verify the name and number shown on the ID card. If the patient is covered, please resubmit the claim.
- No payment can be made. This service is subject to a waiting period as required under the patient's coverage.
- The maximum allowance for bitewing radiographs (x-rays) has been paid.

If you have questions about your remittance, please call Customer Service at 1-888-224-5213 Monday through Friday from 8:00 a.m. to 6:00 p.m. ET.

How to Request a Fee Schedule

Fee schedules can be found on the Dental Provider page under fee schedule at https://www.arkansasbluecross.com/providers/dental-providers/dental-fee-schedule. If you have questions about a fee schedule, please contact your Provider Network Representative, indicating the Plan name (DentalBlue, BlueCare, or FEP).

Sample Dental EOB



1 PROVIDER: WILLIAM M. SMITH, DDS 2 TIN: XXXXXX0123 3 PROVIDER #: 000123456 4 DATE: 12/10/16 5 PAGE 2 OF 2

FIRST DATE OF SVC	LAST DATE OF SVC	NUM OF SVCS	PL OF SVC	PROCEDURE CODE	TOOTH NUMBERS/ SURFACES	PROVIDER CHARGE	ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	SUBSCRIBER LIABILITY AMOUNT	SUB LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODE(S)	CLAIM NUMBER
PATIENT ACCT #: 000123456				6 PATIENT: JANE L. DOE				7 ID NUMBER: 000001234567				8 APPL/SUB NAME: JANE L. DOE				
12/07/16	12/07/16	1	0	00120		59.00	34.10	24.90	N01				34.10		G0125 J9087	
12/07/16	12/07/16	1	0	00110		104.00	66.36	37.64	N01				66.36		G0125 J9087	000000000
					CLAIM TOTALS			90.75		.00		.00	131.25	.00		MBN/FLN 888
PATIENT ACCT #: 000123457				PATIENT: MICHAEL SMITH				ID NUMBER: 000001234566				APPL/SUB NAME: MICHAEL SMITH				
12/08/16	12/08/16	1	0	00274		78.00	40.75	37.25	N01				40.75		G0125 J9087	
12/08/16	12/08/16	1	0	00120		59.00	34.10	24.90	N01				34.10		G0125 J9087	
12/08/16	12/08/16	1	0	00110		104.00	66.36	37.64	N01				66.36		G0125 J9087	000000000
					CLAIM TOTALS			99.79		.00		.00	141.21	.00		MBN/FLN 888
PATIENT ACCT #: 000123458				PATIENT: DOUGLAS J. JOHNSTON				ID NUMBER: 000001234565				APPL/SUB NAME: DOUGLAS J. JOHNSTON				
12/08/16	12/08/16	1	0	09940		500.00	484.90	15.10	N01	242.45	C1		242.45		G0125 J9087	000000000
					CLAIM TOTALS			15.10		242.45		.00	242.45	.00		MBN/FLN 888

EOB TOTALS: TOTAL SUBSCRIBER PAYMENTS = $.00 TOTAL PROVIDER PAYMENTS = $904.66 PATIENT NUMBER: 00000123

MESSAGE(S):
G0125 We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.
J9087 If you have any questions, call the Dental Customer Service unit
Although benefits were requested for a resin restoration, the Subscriber's dental contract provides an allowance for an amalgam restoration on a posterior tooth. Therefore, an allowance has been made for a comparable amalgam restoration. In this situation a Participating Provider may bill to their charge. Any difference between the Provider's charge and our allowance is the subscriber's responsibility.

NON-CHARGEABLE AMOUNT CODES:
N01 = Mac Differential

SUBSCRIBER LIABILITY CODES:
C1= Coinsurance
17 = Coverage Limitation

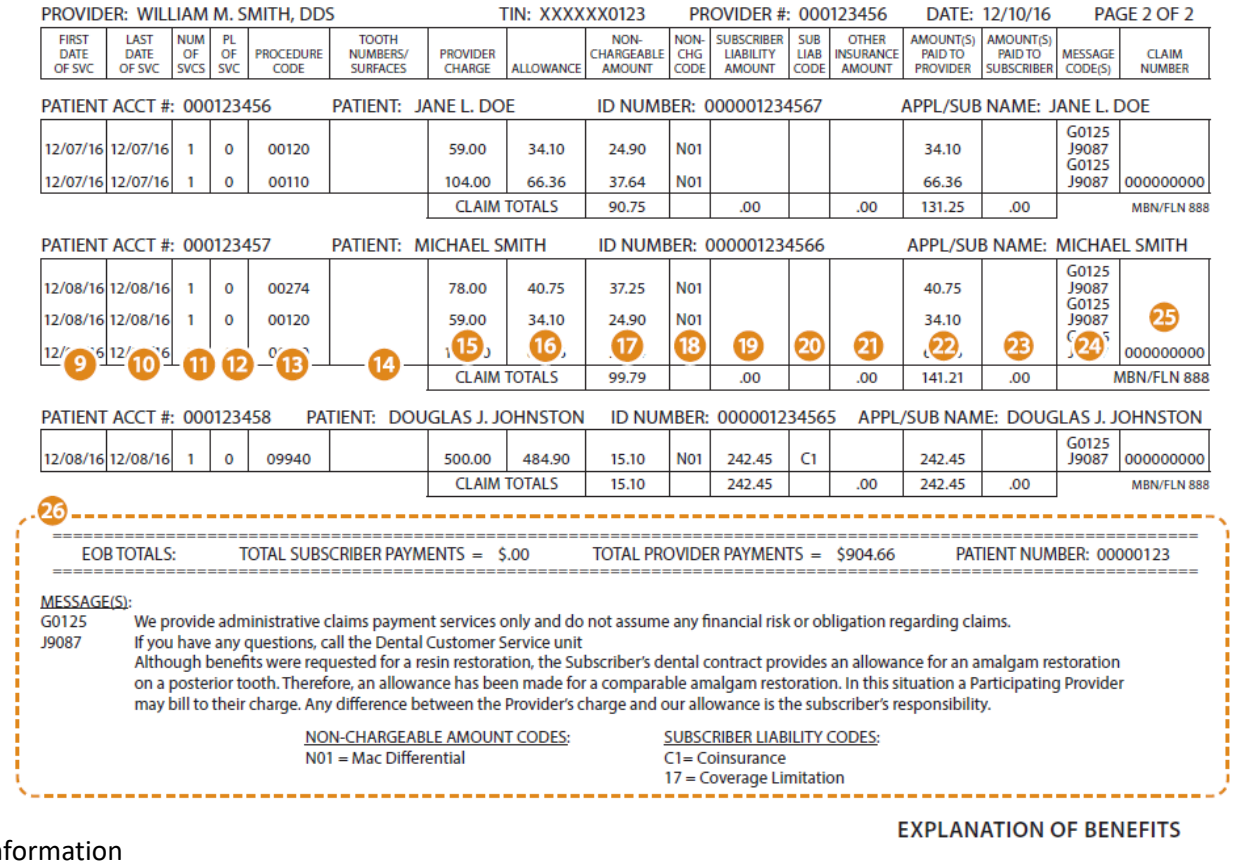
EXPLANATION OF BENEFITS

HOW TO READ THE DEOB

Dentist Information

At the top of the page, the following dentist information is indicated:

1. Provider: The name of dentist who billed the service
2. TIN number: Tax Identification Number as it appears on Federal 1099
3. Provider number: United Concordia's dentist identification number
4. Date: The date United Concordia generated the DEOB
5. Page: The number of pages in the Summary Payment Voucher Patient Information
6. Patient: The name of the member who received the listed services
7. ID Number: Subscriber Identification Number
8. APPL/SUB name: The name of the subscriber



PROVIDER: WILLIAM M. SMITH, DDS TIN: XXXXXX0123 PROVIDER #: 000123456 DATE: 12/10/16 PAGE 2 OF 2

FIRST DATE OF SVC	LAST DATE OF SVC	NUM OF SVCS	PL OF SVC	PROCEDURE CODE	TOOTH NUMBERS/ SURFACES	PROVIDER CHARGE	ALLOWANCE	NON-CHARGEABLE AMOUNT	NON-CHG CODE	SUBSCRIBER LIABILITY AMOUNT	SUB LIAB CODE	OTHER INSURANCE AMOUNT	AMOUNT(S) PAID TO PROVIDER	AMOUNT(S) PAID TO SUBSCRIBER	MESSAGE CODE(S)	CLAIM NUMBER
PATIENT ACCT #: 000123456				PATIENT: JANE L. DOE					ID NUMBER: 000001234567					APPL/SUB NAME: JANE L. DOE		
12/07/16	12/07/16	1	0	00120		59.00	34.10	24.90	N01				34.10		G0125 J9087	
12/07/16	12/07/16	1	0	00110		104.00	66.36	37.64	N01				66.36		G0125 J9087	000000000
						CLAIM TOTALS		90.75		.00		.00	131.25	.00		MBN/FLN 888
PATIENT ACCT #: 000123457				PATIENT: MICHAEL SMITH					ID NUMBER: 000001234566					APPL/SUB NAME: MICHAEL SMITH		
12/08/16	12/08/16	1	0	00274		78.00	40.75	37.25	N01				40.75		G0125 J9087	
12/08/16	12/08/16	1	0	00120		59.00	34.10	24.90	N01				34.10		G0125 J9087	25
12/ 9	12/ 10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	000000000
						CLAIM TOTALS		99.79		.00		.00	141.21	.00		MBN/FLN 888
PATIENT ACCT #: 000123458				PATIENT: DOUGLAS J. JOHNSTON					ID NUMBER: 000001234565					APPL/SUB NAME: DOUGLAS J. JOHNSTON		
12/08/16	12/08/16	1	0	09940		500.00	484.90	15.10	N01	242.45	C1		242.45		G0125 J9087	000000000
						CLAIM TOTALS		15.10		242.45		.00	242.45	.00		MBN/FLN 888

26

EOB TOTALS: TOTAL SUBSCRIBER PAYMENTS = $.00 TOTAL PROVIDER PAYMENTS = $904.66 PATIENT NUMBER: 00000123

MESSAGE(S):
G0125 We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.
J9087 If you have any questions, call the Dental Customer Service unit
Although benefits were requested for a resin restoration, the Subscriber's dental contract provides an allowance for an amalgam restoration on a posterior tooth. Therefore, an allowance has been made for a comparable amalgam restoration. In this situation a Participating Provider may bill to their charge. Any difference between the Provider's charge and our allowance is the subscriber's responsibility.

NON-CHARGEABLE AMOUNT CODES:
N01 = Mac Differential

SUBSCRIBER LIABILITY CODES:
C1= Coinsurance
17 = Coverage Limitation

EXPLANATION OF BENEFITS

Claim Information

9.First date of service
10.Last date of service
11.Number of services reported for that procedure code
12.Place of service: The example provided lists "O", the code for office. Other places of service include hospitals or emergency center facilities
13.Procedure code: Current ADA codes used to identify services performed by the dentist
14.Tooth numbers and surfaces: Identifies the teeth and surfaces that were treated
15.Provider charge: The amount the dentist charged for the procedure
16.Allowance: The amount United Concordia allows for the service reported
17.Non-chargeable amount: If services are performed by a participating dentist, the amount listed here will show the difference between the dentist's charge and United Concordia's allowance, as well as the amount for any non-billable services
18.Non-chargeable code: Indicates the reason for the non-chargeable amount and is explained in the message(s) section of the voucher
19.Subscriber liability amount: The amount the subscriber is responsible for such as deductible, coinsurance or the amount exceeding the maximum.
20.Subscriber liability code: Identifies the nature of any dollar amounts for which the subscriber is liable. For example, C1 = Coinsurance
21.Other insurance amount: Amount paid by primary insurance when the subscriber or spouse has other dental insurance
22.Amount paid to provider: The amount United Concordia paid for the services to the dentist
23.Amount paid to the subscriber: The amount United Concordia paid to the subscriber
24.Message code: The code in this field matches the code in the explanation field at the bottom of the claim
25.Claim number: The identification number assigned to the claim by United Concordia for internal processing purposes
26.Totals and narrative information: Following the second table, a summary of DEOB totals, total subscriber payments, total provider payments and payment number will be listed. Narrative information provides explanations of any message codes, non-chargeable amount codes and subscriber liability codes listed in the fields above

Section 14: Handling Overpayment Requests

Overview

Occasionally, Arkansas Blue Cross may overpay a dental claim. Some reasons for overpayment include:

- Processing under an incorrect procedure code
- Paying a claim for a member who is not a patient of record with the provider's office
- Paying a claim without coordinating benefits

In these circumstances, we are required to correct the action and issue a Request for Refund (invoice) to the provider, which includes information needed for the provider to refund to the Payor the overpayment.

This section does not apply to FEP overpayments. If you discover an overpayment, please call Customer Service at (888) 224-5213 Monday through Friday from 8:00 a.m. to 6:00 p.m. ET.

If You Receive a Request for Refund

If you receive a letter requesting a refund, please:

- Make a copy of the letter and include it with your refund.
- **Make the check payable to ARKANSAS BLUE CROSS.**
- To ensure prompt and accurate posting, send your payment within fifteen (15) days of receipt to:
  Cashier
  Customer Collection Services
  P.O. Box 69402
  Harrisburg, PA 17106

Please note: If payment is not received by the invoice due date, the Payor will collect the money by deducting the overpaid amount from future payments made to you by the Payor. This is called an offset. These payments may be deducted from different claims for claimants other than those who incurred the overpayment.

If You Discover an Overpayment

If you discover that Arkansas Blue Cross or BlueAdvantage Administrators of Arkansas has overpaid you, please call Customer Service at **1-888-224-5213** and provide the amount of the claim, the claim number and the patient ID number. The representative will confirm the overpayment and, if necessary, have a Request for Refund mailed to your office. After that, you may do one of the following:

- Cash the check and wait for the Request for Refund letter, then follow the steps above for "If You Receive a Request for Refund."
- Return the check. To ensure we credit the refund to the appropriate account, we recommend that you wait for the Request for Refund letter to arrive and attach it to the check you are returning.

Section 15: Orthodontic Services

Orthodontic Treatment Types and Claim Submission Guidelines

Review of the Members Orthodontic Benefits and Treatment Planning are essential to the timely and accurate payment of claims for Orthodontic Treatment.

Limited Orthodontic Treatment:

- Orthodontic treatment with a limited objective, not involving the entire dentition.

Example: Treatment in one arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge, implant and partial treatment for closure of a space.

Interceptive Orthodontic Treatment:

- Procedures to lessen the severity of future effects of a malformation and to eliminate its cause.

Example: The redirection of ectopically erupted tooth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.

Comprehensive Orthodontic Treatment:

- Multiple phases of treatment provided at different stages of dentofacial development.

Example: The use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both should be listed as comprehensive treatment modified by the appropriate stage of dental development.

Claim Submission Guidelines and Payments for Orthodontic Services

If you are billing for:	Please include the following on your claim:	We will reimburse you:
Limited, Interceptive or Minor Treatment	Itemized claim for services rendered	Onetime payment deducted from patients overall lifetime ortho maximum
Comprehensive Treatment (when patient's ortho benefit coverage is in effect when treatment begins)	• Appropriate CDT procedure codes • Treatment start date • Total case fee • Length of treatment plan or estimated end date • The monthly visit fee	One installment of 25% of the lifetime maximum treatment liability. Pro-rated payments continue monthly until the treatment has ended or benefits are exhausted. *One lump sum for all new cases in which the total allowable charge is $750 or less.
Comprehensive Treatment (when patient's ortho benefit coverage becomes effective after treatment begins, or if there is a change in providers mid treatment)	• Appropriate CDT procedure codes • Treatment start date • Total case fee • Length of treatment plan or estimated end date • The monthly visit fee	A prorated payment will be calculated by comparing the banding date to the effective date of coverage and remaining length of treatment. Benefit dollars provided by a prior carrier will be considered in determining the patient's available benefit. Payments will be generated monthly.

Section 16: General Policies and Procedures

Quality and Utilization Review

While we continue to conduct utilization review on submitted claims, as a participating dentist we no longer require submission of radiographs or periodontal charting, except in specific cases or unless requested by the plan.

From time to time we may request that your practice participate in utilization management programs that may include, an on-site review of facilities, onsite review of dental records, providing copies of member dental records, audit of dental records, dental care evaluation studies, practice pattern studies and/or analysis based on claims data.

Necessary and Appropriate Care

Our members' Subscriber Certificates or Guide to Benefits specify that all dental care—including services, procedures, supplies and appliances–must be "necessary and appropriate to diagnose or treat [the] dental condition." Necessary and appropriate care must meet these criteria:

- The care must address the prevention, diagnosis and/or treatment of oral disease, decayed or fractured teeth, or a supporting structure weakened by disease (including periodontal, endodontic and related diseases).
- The care must be furnished in accordance with standards of good dental practice.
- The care must be provided in the most appropriate site and at the most appropriate level of services based upon the Member's condition
- The care must not be provided solely to improve a Member's condition beyond normal variation in individual development and aging, including improving physical appearance that is within normal individual variation;
- The care must be as beneficial as any established alternative; and
- The care must not be solely for the member's or dentist's convenience.

Information Needed to Review a Procedure

Please refer to the CDT Guide for information you must submit for procedures **requiring review**. In cases where we request a detailed narrative, please supply details about the patient's condition that will help us evaluate your claim and reimburse you appropriately.

Please refer to the CDT Guide for any specific requirements needed when submitting claims for treatment. Any radiographs you submit must be:

- Preoperative periapicals that are current and dated
- Labeled – left or right side – if duplicates
- Mounted, if they are a full series
- Of diagnostic quality
- Labeled with the patient's name and ID number
- Labeled with the dentist's name and address

Return of Radiographs

Radiographs or attachments will not be returned unless specifically requested by the dental office and accompanied by a pre-addressed, postage-paid envelope.

Section 17: Appeals and Grievances

If we deny payment of a claim, your patient has the right to request an appeal in writing. The appeal must be in writing, and received by Arkansas Blue Cross within a specific time period of the denial, depending on the patient's plan (see chart below.) We will immediately acknowledge the appeal and respond in writing within a specific period, depending on the patient's plan. You may request an expedited appeal if you feel that any delay would prevent a patient from receiving urgently needed services.

	Private Business	Federal Employee Program
Submission Period to file appeal	One year from the date of denial	Six (6) months from the date of denial
Response time by Arkansas Blue Cross *(non-urgent claims)*	60 calendar days from receipt of appeals information	30 days from the date of written request to pay claim, deny claim or request for more information.
Response time by Arkansas Blue Cross *(urgent claims)*	72 hours	72 hours
Mailing Address for Appeals	Dental Claims Administrator PO Box 69437 Harrisburg, PA 17106-9437	Federal Employee Program Dental Claims Reconsideration Arkansas Blue Cross – FEP Dental P.O. Box 2181 Little Rock, AR 72203
Customer Service Contact Number	(888) 224-5213	(800) 482-6655

Section 18: Federal Employee Program (FEP)

Overview

The Federal Employee Program (FEP) is a nationwide Federal Employee program. Claims and customer service functions are administered through the local Blue Cross and Blue Shield Association. The FEP membership card is identified by the following enrollment codes:

ID Card Enrollment Code	Member's Plan
104	Standard Option Individual Policy
105	Standard Option Family Policy
106 (Effective 01/01/16)	Standard Option Self Plus One
111	Basic Option Individual Policy
112	Basic Option Family Policy
113 (Effective 01/01/16)	Basic Option Self Plus One

Providers should always verify member eligibility by using the Availity Provider Portal or call the FEP Customer Service Center at (800-482-6655).

Arkansas Blue Cross is responsible for servicing and recruiting the Participating Dentist Network for FEP, and for ensuring the accuracy of the online provider directory and the provider file used for claims processing.

Dentists who participate in FEP must provide care to members of both the FEP Basic Option and Standard Option plans. You can determine which plan a member has by looking at the ID card. (See samples on the following page.) The card will have a unique ID number beginning with an "R" to indicate FEP, as well as one of these enrollment codes:

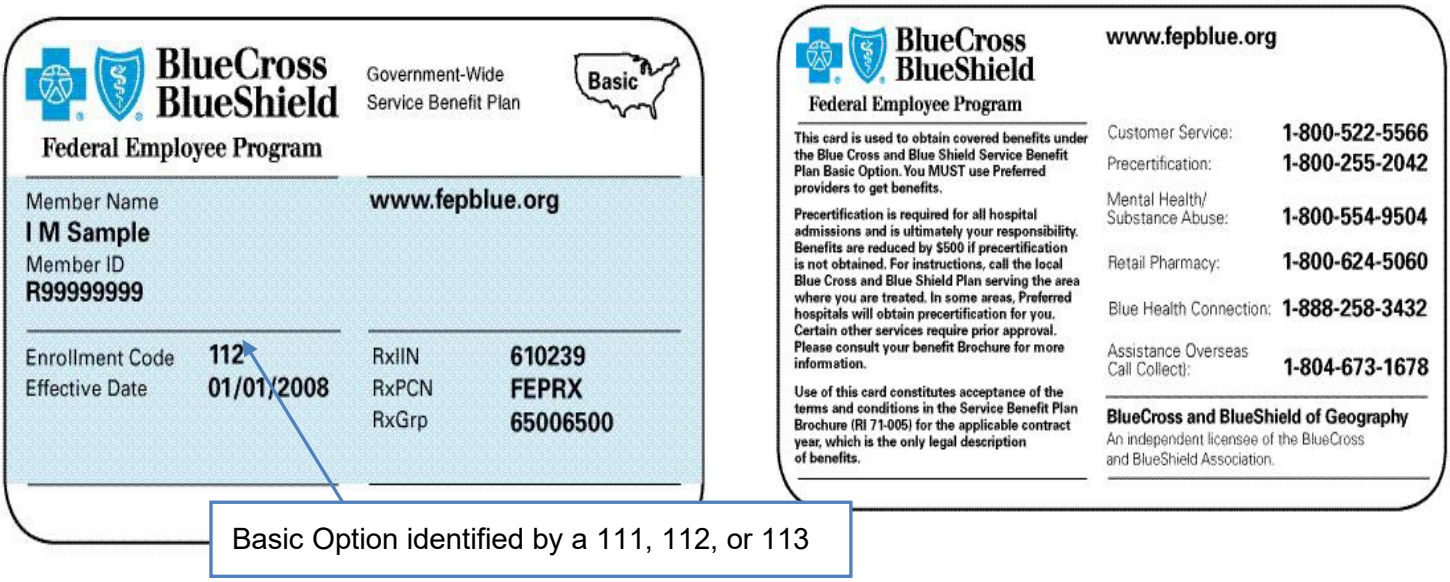
Highlights of Basic and Standard Options

Note: FEP refers nationally to the established allowance for a procedure (the amount you agree to accept as payment in full) as the maximum allowable charge (MAC).

Features of Basic and Standard Options

- The Basic and Standard Options have separate lists of covered services.
- For procedures on both lists, the MAC is the same.
- For procedures not covered under either option, you may charge your usual fee.
- If a procedure is not covered under FEP, do not bill it to FEP (unless you require a rejection for coordination of benefits).
- Neither plan requires payment of a deductible.
- The Customer Service for both options is **1-800-482-6655.**
- Prior approval of coverage will no longer be required for surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof, and floor of mouth for care provided within 72 hours of the accidental injury.

Basic Option



Basic Option Features

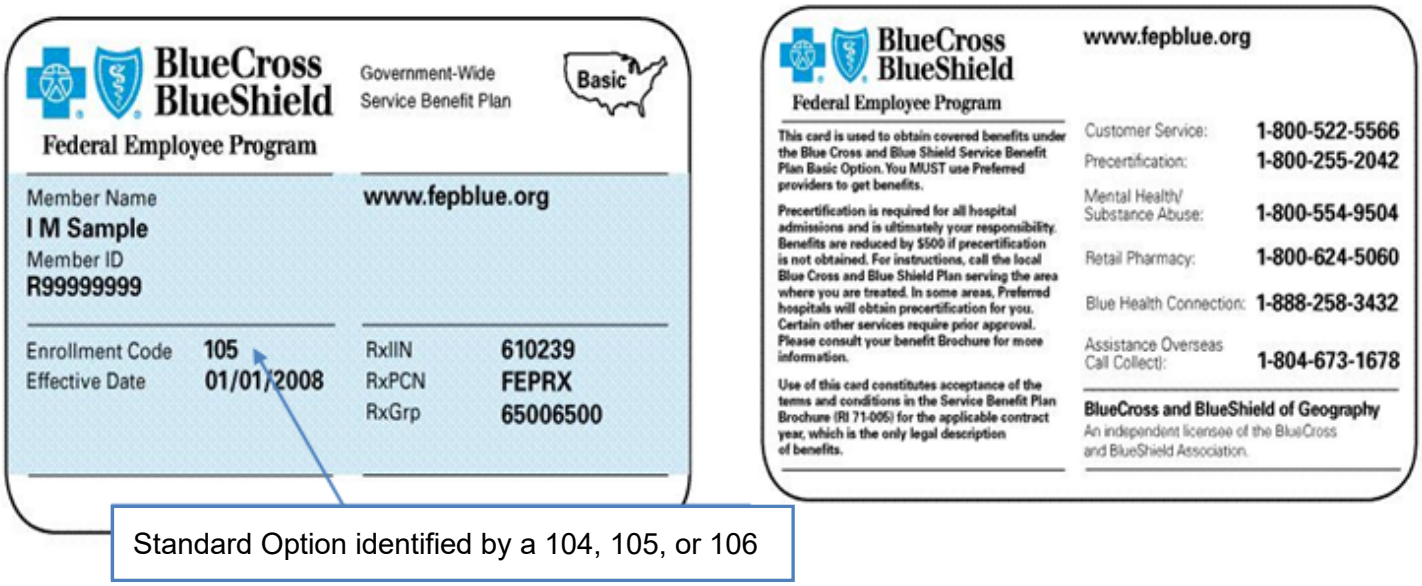
Benefits

- Benefits are available only when a participating dentist renders treatment.
- Coverage is limited to basic and preventive services. Covered codes are listed on the FEP schedule.
- A fixed copayment is applicable when an evaluation is billed (D0120, D0140, D0150). The appliable copayment is payable by the member at the time of service.
- Each covered procedure has a fixed MAC.
- FEP pays MAC for each covered procedure less any applicable copayment.
- Members may not be billed in excess of the applicable copayment for covered services.
- Sealants are covered.

Limitations

- Clinical Oral Evaluations (ADA codes: D0120, D0150): Benefit limited to a combined total of two evaluations per person, per calendar year.
- Radiographs:
  - Intraoral complete series, including bitewings (D0210): Benefit limited to one complete series every five years.
  - Prophylaxis (ADA codes D1110, D1120): Benefits limited to a combined total of two per person, per calendar year.
  - Fluoride (ADA codes D1206, D1208): Benefits up to age 26.
- Sealants: Benefit is available for covered children up to age sixteen at a limit of once per tooth for the first and second molars only.

Standard Option



Standard Option Features

Benefits

- There is a fixed MAC for each covered procedure.
- There is a fixed copayment (a portion of MAC) for each covered procedure dependent upon the patient's age. Copayments are payable by the member at the time of service.
- Sealants are not covered. You may bill Standard Option members at your usual and customary charge for this procedure.

Limitations

- Clinical Oral Evaluations (ADA Code: D0120): Benefit is limited to two evaluations per person, per calendar year.
- Prophylaxis (ADA Codes: 1110, 1120): Benefit is limited to combined total of two per person, per calendar year

On January 1, 2016, FEP removed the following from the Standard Option dental routine care services:

- Tests and laboratory exams
- Space maintenance
- Various restoration services
- Extraction with associated anesthesia

The above services are no longer covered under routine Standard Option dental benefits. However, they are still eligible for benefits associated with accidental dental injury treatment or for restoring the mouth to a pre-cancerous state with applicable regular benefits.

The Postal Service Health Benefits Program

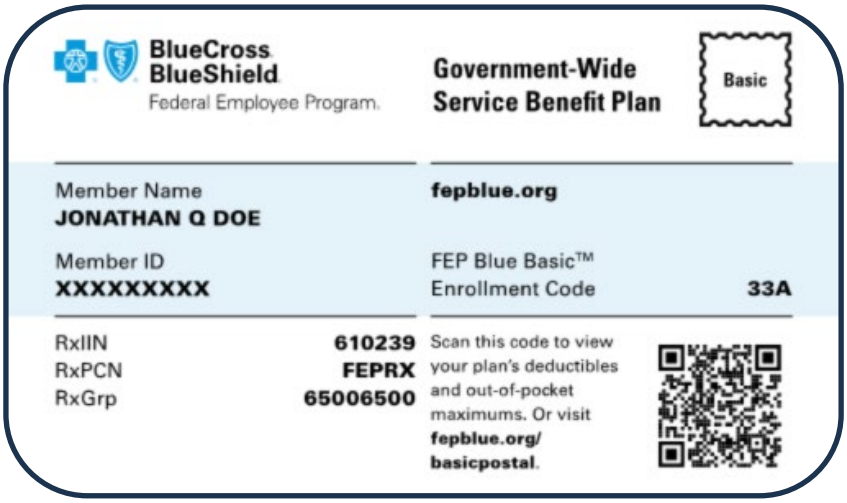
Starting in 2025, the Postal Service Health Benefits (PSHB) Program is a new health benefits program exclusively for Postal Service employees, retirees and their families. FEP is approved to participate in the PSHB Program, which means we're excited to continue providing our coverage to Postal Service employees, retirees and their families.

You may have heard about the Postal Service Reform Act of 2022. This law does not impact the Postal Service Health Benefits for 2024. But in 2025, there will be a new **Postal Service Health Benefits (PSHB) Program.** PSHB will offer health insurance to Postal Service employees, retirees and eligible family members starting January 1, 2025.Postal Service employees, retirees and their families.

Recognizing Postal Service Health Benefits Program Members

A PSHB member can easily be identified by their member ID card. The Postal Service Health Benefits Program name will be displayed on the front of the member ID card along with updated plan language. The member ID number will not change for these Federal Employee Program members moving to the new PSHB plan. Providers will receive two sets of Explanations of Payments (EOPs) for these members, one for postal (designated PSHB) and one for federal (designated FEHB). Nothing additional is required from providers for the two EOPs.

Sample ID Card:



Front of Postal Service Health Benefits Program member ID card.

A new Postal Customer Service line, 855-493-3302, will be live effective November 11, 2024, to support this new member offering, along with our existing
FEP Customer Service line, 800-482-6655.

Coordination of Benefits

As explained in the coordination of benefits (COB) section, COB involves two or more Payors working together to share the cost of health care expenses, with one plan identified as primary (this plan pays first) and the other plan as secondary (this plan pays second). COB allows Payors to help manage the cost of health care by avoiding payment of more than the total reasonable expenses incurred.

When FEP is the secondary Payor, we will adhere to these guidelines:

- We will pay the difference between the primary Payor's payment and the lower of the MAC allowance or the dentist's charge.
- If the primary Payor's payment is equal to or greater than the MAC allowance, FEP will not owe a payment. If the primary Payor's payment is less than our allowance, we will coordinate and process up to the fee schedule not to exceed the MAC.

Whether FEP is the primary or secondary Payor, you may not bill members for the difference between your charges and the MAC. Whenever you bill the secondary plan, always attach a copy of the primary Payor's Explanation of Benefits.

How to File a Claim

When filing claims for FEP Basic and Standard plan members, please do the following:

- Include the policy subscriber's ID number—an R followed by eight digits—in block 15 of the 2012 ADA claim form.
- FEP is able to accept electronic claim submission when billed through the vendor, Availity. Click here to register for Availity provider portal access.
- Include the member's ID number, not the Social Security number. (The SSN is longer than the ID number).
- Make sure the provider has signed the claim form and included his or her Provider Identification Number.
- All paper claims must be mailed to:

  Arkansas Blue Cross – FEP Dental
  P.O. Box 2181
  Little Rock, AR 72203

FEP Reimbursement

Please see the tables below for services covered under the Standard Option and Basic Option.

- The Standard Option allowances listed are those reimbursed by the plan. You can bill Standard Option members up to your MAC less the Standard Option Fee Schedule.
- You can bill Basic Option members the applicable copayment for covered services and your charge for any services not covered under the Basic Option.
- Basic Option benefits are shaded and covered only when rendered by DentalBlue providers.
- Please note age limits: Child age limits are up to age 13, age 13 and over are considered adult.

ADA Code	Narrative	Standard Option Up to 13	Age 13+
CLINICAL ORAL EVALUATIONS			
D0120	Periodic oral evaluation*[1]	$12	$8
D0140	Limited oral evaluation[1]	$14	$9
D0150	Comprehensive oral evaluation[1]	$14	$9
RADIOGRAPHS			
D0210	Intraoral - complete series (seven or more films, including bitewings)[2]	$36	$22

* Limited to two per person per calendar year

[1] Basic Option benefits limited to a combined total of two evaluations per person per calendar year for D0120 & D0150

[2] Basic Option benefits limited to one series every five years for D0210

ADA Code	Narrative	Standard Option Up to 13	Age 13+
PALLIATIVE TREATMENT			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$24	$15
D2940	Sedative filling	$24	$15
PREVENTIVE			
D1110	Prophylaxis - adult	N/A	$16
D1120	Prophylaxis - child	$22	$14
D1206	Topical application of fluoride varnish	$13	$8
D1208	Topical application of fluoride- excluding varnish	$13	$8
D1351	Sealant - per tooth, first and second molar only (*once per tooth for children up to age 16)* FOR BASIC OPTION ONLY	$33	$33
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient- Permanent Tooth- Children ages 0-15	$34	$34

Reconsideration of an FEP claim

This section only applies to the member or with written consent from the member.

FEP Dental Claims are paid by your local Blue Cross Blue Shield Plan (hereinafter referred to as the Local Plan).

Within six months of the initial claim decision, you may ask the Local Plan in writing to reconsider the claim decision. Follow Step 1 of the disputed claims process below.

Step Description

Step 1 To request reconsideration of a claim decision you must:

a) Write to the Local Plan within 6 months from the date of the decision; and
b) Send your request to the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim; and
c) Include a statement about why you believe the initial decision was wrong, based on specific benefit provisions; and
d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, dental records, and explanation of benefits (EOB) forms.

The Local Plan will provide you, in a timely manner, with any new or additional evidence considered, relied upon, or generated at its direction in connection with the claim and any new rationale for the claim decision. The Local Plan will provide you with this information sufficiently in advance of the date that it is required of the reconsideration decision to allow you a reasonable opportunity to respond before that date. However, the Local Plan's failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate its decision on reconsideration.

Step 2 In the case of a post-service claim, the Local Plan has 30 days from the date they receive your request to:

a) Pay the claim or
b) Write to you and maintain its denial or
c) Ask you or your patient for more information.

You or your patient must send the information so that we receive it within 60 days of our request. The Local Plan will then decide within 30 more days.

If the Local Plan does not receive the information within 60 days, a decision will be made within 30 days of the date the information was due.

The decision will be based upon the information already on file. The Local Plan will provide a written response regarding its decision.

Section 19: Technology Solutions

Common Terms

The following terms are important to know when using our technology solutions.

Clearinghouse	The entity that connects your office and the insurance carrier for electronic billing
Electronic Data Interchange (EDI)	The transmission of data from one computer to another
Electronic attachment	Any clinical documentation requested by the insurer to support your claim
Practice management software	The software program that allows you to manage your practice; often includes electronic-claims capability

Electronic Claims Submission

Technology can help you spend less time on paperwork and other administrative tasks, so you can spend more time caring for your patients. Arkansas Blue Cross offers technology solutions to help you and your staff do business with us more efficiently by:

- Improving claim payment time and office cash flow
- Reducing claim errors
- Increasing productivity and efficiency by reducing time spent on billing and benefit inquiries

Electronic Claims Filing Information

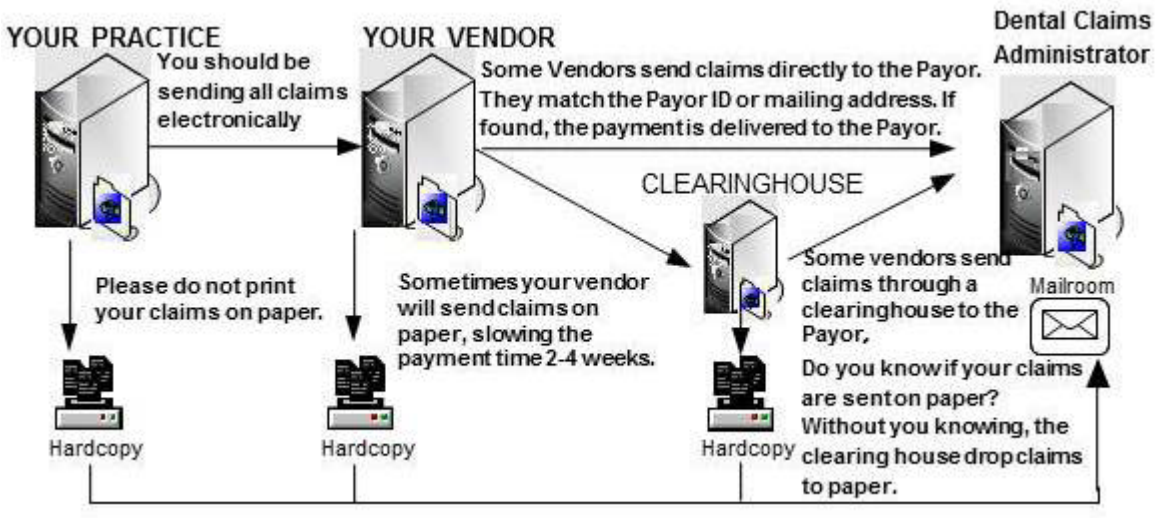
We encourage you to submit claims electronically to enjoy the advantages listed above. One important advantage is that your vendor automatically corrects electronic claims prior to reaching us, so they are more likely to process without delay. You will receive a report confirming that your vendor did or did not receive each claim.

To get started, you will need:

- A computer with a modem and a printer
- Internet access
- Practice management or EDI-enabling software
- Notification to your software vendor of your provider billing number
- Know if your vendor is sending paper claims
- Know if your vendor's clearinghouse choice is sending claims on paper
- Ask your vendor what percentage of your claims is sent to the Payor electronically

Electronic Claims Filing Information

The graphic illustrates how information flows among the entities involved in electronic claims submission.



Our Payor ID Number and Customer Support

Arkansas Blue Cross' Payor ID number is **TLY26**. If you have questions about filing claims electronically, please call our Technology Support Center at **1-800-633-5430** Monday through Friday between 8:00 a.m. and 5:00 p.m. ET.

Self-Service Tools

Self-Service Tools and Services are available to Arkansas Blue Cross Dental Providers through our Dental Administrator's website. Registered users will have access to all of the following online services 24 hours a day, 7 days a week. To register for any of these online services, visit www.arkansasbluecross.com. From there, you will be directed to our Dental Administrator's website where you will click on the For Dentists link, then click on Register at the right-hand side of the page. Once you have completed the registration form, you will have a secure user ID and password, which will provide access to the tools on the following matrix.

Tool Service	What	How
MyDentalCoverage	Provides direct, up-to-the minute access to member information and offers dental offices the ability to check patient eligibility and the status of patients' claims online for free.	**To verify patient eligibility and claim status:** • Go to www.arkansasbluecross.com. After being redirected to our Dental Administrator's website, click on the **For Dentists** link, and then click on the **MyDentalCoverage** link. • Enter the required provider and patient information and click **Retrieve**. The Eligibility information for the patient is displayed. • To check the Claim Status for a patient, perform the same steps as above and click on the **Claim Status** tab. Select a date range and hit **Retrieve**.
PROVIDER CHECK INFORMATION	This online feature allows dentists to view check summaries, check detail and check related claims for a selected date range.	• Go to www.arkansasbluecross.com. After being redirected to our Dental Administrator's website, click on the **For Dentists** link. • Click on the **Reimbursements** link where you will be asked to enter a date range for a review of payments made to your office.

HIPAA ELIGIBILITY AND CLAIM STATUS TRANSACTIONS USING A CLEARINGHOUSE / VENDOR	Dental offices work with a multitude of Payors and it can be difficult to determine which systems are compatible with every carrier. In order to make verifying eligibility and checking claim status easier for dental offices, our Dental Administrator works with numerous clearinghouses and software vendors who can provide the ability for dental offices to perform these electronic transactions with all Payors, using just one system.	Contact your software vendor to find out how you can perform these transactions through your practice management software.

Interactive Voice Response (IVR) System

Our Dental Administrator's IVR System offers dental offices access to information stored in its records and the capability to finalize predeterminations for payment via the telephone. You can choose to listen to the information or, in most instances, request the information by fax or mail.

The IVR System is accessible by calling Customer Service at (888) 224-5213. The IVR system is available 24 hours a day, 7 days a week, except when the databases are undergoing scheduled maintenance.

The IVR System connects you directly to the databases and gives you access to:

- Patient eligibility and benefits
- Claim/predetermination status information
- Orthodontic information
- Procedure history
- Maximum/deductible accumulations
- Co-payment listings
- Procedure allowances

To us the IVR, dial (888) 224-5213 and follow the prompts listed on the next page.

- Once connected to the IVR, navigate through the IVR system to retrieve your desired information about a particular patient.
- You many have instructions repeated by pressing *8.
- Please note that all dates must be entered in the MM/YYYY format. For example, March 15, 2011 would be entered as 032011.

To use the IVR, dial (866) 445-4981
Note: When entering the number portion of the contract ID, include all leading zeros.

Press 1 Benefits, Enrollment and Eligibility	**Press 2** Status of Claims, Predeterminations and Orthodontic Information	**Press 3** Procedure History, Maximums and Deductibles	**Press 4** Copayment Schedules, Coinsurance or Cost Share and Procedure Allowances
Feature	**Feature**	**Feature**	**Feature**
• Claims status • Procedure history, maximum and deductible accumulations • Patient out-of-pocket expense	• To listen to a summary of benefit's and eligibility • Enter date of service on predetermination • Maximum and deductible accumulations only • Procedure code allowances	• Detailed benefits by procedure code • Orthodontic Information • Fax report of the procedure code history, maximum & deductible accumulations	• Enrollment/ Eligibility • Detailed benefits and eligibility report by fax or mail

Section 20: National Network Grid

Through recent negotiations, we can now provide our members and those of our Blue Cross and Blue Shield affiliates with quality dental care through a network of participating providers. This network of affiliated dental plans is known as the National Grid, and your Agreement, as recently amended, now allows you access to the following membership:

National Grid

The National Grid is an alliance of dental networks managed by Blue Cross and Blue Shield affiliates throughout the United States. Members of these affiliate plans who either reside or are traveling outside their home networks will have access to care rendered by Arkansas Blue Cross participating providers when seeking dental care in Arkansas. Benefits for these members will be applied by the members' home Plan but paid based upon the Allowance under your Agreement with Arkansas Blue Cross. Claims for Members of the GRID should be submitted to Arkansas Blue Cross using the Arkansas Payer ID.

United Concordia Companies, Inc.

United Concordia Companies, Inc. members of their UCCI Advantage Plus Plan who either reside or are traveling outside their home networks will have access to care rendered by Arkansas Blue Cross participating providers when seeking dental care in Arkansas. Claims for these members will be processed by the members' home Plan but paid based upon the Allowance under your Agreement with Arkansas Blue Cross.

Access to these additional memberships will enable you to grow your patient panels.

MEMBER PLAN	SERVICES PROVIDED BY NETWORK DDS	FEE SCHEDULE USED	SUBMIT CLAIM TO (Payor ID):
Arkansas Blue Cross	Arkansas Blue Cross	Arkansas Blue Cross	**Dental Claims Administrator
UCCI Advantage Plan	Arkansas Blue Cross	*Arkansas Blue Cross	**UCCI
Out of State Grid Member	Arkansas Blue Cross	Arkansas Blue Cross	**Member Plan

*Unless provider also participates with UCCI Advantage Plan in which case that fee schedule supersedes the Arkansas Blue Cross schedule.

** All claims should be submitted to the claim submission address or Payor ID on the member's current ID card.