



Louisiana

2023

Dental Network Office Manual



Blue Cross and Blue Shield of Louisiana Dental Network Office Manual

This Dental Network Office Manual is designed to be a reference guide for network dentists and office staff. It includes information needed as a participant in our dental networks.

To use this manual, first familiarize yourself with the Quick Reference Guide, Table of Contents, Definitions section and Summary of Changes page.

Periodically, we send newsletters and informational notices to providers. Please keep such information and a copy of your respective provider agreement(s) along with this manual for your reference. Updated office manuals and provider newsletters may be found on the Provider page of our website (www.bcbsla.com/providers >Resources).

If you have questions about the information in this manual or your participation as a network provider, please email provider.contracting@bcbsla.com.

Thank you for working with us to provide our members—your patients—with the best possible dental services and benefits. We appreciate your participation in our dental network(s). We look forward to working with you!

Blue Cross and Blue Shield of Louisiana



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This manual is provided for informational purposes only. You should always directly verify the Blue member's benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Subscriber Contract/Certificate contains information on benefits, limitations and exclusions and managed care benefit requirements. It also may limit the number visits or dollar amounts to be reimbursed.

Quick Reference Guide

This reference guide contains the contact information for the services listed within this manual. Please refer to this guide as needed when reading this manual.

Appeals and Disputes	<p>Please mail appeals and disputes to:</p> <p>United Concordia Dental Claims Administrator P.O. Box 69441 Harrisburg, PA 17106-9441</p>				
Blue365	<p>To become a provider in the Blue365 Dental Solutions program, contact DenteMax:</p> <p>email: customerservice@dentemax.com phone: (248) 327-5405</p>				
Claims	<table><tr><td><p>Advantage Plus or Advantage Plus 2.0 Dental Network Claims United Concordia Dental Claims Administrator P.O. Box 69441 Harrisburg, PA 17106-9441</p></td><td><p>FEP Preferred Dental Claims BCBSLA – FEP Preferred Dental Claims P.O. Box 98028 Baton Rouge, LA 70898-9028</p></td></tr><tr><td><p>Blue Cross Oral Surgery Claims Blue Cross and Blue Shield of Louisiana P.O. Box 98029 Baton Rouge, LA 70898-9029</p></td><td><p>Out-of-State Claims Refer to the member ID card.</p></td></tr></table>	<p>Advantage Plus or Advantage Plus 2.0 Dental Network Claims United Concordia Dental Claims Administrator P.O. Box 69441 Harrisburg, PA 17106-9441</p>	<p>FEP Preferred Dental Claims BCBSLA – FEP Preferred Dental Claims P.O. Box 98028 Baton Rouge, LA 70898-9028</p>	<p>Blue Cross Oral Surgery Claims Blue Cross and Blue Shield of Louisiana P.O. Box 98029 Baton Rouge, LA 70898-9029</p>	<p>Out-of-State Claims Refer to the member ID card.</p>
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<p>Blue Cross Oral Surgery Claims Blue Cross and Blue Shield of Louisiana P.O. Box 98029 Baton Rouge, LA 70898-9029</p>	<p>Out-of-State Claims Refer to the member ID card.</p>				
Customer Care Center	<p>Providers are required to use our self-service tools for member eligibility, claim status inquiries, professional allowable searches and medical policy searches. Our self-service options are:</p> <ul style="list-style-type: none">• iLinkBlue (www.bcbsla.com/ilinkblue)• Interactive Voice Recognition (IVR) - (1-800-922-8866)• HIPAA 27x Transactions - (1-800-216-2583) <p>For all other inquiries, please have your NPI, the member ID number, patient date of birth and the date of service when calling.</p> <p>phone: 1-800-922-8866</p>				

EDI Services	<p>Claims may be submitted electronically to Blue Cross directly from your office or through a Blue Cross-approved clearinghouse.</p> <p>For more information about filing claims electronically and/or approved clearinghouse locations, please contact our EDI Services:</p> <p>email: EDIservices@bcbsla.com phone: 1-800-716-2299, option 3</p>
Electronic Funds Transfer (EFT)	<p>All providers must be part of our EFT program. With EFT, Blue Cross deposits your payment directly into your checking or savings account.</p> <p>For more information, visit the EFT section of the Provider page at www.bcbsla.com/providers > Electronic Services > Electronic Funds or contact us:</p> <p>email: PCDMstatus@bcbsla.com phone: 1-800-716-2299, option 2</p>
Eligibility	<p>To obtain verification of coverage, benefit information or to inquire about a claim, please call:</p> <p>United Concordia for Advantage Plus and Advantage Plus 2.0 questions 1-866-445-5338</p> <p>FEP Customer Service Unit for FEP questions 1-800-272-3029</p>
iLinkBlue	<p>iLinkBlue is a free online provider tool that includes services such as:</p> <ul style="list-style-type: none"> • Eligibility verification • Benefits (copayments, deductible and coinsurance) • Claims status (paid, rejected and pended) • Allowable charges • Action requests • Payment registers • Medical policies • Authorization requests • and more! <p>iLinkBlue: www.bcbsla.com/ilinkblue</p> <p>For questions regarding iLinkBlue please contact our EDI Services:</p> <p>email: EDIservices@bcbsla.com phone: 1-800-716-2299, option 3</p>

Provider Credentialing & Data Management	<p>Blue Cross partners with Vantage Health Plan for the processing of provider credentialing and recredentialing activities.</p> <p>Credentialing packets and criteria are available on our Provider page at www.bcbsla.com/providers >Provider Networks >Join Our Network >Professional Providers >Join Our Network.</p> <p>The Blue Cross Provider Credentialing & Data Management team handles demographic changes.</p> <p>To change your address, phone number, Tax ID number, etc., please use the Provider Update Request Form, located on our Provider page (www.bcbsla.com/providers >Resources >Forms).</p> <p>For more information on our credentialing and data management process, including frequently asked questions, visit www.bcbsla.com/providers >Provider Networks >Join Our Networks >Professional Providers >Join Our Network.</p> <p>For all other inquiries:</p> <p>email: PCDMstatus@bcbsla.com phone: 1-800-716-2299, option 2</p>
Provider Contracting	<p>Provider Contracting supports inquiries related to your provider agreement(s).</p> <p>email: provider.contracting@bcbsla.com phone: 1-800-716-2299, option 1</p>
Provider Identity Management Team (PIM)	<p>PIM is a dedicated team that helps establish and manage system access to our secure electronic services, including the setup process for administrative representatives.</p> <p>email: PIMTteam@bcbsla.com phone: 1-800-716-2299, option 5</p>

Provider Page	<p>Our Provider page is designed to serve provider needs. Use this page to help locate important information such as:</p> <ul style="list-style-type: none"> • Authorizations • Credentialing • Resources • Newsletters • Office of Group Benefits (OGB) • Pharmacy Management • Provider Tools • Quality Blue <p>website: www.bcbsla.com/providers</p>
Provider Relations	<p>Provider Relations representatives assist providers and office staff with information about Blue Cross and its programs and procedures. Provider Relations representatives do not handle routine claim inquiries and benefit questions.</p> <p>email: provider.relations@bcbsla.com phone: 1-800-716-2299, option 4</p>

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Section 1: Dental Network Overview

INTRODUCTION

Blue Cross and Blue Shield of Louisiana offers dental benefits to our members who access either the Advantage Plus Dental, Advantage Plus 2.0 Dental or the Federal Employee (FEP) Preferred network of dentists. These networks emphasize the vital health care roles of dentists and Blue Cross, and are designed to create a more effective business relationship among dentists, consumers and Blue Cross. The Blue Cross Dental Network exists only to provide medical policy benefits when medical services are rendered to a member by a dental professional.

Freedom to Choose

Blue Cross places no disincentives or restrictions on our members' dental benefits. Members can select their own dentist; however, members who choose non-participating dentists may be required to file their own claims and are responsible for paying the dentist for all charges, including any difference between the allowable charge and the fee charged by the dentist.

The Advantage Plus Dental Network and Advantage Plus 2.0 Dental Network are administered by United Concordia Dental. Providers participating in these networks should adhere to the guidelines set forth by United Concordia Dental.

The FEP Preferred Dental Network is administered by Blue Cross.

As a participating dentist, you agree to accept the allowable charge as payment in full and will not balance bill the member. Payment, deductible and coinsurance amounts will be applied, as applicable, to the allowable charge for each service.

For services rendered by a non-participating dentist, payment will be made directly to the member.

Predictable Out-of-pocket Expenses

Blue Cross members have predictable out-of-pocket expenses when they use the services of a participating dentist. Additionally, members can be assured the claims filing and prompt claims payment is being taken care of by their in-network dentist and Blue Cross.

NETWORK PROVIDER RESPONSIBILITIES

This office manual is for you and your staff to use when handling claims for your Blue Cross patients. As a network dentist, you have agreed to:

- Accept the Blue Cross payment, plus any member deductible, coinsurance and copayment, as applicable, as payment in full for covered services.
- File claims for Blue Cross members.
- Refer members to network providers.

Please be aware that member benefit plans have different maximums, deductibles and percentage of benefits payable. If you have questions about benefits or eligibility, use iLinkBlue or call the dental number on the member ID card.

OUR DENTAL NETWORKS

Members with dental benefits have the applicable dental network indicated on their Blue Cross member ID card. The information on the member ID card can be used for verifying eligibility and benefits, submitting claims and making claims inquiries.

Advantage Plus Dental Network

The Advantage Plus Dental Network is our primary dental network for individual members and members with certified dental benefits. The Advantage Plus Dental Network is also the dental network for pediatric essential health benefits.

The Advantage Plus Dental Network is administered by United Concordia Dental (UCD) and providers must be contracted directly with UCD to be in-network for these members.

MEDICAL		DEDUCTIBLE	OUT OF POCKET
In Network		Individual \$5500	Individual \$5500
Out of Network		\$5500	\$5500

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Advantage Plus
Dental Network PPO

To become an Advantage Plus Dental Network provider, contact United Concordia Dental directly at 1-800-291-7920, ext. 9.

There is a Blue Cross-dedicated customer service unit for benefits, authorizations and claims administered by United Concordia Dental on behalf of Blue Cross Advantage Plus. Dental claims should be filed directly with United Concordia Dental.

Essential Health Benefits for members under age 19:

Blue Cross and HMO Louisiana, Inc. non-grandfathered, small group, and individual member benefit plans along with stand-alone dental small group and individual member benefit plans automatically included Dental Essential Health Benefits (EHB) coverage for members under age 19.


Members with stand-alone small group and individual certified dental plans include dental EHB coverage for members up to age 21. Some members under age 19 may have dual dental coverage if they are also on a stand-alone dental plan. Refer to the member ID card for dental filing instructions.

Advantage Plus 2.0 Dental Network

The Advantage Plus 2.0 Dental Network is our primary dental network for members with traditional dental benefits.

The Advantage Plus 2.0 Dental Network is administered by United Concordia Dental (UCD) and providers must be contracted directly with UCD to be in-network for these members.

To become an Advantage Plus 2.0 Dental Network provider, contact UCD directly at 1-800-291-7920, ext. 9.

Louisiana		Preferred Care PPO Network FULLY INSURED
Member Name BLUE SUBSCRIBER	Grp/Subgroup: AAA00000/PPO4	
Member ID XUP000000000	RxMbr ID: 200000000	
	RxBIN: 000000 PCN-A4	
	RxGrp: BSLA	
MEDICAL	DEDUCTIBLE	OUT OF POCKET
	Individual	Individual
In Network	\$5500	\$5500
Out of Network	\$5500	\$5500
04BA0314 R01/22		Advantage Plus Dental Network 2.0 

FEP Preferred Dental Network

The Federal Employee Program (FEP) Preferred Dental Network provides dental services for FEP members. You can identify FEP members by their member ID card. The member identification number always begin with "R." The FEP Preferred Dental Network offers:

- Fee-for-service reimbursement
- Direct payment
- Inclusion in the Service Benefit Plan Directory of Network Providers


Providers in the FEP Preferred Dental Network agree to accept the FEP Maximum Allowable Charge (MAC), which includes Blue Cross payment and member liability, as payment in full for covered dental services. Refer to the Reimbursement Section of this manual for additional reimbursement information.

The FEP Standard Option and FEP Basic Option benefit plans offer dental coverage. The FEP Blue Focus benefit plan does not include dental coverage.

FEP Standard Option

- Greater benefits.
- Blue Cross reimburses FEP Preferred Dentists up to the FEP fee schedule amount.
- Member pays the difference between the Fee Schedule Amount and the maximum allowable charge (MAC)*.

*MAC is the total combined amount a FEP Preferred Dentist may collect from Blue Cross and the FEP member.

BlueCross BlueShield Federal Employee Program.		Government-Wide Service Benefit Plan	
Member Name BLUE SUBSCRIBER	www.fepblue.org		
Member ID R00000000	Standard Option Enrollment Code 106		
Effective Date 01/01/2022	Deductible Individual \$350		
RxLIN 610239	Deductible Family \$700		
RxPCN FEPRX	Out-of-Pocket Maximum		
RxGrp 65006500	In-Network	Out-of-Network	
	Individual \$6,000	\$8,000	
	Family \$12,000	\$16,000	

FEP Basic Option

- Limited benefits.
- No benefits for non-FEP dentists.
- \$30 copayment.

If you have any questions about the Blue Cross FEP Preferred Dental Network, please call our FEP Customer Service Unit at 1-800-272-3029.

BlueCross BlueShield Federal Employee Program		Government-Wide Service Benefit Plan	
Member Name	www.fepblue.org		
BLUE SUBSCRIBER			
Member ID	Basic Option		
R00000000	Enrollment Code	113	
Effective Date	01/01/2022	Deductible Individual	\$0
RxIIN	610239	Deductible Family	\$0
RxPCN	FEPRX	Out-of-Pocket Maximum	In-Network
RxGrp	65006500	Individual	\$6,500
		Family	\$13,000

***Please Note:** There are certain Blue Cross members who DO have dental benefits but who DO NOT have access to the FEP Preferred Dental Network. These members are not subject to the terms and conditions of the Participating Dental Agreement. If they do not access the FEP Preferred Dental Network, you may bill them for any amounts over our allowable charge and are not required to file claims on their behalf. In some instances, self-funded, Administrative Service Only (ASO) groups may not be limited to Dental Allowables. Please call the number on the member ID card to determine if you are entitled to collect in excess of the Allowables.*

Blue Cross Dental Network

Blue Cross and HMO Louisiana no longer offer members dental benefits that directly access the Blue Cross Dental Network. However, we have maintained our Blue Cross Dental Network for dental services, such as oral surgery, that are covered under members' medical benefits. Dental providers in this network are contracted directly with Blue Cross. Benefits, authorizations and claims are handled directly by Blue Cross.

Blue365 Discount Dental

Dentists who wish to provide discount dental services may do so through a national dental program called Dental Solutions, available through Blue365. Blue365 offers access to health and wellness deals exclusive to Blue Cross members, including personal care, healthy eating, fitness, financial health and much more. Dental Solutions is administered through our partner, DenteMax. As a Dental Solutions provider, you will receive national exposure to Blue members seeking discount dental services. Visit www.blue365deals.com to learn more about Blue365. Participating dentists must meet DenteMax's usual requirements.

HOW TO FIND PARTICIPATING DENTISTS

For Advantage Plus, you may find the information at www.bcbsla.com >Find a Doctor >BlueDental Provider Directory.

For FEP, you may find information at www.FEPBLUE.org.

For Blue365, you may find information at www.blue365deals.com.

SUBMITTING DEMOGRAPHIC INFORMATION CHANGES

If you have changes in your name, telephone number, address, specialty or group practice, please fill out a Provider Update Request Form available under the Resources section on our Provider page.

Section 2: Dental Billing Guidelines

The following billing guidelines are to assist you with filing dental claims. Please follow these guidelines regardless if the claim pays under the member's major medical or dental benefits.

GENERAL GUIDELINES

- When filing Current Dental Terminology® (CDT) codes, please use the 2006 American Dental Association (ADA) Dental Claim Form.
- Do not file both an ADA claim form and a CMS-1500 claim form for the same service. We will reject the second claim as a duplicate claim.
- Do not list both the CDT and Current Procedural Terminology® (CPT) code for each service on a claim form. When both CPT and CDT codes are listed, it is our policy to process the claim using the CDT code.
- File your actual charge.
- Do not file OSHA charges separately. OSHA charges are included as an integral part of the procedures performed on the same date of service. There is no member liability for OSHA charges.

CLAIMS FILING PROCESS FOR DENTAL CLAIMS

- Dental claims must be filed with the appropriate CDT code. Dental procedure claims filed with CPT codes will be returned to the dentist for proper coding.
- When filing code D9630, include the name(s) of the drug(s) used (Block 30 of the ADA Dental Claim Form).

CLAIMS FILING PROCESS FOR ORAL SURGERY CLAIMS

Oral surgeons may bill either CPT or CDT codes for major oral surgical procedures but cannot file them together on the same claim form. CPT codes must be billed on the CMS-1500 claim form. If CPT codes are billed on an ADA Dental Claim Form, the claim will be returned for the appropriate claim form. Oral surgeons may also bill for medical evaluation and management (E&M) services only when associated with major oral surgical procedures as appropriate. Claims for these services must be filed on a CMS-1500 claim form.

Our member benefit plans require that oral surgery claims are processed first under the patient's dental coverage. Do not submit as a medical claim first.

Appropriate CDT codes must be billed when performing extractions. If CPT codes are submitted for extractions, the claim will be returned for appropriate CDT code.

- Any and all services related to impacted teeth must be filed with a diagnosis code indicating impacted teeth. This includes all surgical and non-surgical procedures.
- Claims filed for office visits and X-rays with diagnosis codes indicating *anomalies of tooth position of fully erupted teeth*, but without a primary procedure code, must have a brief description of services that will be rendered (Block 30 of the ADA form). If there is no description, the claim will be rejected.
- Do not file CPT code 41899 for surgical services, such as extractions. Any claim filed with CPT code 41899 will be returned for the appropriate CDT code.
- Please bill CDT code D6010 for dental implants to expedite the processing of your claims.

SEDATION

When billing for sedation, dentists and oral surgeons should bill the appropriate CDT codes (D7210, D7220, D7230, D7240, D7241 and D7250) for the removal of impacted wisdom teeth in conjunction with the following sedation code guidelines:

Code	Units
D9222	deep sedation/general anesthesia - first 15 minutes
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment
D9239	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment
D9243	intravenous moderate (conscious) sedation/analgesia - first 15 minutes

Note: Anesthesia time begins when the doctor administering the anesthetic agent initiates the anesthesia and monitoring protocol and is in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of a trained personnel.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures are those performed during the same operative session. Bilateral procedures are considered multiple procedures. When multiple procedures are performed, the primary or major procedure is considered to be the procedure with the greatest value based on the allowable charge and may be reimbursed up to the allowable charge. Use Modifier 51 to report multiple procedures and Modifier 50 to report bilateral procedures.

- Secondary covered procedures are reimbursed up to 50% of the allowable charge.
- Extractions of impacted teeth are not subject to multiple surgery reduction.

If a service includes a combination of procedures, one code should be used rather than reporting each procedure separately. If procedures are coded separately, Blue Cross may recode the procedures and apply the appropriate allowable charge.

ORTHODONTIA WORK IN PROGRESS

Blue Cross will honor claims for monthly adjustment visits for orthodontia work in progress up to the orthodontic maximum specified in the member's contract. Orthodontists may file claims either monthly or quarterly.

NITROUS OXIDE

Blue Cross includes nitrous oxide charges with other dental services rendered and does not reimburse these charges separately. This applies to all CDT codes.

ALTERNATIVE DENTAL PROCEDURE PAYMENT RESPONSIBILITY FORM

The Alternative Dental Procedure Payment Responsibility Form included in this manual should be used when a member chooses an alternative, non-covered treatment. The form is completed by the dentist and signed by the member, and the member agrees to be responsible for the difference between the allowed amount of the covered service and the amount charged by the dentist for the chosen alternative procedure in addition to any applicable member cost-sharing amount. The form should be attached to the dental claim form.

Section 3: Filing Claims

HOW TO FILE DENTAL INSURANCE CLAIMS

Dental providers and oral surgeons filing claims for dental services for members with Advantage Plus or Advantage Plus 2.0 Dental Network dental benefits administered by United Concordia Dental (UCD) should file claims directly with UCD.

Dental providers and oral surgeons filing claims for medical services for members should file claims on the ADA Dental Claim Form with Blue Cross. Blue Cross accepts dental claims hard copy (paper claims) and electronically. It is extremely important that you complete all applicable information in full to facilitate prompt and accurate reimbursement. An example of the ADA Dental Claim Form and instructions on its completion are included in this manual.

USING CDT CODES

Blue Cross uses CDT, a systematic listing and coding of procedures and services performed by dentists, for processing claims. Each procedure or service is identified with a five-digit code. By using these procedure codes, a dentist can enhance the speed and accuracy of claims payments. **Please include the valid, current CDT code(s) when filing a claim.** Blue Cross cannot accept unspecified codes. Please use the current CDT code that most closely matches the description of the service rendered.

IMPORTANT: If CPT codes are used for a non-surgical procedure, the CPT codes will be rejected and returned for the proper CDT code.

Also, when using code D9630, "Other drugs and/or medicaments, by report," please indicate the name of the medication in the "Description" area and the applicable National Drug Code.

Please ensure that your office is using the most current edition of CDT codes. To obtain a current book of CDT codes, order online at www.ada.org or call 1-800-947-4746.

NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard unique identifier for health care providers. The Centers for Medicare and Medicaid Services (CMS) has assigned national provider identifiers (NPIs) to comply with this requirement. NPIs are issued by the National Plan and Provider Enumeration System (NPPES). This one unique number is to be used when filing claims with Blue Cross as well as with federal and state agencies, thus eliminating the need for you to use different identification numbers for each agency or health plan. To comply with the legislation mentioned above, all covered entities must use their NPI when filing claims. All providers who apply for Blue Cross provider credentialing or who are undergoing recredentialing, regardless of network participation, must include their NPI(s) on their application. **Claims processing cannot be guaranteed unless you notify Blue Cross of your NPI(s) prior to filing claims using your NPI(s).**

Notifying Blue Cross of your NPI:

Once you have been assigned an NPI, please notify us as soon as possible. To do so, you may use one of the following ways:

1. Include it on your Louisiana Standardized Credentialing Application (LSCA), Health Delivery Organization (HDO) Application or Blue Cross recredentialing application.
2. Include it on the Provider Update Request Form.

Filing Claims with NPIs:

Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your Tax ID number. To appropriately indicate your NPI and Tax ID number on ADA and CMS-1500 claim forms, follow the corresponding instructions for each form included in this manual. Remember, claims processing cannot be guaranteed if you have not notified Blue Cross of your NPI, by using one of the methods listed above, prior to filing claims. See the first part of this section for more details on how to submit claims to Blue Cross. For more information, including **whom should apply** for an NPI and **how to obtain** your NPI, visit our website or CMS' site at www.cms.hhs.gov/NationalProvIdentStand. If you have any questions about the NPI relating to your Blue Cross participation, please contact Provider Credentialing & Data Management.

ELECTRONIC CLAIMS

Dental Claims may be submitted electronically to Blue Cross directly from your office or through Blue Cross approved clearinghouse locations. For more information about filing dental claims electronically and/or approved clearinghouse locations, please contact our EDI Clearinghouse Support.

CLAIMS MAILING ADDRESSES

Please refer to the Quick Reference Guide located at the front of this manual for claims mailing information.

TIPS FOR SUBMITTING BLUECARD® (OUT-OF-STATE) CLAIMS

Dental providers and oral surgeons must verify benefits of BlueCard® Program members prior to performing services. To do this, call the number on the member ID card.

ADA Dental Claim Form

- Dental providers and oral surgeons filing claims for dental services on an ADA Dental Claim form (hardcopy) should submit the claim to the Blue Plan named on the member ID card. **Blue Cross and Blue Shield of Louisiana is not necessarily the correct place for billing dental claims.**
- Dental providers and oral surgeons calling for claim status regarding dental services filed on an ADA Dental Claim Form should call the number on the member ID card.
- ADA Dental Claim Forms received by Blue Cross for dental services for BlueCard members will be sent back to the provider advising the provider to file the claim to the Blue Plan named on the member ID card.
- Dental claims submitted on an ADA Dental Claim Form must be processed through the Blue Plan on the member's ID card. Providers should not expect payment from Blue Cross. The member or provider will get paid directly from the BlueCard member's home plan or intermediary adjudicating the claim.

CMS-1500 and Electronic Claim Forms

- Electronic claims received by Blue Cross for dental services provided to BlueCard members will be returned to the provider to refile the claim to the Blue Plan named on the member ID card.
- It is recommended by BlueCard that dental providers and oral surgeons filing dental service claims that fall under the medical care category do so on a CMS-1500 (professional) claim form or submit electronically. Claims will be processed by Blue Cross and sent to the Blue Plan named on the member ID card for adjudication under medical policy guidelines. This does not guarantee payment.
- Dental service claims filed incorrectly or with missing information on a CMS-1500 claim form or professional electronic claim form will be returned to the provider for a corrected claim.
- Dental claims submitted on a CMS-1500 claim form or professional electronic claim form may be processed through BlueCard; therefore, providers should expect the remit or payment to come from Blue Cross and Blue Shield of Louisiana, if the claim is processed to pay the provider. If the claim is processed by the member's home plan to pay the BlueCard member, the member will receive payment from the member's home Plan and not from Blue Cross and Blue Shield of Louisiana.
- Providers should call Blue Cross for inquiries regarding claim status for medical care services filed on a CMS-1500 claim form or professional electronic claim form.

ADA DENTAL CLAIM FORM - ADVANTAGE PLUS OR ADVANTAGE PLUS 2.0 DENTAL NETWORK CLAIMS

Dental providers and oral surgeons filing dental service claims for members with Advantage Plus or Advantage Plus 2.0 Dental Network benefits administered by United Concordia Dental (UCD), should file claims directly to United Concordia Dental using the standard ADA Dental Claim Form-Attending Dentist's Statement, to the UCD claim filing address published in the Quick Reference Guide located in the front of this manual.

See ADA Dental Claim Form - Attending Dentist's Statement for UCD claims in the Forms section of this manual.

Section 4: Reimbursement

ALLOWABLE CHARGES

Blue Cross reimburses network dentists based on allowable charges. The allowable charge is the maximum amount allowed for covered dental services. As a network dentist, you agreed to accept the Plan's payment, plus the member's deductible, coinsurance and/or copayment, as applicable, as full payment for covered services and not collect from the member any amount above the allowable charge. *See the examples below for members with an HSA plan, like BlueSaver.* Allowable charges are provided to Blue Cross dentists to help avoid refund situations.

Examples of what to collect from members:

1) Member's Total Deductible	\$2000	} Member Has Met Deductible
Member's Deductible Paid	\$2000	
<u>Allowable Charge</u>	<u>\$100</u>	
Amount to be collected from member	\$0	
Plan Payment	\$100	
2) Member's Total Deductible	\$2000	} Member Has NOT Met Deductible
Member's Deductible Paid	\$1000	
<u>Allowable Charge</u>	<u>\$100</u>	
Amount to be collected from member	\$100	
3) Member's Total Deductible	\$2000	} Member with Coinsurance
Member's Deductible Paid	\$2000	
Allowable Charge	\$100	
<u>Member's Coinsurance (20%)</u>	<u>\$20</u>	
Amount to be collected from member	\$20	
Plan Pays	\$80	

MAXIMUM ALLOWABLE CHARGE

FEP Preferred Dentists are reimbursed based on a negotiated, discounted amount known as the Maximum Allowable Charge (MAC). As a FEP Preferred Dentist, you have agreed to accept the MAC as payment in full for covered dental services.

- Under FEP Standard Option, Blue Cross reimburses FEP Preferred Dentists up to a Fee Schedule Amount. FEP members may be billed for the difference between the Fee Schedule Amount and the MAC.
- Under FEP Basic Option, Blue Cross reimburses FEP Preferred Dentists up to the MAC, minus the FEP member's copayment amount.

Complete listings of MACs for the FEP Standard and FEP Basic options are available in iLinkBlue.

Example	MAC (Maximum Allowable Charge)*	\$38
	FEP Fee Schedule Amount (Blue Cross payment)	- \$ 9
	FEP Member Liability (amount you should collect from your patient)	= \$29

*The total combined amount a FEP Preferred Dentist can collect from Blue Cross and the FEP member.

CANCELLATIONS AND NO-SHOWS

Any charges for cancellations or no-shows are not covered under our member contracts and therefore would become the patient's responsibility. The patient should be notified in advance of such charges.

COORDINATION OF BENEFITS

Other health insurance coverage information is important in the coordination of benefits (COB) process. COB occurs when a member is covered by two or more insurance plans. You can assist in the COB process by asking your Blue Cross patients if they have other coverage and indicating this information in Block 11 on the ADA Dental Claim Form. When COB is involved, claims should be filed with the primary insurance carrier first. When an explanation of benefits (EOB) is received from the primary carrier, the claim then should be filed with the secondary carrier, attaching the primary carrier's EOB. If claims are filed with the primary and secondary insurance carrier at the same time and Blue Cross and Blue Shield is the secondary carrier, a Duplicate Coverage Inquiry (DCI) is sent to the primary carrier requesting the benefit payment amount, if any. Benefits are processed when the requested information is received.

DUAL BENEFITS FOR ORAL SURGERY

Dual benefits occur when the patient has dual coverage under the same plan for a service. Dual coverage does not mean that the patient's benefits are doubled, only that the two components of coverage (dental and medical) work together to cover any outstanding member balance.

Our benefit plans require that oral surgery claims are processed first under the patient's dental coverage. Do not submit as a medical claim first.

- When the patient has **Advantage Plus or Advantage Plus 2.0 Dental Network** benefits - submit the dental claim first to UCD, following their claim submission rules. UCD does not accept CPT codes on dental claims. Once the patient's applicable dental benefits are applied, you should then submit a second claim to Blue Cross for processing under the patient's medical benefits.

Claims processed under the patient's medical plan are considered **up to the contracted dental allowable amount**. Oral surgery claims submitted to the medical plan first or without documentation of the dental payment will be returned to the provider for documentation.

Below are examples of how a claim is processed for a patient with dual coverage when services are rendered by an **Advantage Plus or Advantage Plus 2.0 Dental Network** provider:

Medical deductible has not been met:

Dental Plan

Total Charge	\$120
Contracted Dental Allowable <i>provider writes off \$20 above allowable amount</i>	\$100
Member Cost Share	\$20 <i>coinsurance</i>
Dental Claim Payment Amount	\$80

Medical Plan

Total Charge	\$120
Contracted Dental Allowable <i>provider writes off \$20 above allowable amount</i>	\$100
Paid by Dental Plan	\$80
Member Cost Share from Dental Plan Considered	\$20
Dental Plan Cost Share Applied to Medical Deductible	\$20 <i>deductible</i>

Because the member's medical deductible has not been met, the member is billable for the dental cost share amount.

Medical deductible has been met:

Dental Plan

Total Charge	\$120
Contracted Dental Allowable <i>provider writes off \$20 above allowable amount</i>	\$100
Member Cost Share	\$20 <i>coinsurance</i>
Dental Claim Payment Amount	\$80

Medical Plan

Total Charge	\$120
Contracted Dental Allowable <i>provider writes off \$20 above allowable amount</i>	\$100
Paid by Dental Plan	\$80
Member Cost Share from Dental Plan Considered	\$20
Medical Claim Payment Amount	\$20

When the member's medical deductible has been met, Blue Cross pays the patient's dental cost share, making the claim **paid in full**. The patient should not be billed.

Section 5: Appeals

We recognize that disputes may arise between members and Blue Cross regarding covered services. An appeal is a written request from the member to change a prior decision that Blue Cross has made. Examples of issues that qualify as appeals include denied authorizations, denied claims or determinations of medical necessity. We will distinguish the appeal as either an administrative appeal or a medical necessity appeal. Depending on the amount at issue, appeals for investigational denials will follow either the administrative appeal process, or the medical necessity appeal process.

Member appeals processes vary at the current time due to variations in state and federal laws. We will apply the law that governs the benefits purchased by the member or the member's employer. In some instances this is state law, and in others, it is federal law. The member's contract or certificate describes the appeals processes applicable to the member. We will follow the language in the member's contract or certificate, should there be any variance between that language and what is printed below.

Blue Cross has been authorized by the Louisiana Department of Insurance as a medical necessity review organization (MNRO). At the present time, MNRO laws apply to individual contracts of insurance, employer insurance plans that are not governed by ERISA, and non-federal government insurance plans. Blue Cross generally refers to these processes as "Non-ERISA" processes. We will follow MNRO laws set out in La. R.S. 22:3070 et seq. and applicable regulations for these types of plans. We will follow the appeal rules for ERISA plans as set out in 29 CFR 2560 et seq. If the laws that affect appeals for any type of plan change, we will revise our process to maintain compliance.

There are some plans that are not governed by either the MNRO laws or the ERISA laws. Examples are some plans for whom we provide administrative services only and the Federal Employee Program. For these members, we will follow the appeals processes stated in their member contracts. The bulk of appeals should fall within the ERISA or non-ERISA (MNRO) processes.

Due to variations between federal and state laws, appeals for ERISA members are handled differently from non-ERISA member appeals. Both ERISA and non-ERISA appeals processes are outlined below. If members are unsure which process applies to them, they should contact their employer, Plan Administrator, Plan Sponsor or Blue Cross at 1-800-376-7741 or (225) 293-0625. Members and providers are encouraged to provide Blue Cross with all available information and documentation at the time of the appeal request to help us completely evaluate the appeal.

The member may submit appeals by writing to **United Concordia Dental (UCD)**. For contact information, please refer to the Quick Reference Guide.

If the member has questions or needs assistance putting the appeal in writing, the member may call Blue Cross Customer Care. Providers will be notified of appeal results only if the provider filed the appeal.

INFORMAL RECONSIDERATION

We have a process that allows providers to discuss utilization management decisions with our medical directors. An informal reconsideration is the provider's telephone request to speak to our medical director or peer reviewer on a member's behalf about a utilization management decision that we have made. An informal reconsideration typically is based on submission of additional information or a peer-to-peer discussion. An informal reconsideration is available only for initial or concurrent review determinations that are requested within 10 days of the denial. We will conduct an informal reconsideration within one working day of receipt of the request.

APPEALS PROCESS FOR NON-ERISA MEMBERS (MNRO)

Blue Cross will distinguish a member's appeal as either an **administrative appeal** or a **medical necessity appeal**. Depending on the amount at issue, appeals for investigational denials will follow either the administrative appeal process, or the medical necessity appeal process. The appeals procedure has **two internal levels**, including review by a committee at the second level. The member is encouraged to provide us with all available information to help us completely evaluate the member's appeal. Medical necessity appeals also offer the member the opportunity to appear in person or telephonically at a committee meeting as well as an opportunity for review by an independent external review organization.

The member has the right to appoint an authorized representative to represent the member in their appeals. An authorized representative is a person to whom the member has given written consent to represent the member in an internal or external review of a denial. The authorized representative may be the **member's treating provider**. If the member appoints the provider in writing and the provider agrees, any right to payment from the member other than any applicable copayment or coinsurance amount is waived.

Investigational Appeals

A member appealing an investigational denial will receive the process for an informal reconsideration and the process for first level internal appeals of medical necessity issues.

First Level of Internal Appeal

- The member, their authorized representative, or a provider acting on the member's behalf, must submit a written request to appeal the decision. The member has 180 days following the receipt of an adverse benefit determination to request an appeal. Requests submitted to Blue Cross after 180 days of the denial will not be considered.
- We will investigate the member's concerns. Health care professionals, including a physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review not previously involved in the initial decision, will review all appeals of medical necessity denials.

- If we change our original decision at the appeal level, we will process the member's claim and notify them and all appropriate providers, in writing, of the first level appeal decision.
- If the member's claim is denied on appeal, we will notify the member and all appropriate providers, in writing, of our decision within 30 calendar days of the member's request, unless we mutually agree that an extension of the time is warranted. At that time, we will inform the member of the right to begin the second level appeal process.

Second Level of Internal Appeal

- Within 60 calendar days of the date of our first level appeal decision, a member who is not satisfied with the decision may initiate, with assistance from the Customer Service Unit, if necessary, the second level of appeal process. Requests submitted to Blue Cross after 60 days of the denial will not be considered.
- A Member Appeals Committee not involved in any previous denial will review all second level appeals. The committee's decision is final and binding as to any administrative appeal and will be mailed to the member within five working days of the committee meeting. For medical necessity appeals only, we will advise the member or their authorized representative of the date and time of the review meeting, which the member or their authorized representative may attend. The review meeting is normally held within 45 working days of our receipt of the member's request for a second level appeal.
- The member or their authorized representative has the right to attend the review meeting for medical necessity appeals, present the member's position and ask questions of the committee members present, subject to the rules of procedure established by the committee.
- If the member is unable to appear before the committee, but wishes to participate, we will make arrangements for the member to participate by means of available technology.
- For medical necessity appeals, a physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review must agree with any adverse decision made by the committee. The committee will mail its decision regarding the member's medical necessity appeal to the member within five working days after the meeting. Medical necessity appeals may only be elevated to the third and final review by an independent external review organization.

Independent External Review

- If the member still disagrees with the medical necessity denial, and has the concurrence of the member's treating physician, the member may request an independent external appeal conducted by a non-affiliated independent review organization (IRO). The IRO process applies to stand-alone dental benefits only for claims over \$250.
- Within 60 days of receipt of the second level appeal decision, the member should send their written request for an external review to Blue Cross. Requests submitted to us after 60 days of receipt of the denial will not be considered.
- We will provide the IRO all pertinent information necessary to conduct the appeal. The IRO decision will be considered a final and binding decision. The IRO review will be completed within 72 hours after the appeal is commenced if the request is of an urgent or emergent nature. Otherwise, the review will be completed within 30 days from the receipt of the information from us, unless the parties agree to a longer period. The IRO will notify the member or their authorized representative and the member's health care provider of its decision.

Expedited Internal Appeal

- We provide an expedited internal appeal process for review of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize a member's life, health or ability to regain maximum function. In these cases, Blue Cross will make a decision no later than 72 hours after the review commences.
- An expedited appeal is a request concerning an admission, availability of care, continued stay, or health care service for a covered person who is requesting **emergency services** or has received emergency services, but has not been discharged from a facility. Expedited appeals are not provided for review of services previously rendered. An expedited appeal shall be made available to, and may be initiated by, the covered person or an authorized representative, with the consent of the covered person's treating health care provider, or the provider acting on behalf of the covered person.
- Requests for an Expedited Internal Appeal may be oral or written and should be made to **United Concordia**.
- We must receive proof that the member's provider supports this request for an Expedited Internal Appeal. In any case where the Expedited Internal Appeal process does not resolve a difference of opinion between us and the covered person or the provider acting on behalf of the covered person, the appeal may be elevated to a second level standard internal appeal or an expedited external review.

Expedited External Review

An expedited external review is a request for immediate review, by an independent review organization (IRO), of an adverse initial determination not to authorize continued services for members currently in the emergency room, under observation in a facility or receiving inpatient care. The member's **health care provider must request** the expedited external review. Expedited external reviews are not provided for review of services previously rendered. An expedited external review of an adverse decision is available if pursuing the standard appeal procedure could seriously jeopardize the member's life, health or ability to regain maximum function. Within 60 days of the denial, the provider should contact Blue Cross to request this level of review. We will forward all pertinent information to the IRO so the review is completed no later than 72 hours after the review commences. Any decision rendered by the IRO is binding on us and the member for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity. This appeals process shall constitute the member's sole recourse in disputes concerning determinations of whether a health service or item is or was medically necessary. The IRO process applies only for medical services under the patient's medical benefits and is not available for stand-alone dental benefits.

APPEALS PROCESS FOR ERISA MEMBERS

If the member is an ERISA Member, we offer the member **two levels of appeal**. The member is required to complete the first level of appeal prior to instituting any civil action under ERISA section 502(a). The second level of appeal is voluntary. The two levels of review for administrative appeals will be internal. The first level of review for medical necessity appeals will be internal and an external independent review organization (IRO) that is not affiliated with Blue Cross will handle the second voluntary level of review.

The member has the right to appoint an authorized representative in any appeal. An authorized representative is a person to whom the member has given written consent to represent the member in an internal or external review.

The member is encouraged to submit written comments, documents, records and other information relating to the claim for benefits. We will provide the member, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the member's claim for benefits.

Persons not involved in previous decisions regarding the member's claim will decide all appeals. A physician or other health care professional in the same or an appropriate specialty that typically manages the medical condition, procedure or treatment under review who is not subordinate to any previous decision maker on the member's claim will review medical necessity appeals.

Investigational Appeals

A member appealing an investigational denial will receive the process for an informal reconsideration and the process for first level internal appeals of medical necessity issues.

First Level of Internal Appeal (Mandatory prior to instituting legal action)

The member, their authorized representative, or provider acting on the member's behalf must submit a request to appeal the decision in writing within 180 days following the receipt of an adverse benefit determination. Requests submitted after 180 days will not be considered.

In the case of a claim involving urgent care as defined below, Blue Cross will expedite the review process. The member may request an expedited review orally or in writing. All necessary information may be transmitted between the parties by telephone, facsimile or other available similarly expeditious means.

We will review the member's appeal promptly. The member will receive notice of our review decision for:

1. Urgent care claims as soon as reasonably possible taking into account medical exigencies, but not later than 72 hours after we receive the member's request for an appeal of an adverse benefit determination. ("Urgent care claim" means any claim with respect to which the application of the time periods for making non-urgent care determinations (a) could, in the opinion of a prudent person with an average knowledge of health or medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.)
2. Pre-service claims within a reasonable period of time appropriate to the medical circumstances but not later than 30 days after we receive the member's request for appeal of an adverse benefit determination. ("Pre-service claim" means any claim for a benefit under the plan with respect to the terms of the plan condition receipt of the benefit, in whole or in part, on approval or authorization of the benefit in advance of obtaining care or treatment.)
3. Post-service claims within a reasonable period of time but not later than 30 days after we receive the member's request for appeal of an adverse benefit determination. ("Post-service claim" means any claim for a benefit under the plan that is not an urgent care claim or a pre-service claim as defined.)

We may extend the initial period for review of a post-service claim by 15 days prior to the end of the initial 60-day period if special circumstances require an extension of time. Any notice of extension will be in writing, explain the special circumstances that may dictate an extension of the time period needed to review the member's appeal and give the date by which we expect to make our decision. In any event, the member will receive written notice of our decision no later than 45 days after the member's request for review is received. If our initial decision is not overturned on appeal, we will inform the member in writing of their right to begin the voluntary second level appeal process and any other ERISA rights that may be available to the member at that time.

Second Level Administrative Appeal (Voluntary)

- Within 60 calendar days of the date of our first level administrative appeal decision, a member who is not satisfied with the decision may initiate a voluntary second level appeal process. Requests submitted to Blue Cross after 60 days of the denial will not be considered.
- It is not necessary to complete this voluntary process in order to bring a civil action under ERISA section 502(a). Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending. The member's decision whether or not to submit to this voluntary level of review will have no effect on the member's rights to any other benefits under the plan. No fees or costs will be imposed on the member.
- The second level appeal will involve a committee review not previously involved in the member's claim determination. The committee will mail its decision to the member within five (5) working days after the meeting. The result of this committee is the final review decision for claims not involving medical necessity determinations.

Second Level Medical Necessity Appeal (Voluntary)

- Within 60 calendar days of the date of our first level medical necessity appeal decision, a member who is not satisfied with the decision may initiate a voluntary second level appeal process. Requests submitted to Blue Cross after 60 days of the denial will not be considered.
- If the member wishes to elevate their appeal of a medical necessity denial to the second and final level, a non-affiliated external IRO will perform the member's review. It is not necessary to complete this voluntary process in order to bring a civil action under ERISA section 502(a). Any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending. The member's decision whether or not to submit to this voluntary level of review will have no effect on the member's rights to any other benefits under the plan. No fees or costs will be imposed on the member.
- The member's provider may make the request for an expedited external review if the member's medical condition is of an urgent or emergent nature. Expedited reviews will be completed within 72 hours after the appeal is commenced. Otherwise, the member will need to have the concurrence of the member's treating physician to request the external review.
- The member may request this level of appeal by sending a written request for an external review to Blue Cross within 60 days of the member's receipt of a level one denial. Requests submitted to Blue Cross after 60 days of receipt of the denial will not be considered. Members are entitled to only one IRO appeal. We will provide the IRO all necessary documents and information used in making the adverse determination to the IRO. The review will be completed within 30 days from the IRO's receipt of the information from Blue Cross, unless the parties agree to a longer period. The IRO will notify the member or their authorized representative and the member's health care provider of its decision.

FEP RECONSIDERATIONS AND APPEALS PROCESS/GUIDELINES

Providers cannot appeal an FEP claim denial unless they are appealing on the member's behalf with signed consent from the member. For proper protocol on FEP appeals, please see the member's instructions below, paraphrased from the member's Service Benefit Plan brochure:

1. Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must:
 - Write to us within six months from the date of the decision; and
 - Send your request to the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription Drug Benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and
 - Include a statement about why you believe our initial decision is wrong, based on specific benefit provisions outlined in this brochure; and
 - Include copies of documents that support the claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2. We have 30 days from the date we receive your request to:
 - Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug or supply); or
 - Write to you and maintain our denial; or
 - Ask your provider for more information. If we ask the provider, we will send you a copy our request, go to Step 3.
3. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

Section 6: Questions and Answers

How does payment under the Blue Cross Dental Network work?

The Blue Cross Dental Network only exists to process medical policy benefits when medical services are rendered to a member by a dental professional. The Blue Cross Dental Network only administers claims for medical services to members, it does not process or administer claims for dental services provided to a member. If you provide medical services as a dentist within your professional licensure, then claims for medical services rendered by a dentist to a Blue Cross member for covered medical services are processed and paid through the Blue Cross Dental Network.

How does payment under the Advantage Plus or Advantage Plus 2.0 Dental Network work?

The Advantage Plus and the Advantage Plus 2.0 Dental Networks are owned and administered by United Concordia Dental (UCD) and providers must be contracted directly with UCD to be in-network for these members. Payment will be administered for Blue Cross by UCD.

How does payment under the FEP Preferred Dental Network work?

As a FEP Preferred Dentist, you agree to accept the FEP MAC as payment in full for covered services as well as file claims for FEP members. FEP members with Standard Option benefits agree to pay the difference between the Fee Schedule Amount and the MAC. FEP members with Basic Option benefits agree to pay a copayment for covered services.

What is the allowable charge?

The allowable charge is the maximum amount allowed by Blue Cross for covered services. The allowances reflect charging patterns of Louisiana dentists and establish a value relative to the degree of service involved.

Do I have to accept the allowable charge as payment in full?

Yes. You may bill the patient for any copayment, deductible, coinsurance and non-covered charges, but you may not bill the patient for any amount over the allowable charge for covered services.

What is the Maximum Allowable Charge?

The maximum allowable charge (MAC) is a negotiated, discounted amount that participating FEP Preferred Dentists accept as payment in full.

Do FEP participating dentists have to accept the MAC as payment in full?

Yes. You may bill the patient, depending on their benefit plan, for the difference between the fee schedule amount and the MAC and/or a copayment as applicable.

Can I terminate the network agreement(s) whenever I want?

Blue Cross is not a party to any provider's contract with UCD for either the Advantage Plus or Advantage Plus 2.0 Network. As such, those agreements should be consulted as to termination. As to the Blue Cross Dental Network—which exists solely to provide medical policy benefits when medical services are rendered to a member by a dental professional—either the dentist or Blue Cross may terminate the agreement(s) with 30 days advance written notice.

Does my network agreement(s) restrict my charges?

Please consult your UCD network agreement regarding dental service fees. If you provide medical services as a dentist, your agreement(s) with Blue Cross does not restrict your right to determine how much you should charge or how often to increase your fees. However, you agree to charge Blue Cross and Blue Shield patients no more than you ordinarily charge your other patients for the same or similar services and to accept the allowable charge as payment in full.

Does this agreement(s) affect Medicare or Medicaid?

No. The Blue Cross and FEP Preferred Dental networks are not Medicare or Medicaid programs. Each pertains to your Blue Cross patients only, which includes members whose contracts are underwritten and/or administered by Blue Cross.

What claim form do you accept?

Blue Cross accepts the ADA Dental Claim Form approved by the American Dental Association, or a CMS-1500 claim form for Blue Cross and Blue Shield of Louisiana members who receive medical services from a dental professional. When filing a claim for BlueCard® members on the ADA Dental Claim Form, providers must follow the instructions on the back of the member ID card. When billing for oral surgery or medical services using CPT codes, oral surgeons should use a CMS-1500 claim form. Please consult your UCD and/or FEP network agreements as to the forms each accept for dental services.

Do you accept attachments such as "superbills?"

No, the ADA Dental Claim Form or CMS-1500 are the only acceptable paper forms for filing dental claims.

Who can I call if I have problems filing my dental services claims?

You may call United Concordia at 1-866-445-5338 for questions on Advantage Plus or Advantage Plus 2.0 dental claims, and 1-800-272-3029 for questions on FEP Preferred dental claims.

How do Blue Cross members know I'm an Advantage Plus, Advantage Plus 2.0 or FEP Preferred network dentist?

Blue Cross members with internet access can view and print an online directory of network dentists at our website and Advantage Plus and Advantage Plus 2.0 network dentists at www.bcbsla.com >Find a Doctor >BlueDental Provider Directory. Printed FEP directories are also available to members upon request.

Where do I send claims for Advantage Plus or Advantage Plus 2.0 members?

Dental claims for Advantage Plus and Advantage Plus 2.0 members should be filed directly to UCD. Please refer to the Quick Reference Guide for more information.

Where do I send dental claims for BlueCard® out-of-state members?

When treating a member with dental benefits provided by another Blue Plan, non-medical dental claims should be filed directly to the Blue Plan that owns the policy on an ADA claim form. Medical-related dental claims should be filed directly to Blue Cross on a CMS-1500 claim form.

Where do I send dental claims for FEP members?

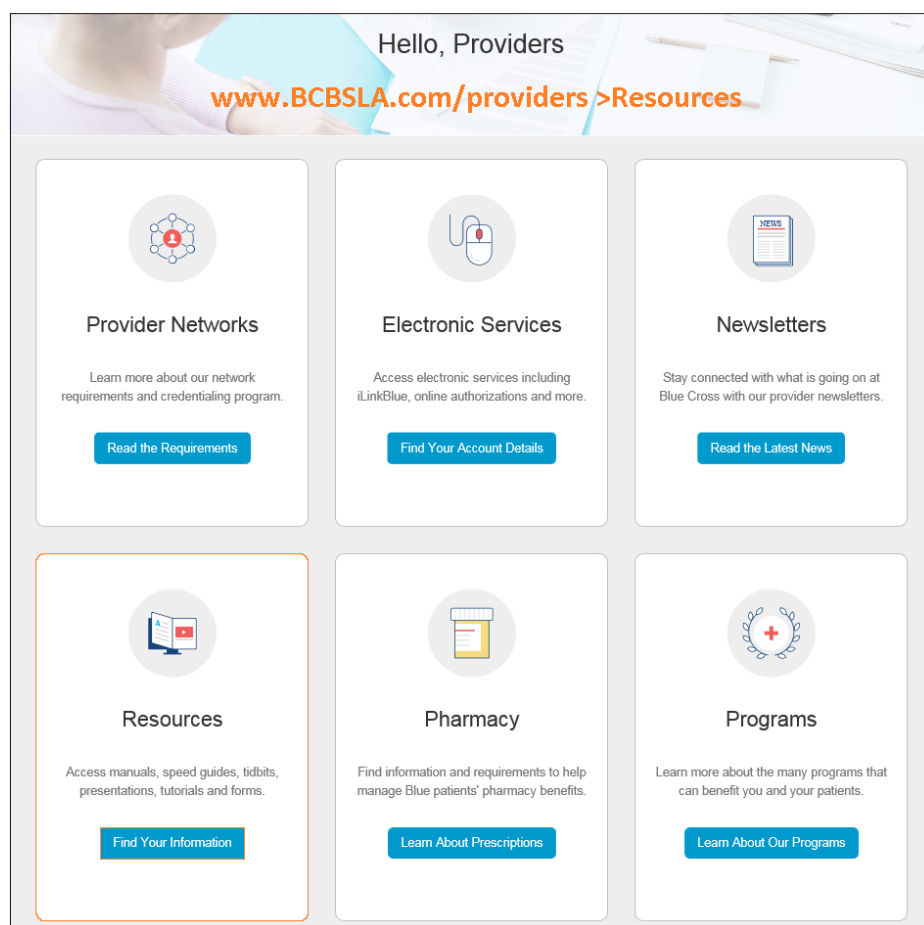
Dental claims for FEP members, whether dental or medical, should be filed directly to Blue Cross and Blue Shield of Louisiana.

Appendix I - Online Resources

Blue Cross Provider Page	Page I-2
iLinkBlue	Page I-3
• Sample Weekly Provider Payment Register	Page I-4
• Payment Register/Remittance Advice Explanation	Page I-5

Provider Page

Blue Cross and Blue Shield of Louisiana's provider website serves our provider needs. Use this page to help locate important information.



You will find information on:

- Provider Networks
 - Credentialing
 - Provider Support
- Electronic Services
 - Learn about iLinkBlue
 - Clearinghouse Services
 - Admin Reps
 - Electronic Funds
- Newsletters
 - Network News
 - Blue Advantage Insight
 - Past Newsletters
- Resources
 - Manuals
 - Speed Guides
 - Tidbits
 - Workshops and Webinars
 - Forms for Providers
- Pharmacy
- Programs
 - Quality Blue
 - Care Management
 - Specialty Care Insight

www.bcbsla.com/providers

iLinkBlue

Blue Cross and Blue Shield of Louisiana's iLinkBlue is our secure online tool for facility and professional health care providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, and payment queries and transactions.

To gain access to iLinkBlue, you must complete the iLinkBlue agreement packet. The iLinkBlue provider agreement packet is available on our Provider page.

Welcome to iLinkBlue

Tips to Know

Need Coverage Information But Don't Have the Member ID?
You can search for coverage information by a BCBSLA subscriber's social security number if you do not have their BCBSLA member ID. The coverage information tool is located under the Coverage menu.

Medical Record Requests

You have **10** new Medical Record Requests that require action.

Please visit [Out of Area Medical Record Requests](#) to view requests.

[Document Upload](#)

Research Claims **BCBSLA Coverage** **OOA Coverage** **Need an Auth?** **Payment Registers** **EFT Notices**

Important Blue Cross Messages

Informational

A **NEW** Document Upload feature is now available. Users can now upload medical records and other documents securely to various departments within Blue Cross and Blue Shield of Louisiana by selecting 'Document Upload' from the Home page or Claims < Medical Records menu option. Click **here** for important FAQs regarding this upload feature.

Other Sites

- Davis Vision Network
- Dental Advantage Plus Network - United Concordia Dental
- Blue Advantage
- Healthy Blue

iLinkBlue is your one-stop for:

- Benefits
- Eligibility
- Claims Research
- Payment Information
- Authorizations
- Electronic Funds Transfer
- BlueCard Medical Record Requests
- Medical Policies
- Manuals
- Allowable Charges
- Estimated Treatment Cost
- Grace Period Notices
- Medical Code Editing
- And so much more!

www.bcbsla.com/ilinkblue

Sample Weekly Provider Payment Register

Sample Weekly Provider Payment Register

Sample weekly Provider Payment Register

BLUE CROSS BLUE SHIELD OF LOUISIANA WEEKLY PROVIDER PAYMENT REGISTER													
Date: 01/15/2019 Provider Name: Family Dental Clinic													
(1) Patient Name	(2) Contract Number	(3) Patient Acct	(4) Days/Units	(5) Admt/Dis Dt	(6) Claim Number	(7) CPT4 Rev	(8) Sch Drg	(9) Total Charges	(10) Above Allow Amt	(11) COB /OC Pay	(12) OC Code	(13) Not Covered Ded-Coin-Incl	(14) Amt Paid
PUBLIC, JQ	XUH123456789	ABCDEFH00	1	04/15/2018 04/15/2018	1000000	99999		\$155.00	\$55.00 PDC-CO			\$100.00 DED-PR	\$ 0.00
(15) Performing/Prov: 0123456789 (16) Prov Name: John Doe, DDS													
PUBLIC, JQ	XUH123456789	ABCDEFH00	1	04/15/2018 04/15/2018	1000000	99999		\$ 55.00	\$12.00 PDC-CO			\$ 0.00 DED-PR	\$43.00
Performing/Prov: 0123456789 Prov Name: John Doe, DDS													
PUBLIC, SU	XUH987654321	ABCDEFH01	1	06/30/2018 06/30/2018	1000012	99999		\$120.00	\$30.00 PDC-CO			\$ 90.00 DED-PR	\$ 0.00
Performing/Prov: 0123456789 Prov Name: John Doe, DDS													
SMITH, JOHN	XUH999999999	ABCACAB01	1	07/15/2018 07/15/2018	1000030	99999		\$175.00	\$60.00 PDC-CO			\$100.00 DED-PR	\$15.00
Performing/Prov: 0123456789 Prov Name: John Doe, DDS													
(17) Totals:			4					\$505.00	\$157.00			\$290.00	\$58.00

ALL NAMES, CHARGES AND
CODES ARE FOR
EXAMPLE PURPOSES ONLY

PR - This is the amount determined by Blue Cross to be the responsibility of the patient.
OA - The liability for this amount is not determined on this processing because this amount was previously processed or may be processed in the future
CO - This amount is determined by Blue Cross to be the responsibility of the provider.
PDC - The charge exceeds the allowed amount for this service.

FAMILY DENTAL CLINIC 111 MAIN STREET ANYTOWN, LA 70000-0000	BLUE CROSS BLUE SHIELD LOUISIANA P.O. BOX 98029 BATON ROUGE, LA 70898-9029	(18) PAID PROV: 0123456789 (19) DATE: 01/15/2019 (20) CHECK NO: 99999999
---	--	--

Note: All charges and
codes are examples only.

Provider Payment Register Explanation

Following is a description of each item on the Blue Cross Weekly Provider Payment Register.

- 1. Patient's Name** - The last name and first five letters of the first name of the patient.
- 2. Contract Number** - The member's Blue Cross identification number.
- 3. Patient Acct** - The patient identification number assigned by the provider's office. This information will appear only if provided on the claim.
- 4. Days/Units** - The number of visits that the line item charge represents.
- 5. Admit/Dis Dt** - The beginning and ending date(s) of service for a claim.
- 6. Claim Number** - The number assigned to the claim by Blue Cross for document identification purposes. NOTE: When making inquiries about a specific payment, always refer to this number.
- 7. CPT4 Rev** - CPT Code: The code used to describe the services performed by the provider.
- 8. Sch Drg** - Not applicable to providers.
- 9. Total Charges** - The charge for each service and the total claim charges submitted to Blue Cross and Blue Shield.
- 10. Above Allowable Amount** - The amount above the allowable charge. NOTE: This amount cannot be collected from the member.
- 11. COB/OC Pay** - An asterisk in this column denotes that Blue Cross and Blue Shield is the secondary carrier.
- 12. OC Code** - C = Commercial Carrier, M = Medicare.
- 13. Not Covered Ded-Coin-Inel** - The total amount owed by a patient for each claim including deductible, coinsurance, copayment, non-covered charges, etc.
- 14. Amt Paid** - The amount paid by Blue Cross.
- 15. Performing/Prov** - The name and provider number of the provider who performed the service.
- 16. Provider Name** - Provider/Clinic name and address to which payment is made.
- 17. Totals** - The total of days, charges, contract benefits, patient liability, above allowable amount and amount paid for all patients listed.
- 18. Paid Prov.** - Provider's/Clinic's NPI under which payment is made.
- 19. Date** - Date the Provider Payment Register is generated by Blue Cross.
- 20. Check No.** - The number assigned to the check mailed with the payment register.

Appendix II - Forms

Alternative Dental Procedure Payment Responsibility Form	Page II-1
1500 Claim Form and Explanation	Page II-2
ADA Dental Claim Form and Explanation	Page II-9
Attending Dentist's Statement	Page II-13

Forms are available online at www.bcbsla.com/providers >Resources >Forms.



Alternative Dental Procedure Payment Responsibility Form

Complete and attach this form to the dental claim form when a member chooses an alternative, non-covered treatment.

Pursuant to Louisiana Senate Bill 73, which amended and/or reenacted La. R.S. 22:1513(C)(2)(b); 22:250.43(C) and 22:250.48, a Blue Cross and Blue Shield of Louisiana (BCBSLA) member may choose any type, form or quality of dental procedure, for which insurance coverage is not available, as long as the member approves in advance and in writing the charges for which he/she will be responsible. Additionally, if a member receives a dental diagnosis from a contracted provider that qualifies for a covered service pursuant to the member's contract/certificate or dental contract, the member may:

1. Choose the covered service provided for in the member contract/certificate or dental contract for the treatment of the condition diagnosed; or
2. Choose an alternate type, form or quality of dental procedure of equal or greater price to treat the diagnosed condition. If the member chooses this option, he/she must agree in advance and in writing to pay the difference between the allowed amount of the covered service and the amount of the chosen alternative service or procedure.

DENTIST INFORMATION	
Dentist Name	
Contact Name	National Provider Identifier (NPI)
Phone Number	Fax Number
COVERED SERVICE	
CDT Code	Description
Additional CDT Code	Description
ALTERNATIVE TREATMENT/SERVICE	
CDT Code	Description
Additional CDT Code	Description
MEMBER INFORMATION	
By receiving the above alternative treatment/service, I agree that I will be responsible for the difference between the allowed amount paid by BCBSLA and the amount charged by the dentist for the chosen alternative service or procedure.	
Member Signature	Date
Member Name (please print)	Member ID



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12



**Blue Cross only accepts CMS-1500
"version 02/12." No black and white
copies or faxed claims are accepted.**

<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> PICA </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small> </div> <div> 1a. INSURED'S I.D. NUMBER (For Program in Item 1) </div> </div>										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY		STATE			CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code) ()			ZIP CODE		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____		b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____					15. OTHER DATE MM DD YY QUAL. _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____					23. PRIOR AUTHORIZATION NUMBER					
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					
1							NPI			
2							NPI			
3							NPI			
4							NPI			
5							NPI			
6							NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (If or govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____ DATE _____					a. NPI b. _____		a. NPI b. _____			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



Louisiana

Blue Cross and Blue Shield of Louisiana
Dental Network Office Manual

II-3
January 2023

Health Insurance Claim Form (CMS-1500 Version 02-12) Explanation

- Block 1** Type(s) of Health Insurance - Indicate coverage applicable to this claim by checking the appropriate block(s).
- Block 1A** Insured's I.D. Number - Enter the member's Blue Cross and Blue Shield identification number, including prefix, exactly as it appears on the identification card.
- Block 2** Patient's Name - Enter the full name of the individual treated.
- Block 3** Patient's Birth Date - Indicate the month, day and year.
Sex - Place an X in the appropriate block.
- Block 4** Insured's Name - Enter the name from the identification card except when the insured and the patient are the same; then the word "same" may be entered.
- Block 5** Patient's Address - Enter the patient's complete, current mailing address and phone number.
- Block 6** Patient's Relationship to Insured - Place an X in the appropriate block. Self - Patient is the member. Spouse - Patient is the member's spouse. Child - Patient is either a child under age 19 or a full-time student who is unmarried and under age 25 (includes stepchildren). Other - Patient is the member's grandchild, adult-sponsored dependent or of relationship not covered previously.
- Block 7** Insured's Address - Enter the complete address; street, city, state and zip code of the policyholder. If the patient's address and the insured's address are the same, enter "same" in this field.
- Block 8** Reserved for NUCC USE - This section is reserved for NUCC use.
- Block 9** Other Insured's Name - If the patient has other health insurance, enter the name of the policyholder, name and address of the insurance company and policy number (if known).
- Block 10** Is patient's condition related to: a. Employment (current or previous)?; b. Auto Accident?; c. Other Accident?. Check appropriate block if applicable.
- Block 10D** When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the CMS-1500 claim form are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code.



Block 11 Not required.

Block 11D When appropriate, enter an X in the correct box. If marked "YES," complete 9, 9A, and 9D. Only mark one box.

Block 12 Patient's or Authorized Person's Signature - Appropriate signature in this section authorizes the release of any medical or other information necessary to process the claim. Signature or "Signature on File" and date required. "Signature on File" indicates that the signature of the patient is contained in the provider's records.

Block 13 Insured's or Authorized Person's Signature - Payment for covered services is made directly to participating providers. However, you have the option of collecting for office services from members who do not have a copayment benefit and having the payments sent to the patients. To receive payment for office services when the copayment benefit is not applicable, Block 13 must be completed. Acceptable language is:

- | | |
|-----------------------|----------------------|
| a. Signature in block | d. Benefits assigned |
| b. Signature on file | e. Assigned |
| c. On file | f. Pay provider |

Please Note: *Assignment language in other areas of the CMS-1500 claim form or on any attachment is not recognized. If this block is left blank, payment for office services will be sent to the patient. Completion of this block is not necessary for other places of treatment.*

Block 14 Enter the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date of the present illness, injury or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported.

Block 15 Enter another date related to the patient's condition or treatment. Enter the date in the six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format. Enter the applicable qualifier to identify which date is being reported.

Block 16 Dates Patient Unable to Work in Current Occupation - Enter dates, if applicable.

Block 17 Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported to the left of the vertical, dotted line.



- Block 17A** Other ID #. The non-NPI ID number of the referring physician, when listed in Block 17.
- Block 17B** **NPI – Required.** Enter the national provider identifier (NPI) for the referring physician, when listed in Block 17.
- Block 18** For Services Related to Hospitalization - Enter dates of admission to and discharge from hospital.
- Block 21** **Diagnosis or Nature of Illness or Injury** - Enter the applicable ICD indicator to identify which version of ICD codes is being reported: "0" for ICD-10-CM codes- Note: All transactions, electronic or paper-based, for services on and after October 1, 2015, must contain ICD-10 codes or they will be rejected. Blue Cross will not accept ICD-10 codes for dates of services on or after October 1, 2015. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. Use the most specific diagnosis codes when reporting codes. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
- Block 23** Prior Authorization Number - Enter the authorization number obtained from Blue Cross/HMO Louisiana, if applicable.
- Block 24A** Date(s) of Service - Enter the "from" and "to" date(s) for service(s) rendered.
- Block 24B** Place of Service - Enter the appropriate place of service code. Common place of service codes are:
Inpatient - 21 Outpatient - 22 Office - 11
- Block 24C** EMG - Enter the Type of Service code that represents the services rendered.
- Block 24D** Procedures, Services, or Supplies - Enter the appropriate CPT or HCPCS code. Please ensure your office is using the most current CPT and HCPCS codes and that you update your codes annually. Append modifiers to the CPT and HCPCS codes, when appropriate.
- Block 24E** Diagnosis Pointer - Enter the diagnosis code reference letter (pointer) as shown in Block 21 to relate the date of service and procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. ICD-10-CM diagnosis code must be entered in Block 21 only. Do not enter it in 24E.
- Block 24F** Charges - Enter the total charge for each service rendered. You should bill your usual charge to Blue Cross regardless of our allowable charges.

- Block 24G** Days or Units - Indicate the number of times the procedure was performed, unless the code description accounts for multiple units, or the number of visits the line item charge represents. Base units value should never be entered in the "units" field of the claim form.
- Block 24J** Rendering Provider ID # - Enter the NPI for the rendering physician for each procedure code listed when billing for multiple physicians' services on the same claim. Laboratory, Durable Medical Equipment, Emergency Room Physicians, Diagnostic Radiology Center, Laboratory and Diagnostic Services, and Urgent Care Center providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed.
- Block 25** Federal Tax ID Number - Enter the provider's/clinic's federal tax identification number to which payment should be reported to the Internal Revenue Service.
- Block 26** Patient's Account Number - Enter the patient account number in this field. As many as nine characters may be entered to identify records used by the provider. The patient account number will appear on the Provider Payment Register/Remittance Advice only if it is indicated on the claim form.
- Block 27** Accept Assignment - Not applicable - Used for government claims only.
- Block 28** Total Charge - Total of all charges in Item F.
- Block 29** Amount Paid - Not required.
- Block 30** Not required.
- Block 31** Signature of Provider - Provider's signature required, including degrees and credentials. Rubber stamp is acceptable.
- Block 32** Name and Address of Facility - Required, if services were provided at a facility other than the physician's office.
- Block 32A** NPI - Enter the NPI for the facility listed in Block 32.
- Block 32B** Other ID - The non-NPI number of the facility refers to the payer-assigned unique identifier of the facility.
- Block 33** Billing Provider Info & Ph # - Enter complete name, address, telephone number for the billing provider.
- Block 33B** Other ID # - The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional.
- Block 33A** NPI - Enter the NPI for the billing provider listed in Block 33.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION															
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX															
2. Predetermination/Preauthorization Number															
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION															
3. Company/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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other															
19. <input type="checkbox"/> Current <input type="checkbox"/> Future															
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)											
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other													
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code															
Date of Birth (MM/DD/CCYY) Gender 3. Patient ID/Account															
M F															
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)		29. Procedure Code		30. Description		31. Fee			
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
33. Missing Teeth (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)		31a. Other Fee(s)			
1		2		3		4		5		6		7			
8		9		10		11		12		13		14			
15		16		17		18		19		20		21			
22		23		24		25		26		27		28			
29		30		31		32		33		34		35			
34a. Diagnosis Code(s)										A		C			
(Primary diagnosis in "A")										B		D			
35. Remarks										32. Total Fee		\$0.00			
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION					
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 _____										38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")				39. Enclosures (Y or N) <input type="checkbox"/>	
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 _____										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)				41. Date Appliance Placed (MM/DD/CCYY)	
										42. Months of Treatment				43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	
										44. Date of Prior Placement (MM/DD/CCYY)					
										45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION					
48. Name, Address, City, State, Zip Code										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 _____					
49. NPI										54. NPI				55. License Number	
50. License Number										56. Address, City, State, Zip Code				56a. Provider Specialty Code	
51. SSN or TIN										57. Phone Number				58. Additional Provider ID	

©2012 American Dental Association
 J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
 or go online at adacatalog.org



Louisiana

Blue Cross and Blue Shield of Louisiana
 Dental Network Office Manual

II-8
 January 2023

Description of ADA Dental Claim Form Explanation

- Block 1** Mark this box if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under 21.
- Block 2** Enter the number provided by the payer when submitting a claim for services that have been predetermined or preauthorized.
- Block 3** Enter the patient's primary insurance carrier's information.
- Block 4-11** Fill in other coverage information. Leave blank if no other coverage.
- Block 8** Policy Holder/Subscriber's identification number for additional coverage.
- Block 12-14** Enter Subscriber's personal insurance information here.
- Block 15** This is the member's identification number assigned by Blue Cross.
- Block 16-17** This is the member's or employer group's plan or policy number. May also be known as the certificate number and employer name.
- Block 18** Check indicating the relationship of the patient to the Policyholder/Subscriber.
- Block 19-23** Complete only if the patient is not the primary subscriber (i.e., "Self" not checked in Block 18).
- Block 19** Check "FTS" if the patient is a dependent and a full-time student; "PTS" is a part-time student. Otherwise, leave blank.
- Block 23** Enter if dentist's office assigns a unique number to identify the patient that is not the same as the subscriber identifier number assigned by the payer (e.g., chart number).
- Block 24** Enter date the procedure was performed.
- Block 25** Designate tooth number or letter when the procedure code directly involves a tooth. Use the area of the oral cavity code set from ANSI/ADA/ISO Specification number 3950m, "Designation System for Teeth and Areas of the Oral Cavity."
- Block 26** Enter applicable ANSI ASC X12 code list qualifier. Use "JP" when designating teeth using the ADA's Universal/National Tooth Designation System. Use "JO" when using the ANSI/ADA/ISO Specification No. 3950.
- Block 27** Designate tooth number when the procedure code reported directly involves a tooth. If a range of teeth is being reported, use a hyphen (-) to separate the first and last tooth in the range. Commas are used to separate individual tooth numbers or ranges applicable to the procedure code reported.

- Block 28** Designate tooth surface(s) when the procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes, without spaces: B=Buccal; D=Distal; F=Facial; L=Lingual; M=Mesial and O=Occlusal.
- Block 29** Use the appropriate dental procedure code from the current version of the Code on Dental Procedures and Nomenclature.
- Block 30** Description of codes.
- Block 31** This is the dentist's full fee for the dental procedure reported.
- Block 32** This is used when other fees applicable to dental services provided must be recorded. Such fees include state taxes, where applicable, and other fees imposed by regulatory bodies.
- Block 33** This is the total of all fees listed on the claim form.
- Block 34** Report missing teeth on each claim submission.
- Block 35** Use "Remarks" space for additional information such as "reports" for "999" codes or multiple supernumerary teeth. Oral surgeons should place the diagnosis code in this field.
- Block 36** The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian or other individual as appropriate under state law and the circumstances of the case.
- Block 37** Subscriber Signature: This is necessary when the patient/insured and dentist wish to have benefits paid directly to the provider. This is an authorization of payment. It does not create a contractual relationship between the dentist and the payer.
- Block 38** Indicate the place of treatment by choosing "Provider's Office," "Hospital," "Extended Care Facility (ECF)" (e.g., nursing home) or "Other."
- Block 39** Fill in the number of each type of enclosures in the appropriate boxes provided.
- Block 40** Indicate whether or not the treatment is for orthodontics purposes.
- Block 41** If "yes" is checked in Block 40, list date appliance was placed.
- Block 42** If "yes" is checked in Block 40, list how many months of treatment are remaining.
- Block 43** If "yes" is checked in Block 40, indicate whether or not a replacement of prosthesis was done.
- Block 44** If "yes" is checked in Block 43, list date of prior placement.
- Block 45** Indicate what the treatment is resulting from, if applicable.



- Block 46** List date of accident.
- Block 47** Report what state the accident occurred.
- Block 48** This is the individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
- Block 49** Billing dentist's national provider identifier (NPI).
- Block 50** This refers to the license number of the billing dentist. This may differ from that of the treating dentist that appears in the treating dentist's signature block.
- Block 51** The Internal Revenue Service requires that either the SSN or TIN of the billing dentist or dental entity be supplied only if the provider accepts payment directly from the third-party payer. When the payment is being accepted directly, report the: 1) SSN if the dentist is unincorporated; 2) Corporation TIN if the billing dentist is incorporated; or 3) Entity TIN when the billing entity is a group practice or clinic.
- Block 52** Billing dentist or dental entity's phone number.
- Block 52a** Additional Provider ID #.
- Block 53** This is the treating, or rendering, dentist's signature and date the claim form was signed. Dentists should be aware that they have ethical and legal obligations to refund fees for services that are paid in advance, but not completed.
- Block 54** Treating dentist's NPI.
- Block 55** Treating dentist's license number.
- Block 56** This is the full address, including city, state and zip code, where treatment is performed by the treating (rendering) dentist.
- Block 57** Treating dentist or treatment location phone number.
- Block 58** Additional Provider ID #.

An independent licensee of the Blue Cross and Blue Shield Association

ATTENDING DENTIST'S STATEMENT

FOR OFFICE USE ONLY

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

X _____
SIGNATURE (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY THE DATE HAVE BEEN COMPLETED.		TOTAL FEE CHARGED		
X	_____	DATE	_____	_____
DENTIST SIGNATURE		MAX. ALLOWABLE DEDUCTIBLE	_____	_____
		CARRIER %	_____	_____
		CARRIER PAYS	_____	_____
		PATIENT PAYS	_____	_____

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company



II-12
January 2023

Appendix III - Definitions

Definitions

Advantage Plus and Advantage Plus 2.0 Dental Networks

Dental networks that are owned and administered by UCD. Providers participating in these networks should adhere to the guidelines set forth by UCD. All groups with dental benefits are on this network with the exception of FEP.

Allowable Charge

The lesser of the submitted charge or the amount established by the Plan, or negotiated based on an analysis of dentists' charges, as the maximum amount allowed for dental services covered under the terms of the Subscriber Contract/Certificate.

Authorization

A determination by the Plan regarding an admission, continued stay or other health care service for the purpose of determining medical necessity, appropriateness of the setting or level of care.

Benefit(s)

Coverage for medical or dental services and/or supplies provided under the terms of a Subscriber Contract/Certificate. Benefits provided by Blue Cross are based on the Professional Allowance/Allowable charge for Covered Services.

Blue Advantage

Our Medicare Advantage network that is available statewide.

Billed Charges

The total charges made by a dentist for all services and supplies provided to the member.

Blue Cross

Refers to Blue Cross and Blue Shield of Louisiana.

Blue Cross Dentist

A licensed dentist who has met the minimum credentials verification requirements of Blue Cross and Blue Shield of Louisiana and who has a formal and binding Agreement with Blue Cross pertaining to payment for Covered Services rendered to members.

Clean Claim

A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special or additional treatment that prevents timely payment from being made on the claim.

Coinsurance

The sharing of eligible charges for covered services between Plan and member. The sharing is expressed as a percentage. Once the member has met any applicable deductible amount, the member's percentage will be applied to the allowable charges for covered services to determine the member's financial responsibility. Plan's percentage will be applied to the allowable charges for covered services to determine the benefits provided.

Coordination of Benefits (COB)

Determining primary/secondary/tertiary liability between various health care benefit programs and paying benefits in accordance with established guidelines when members are eligible for benefits under more than one health care benefits program.

Copayment/Co-pay

That portion of charges for covered services usually expressed as a dollar amount that must be paid by the member and usually collected by a dentist at the time of service.

Covered Services

Those medically necessary services and supplies for which benefits are specified under a subscriber contract/certificate.

Current Dental Terminology (CDT[®])

A system of terminology and coding developed by the American Dental Association that is used for describing, coding and reporting dental services and procedures.

Current Procedural Terminology (CPT[®])

A system of terminology and coding developed by the American Medical Association that is used for describing, coding and reporting medical services and procedures.

Deductible

A specific amount of charges for Covered Services, usually expressed in dollars, that must be incurred by a member before Blue Cross is obligated to the member to assume financial responsibility for all or part of the remaining Covered Services under a Subscriber Contract/Certificate.

Dental Care and Treatment

All procedures, treatments and surgeries performed by a dentist that are considered to be within the scope of the practice of dentistry.

Electronic Funds Transfer (EFT)

EFT allows Blue Cross to send claims directly to iLinkBlue enrolled providers' checking or savings accounts. With EFT, providers can view their Weekly Provider Payment Registers in iLinkBlue and they no longer receive a payment register by mail.

Emergency

A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: a) placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Experimental/Investigational Services

The use of any treatment, procedure, facility, equipment, drug, device or supply not yet recognized by the National Association of Blue Cross and Blue Shield Plans as accepted practice for treatment of the condition. Note: Blue Cross makes no payment for Experimental/Investigational Services.

Explanation of Benefits (EOB)

A notice sent to the member after a claim has been processed by the Plan that explains the action taken on that claim.

Federal Employee Program (FEP)

A health care benefits plan designed for personnel employed by the Federal Government.

FEP Preferred Dental Network

A network of dentists who have signed contracts with Blue Cross and agreed to file claims for members and accept the FEP Maximum Allowable Charge (MAC) as payment in full for covered services.

Identification Card

The card issued to the member identifying him/her as entitled to receive Benefits under a Subscriber Contract/Certificate for services rendered by health care providers and for such providers to use in reporting to Blue Cross those services rendered to the member.

Identification Number

The number assigned to the member and all of his/her Blue Cross records. This number is a unique number selected at random, has a three-character prefix in the first three positions and is noted on the Identification Card.

iLinkBlue

A secure Web portal available at no cost for health care providers, designed to help you quickly complete important functions such as claims entry, authorizations and billing information.

Medical Necessity

Those health care services, treatments, procedures, equipment, drugs, devices, items or supplies that a dentist exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are: a) in accordance with nationally accepted standards of medical or dental practice; and b) clinically appropriate in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the personal comfort or convenience of the patient, dentist or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

Maximum Allowable Charge (MAC)

A negotiated, discounted amount that FEP Preferred Dentists have agreed to accept as payment in full for covered services.

National Provider Identifier

An exclusive number assigned to a provider by the Centers for Medicare and Medicaid Services (CMS) that allows providers to submit transactions to federal and state agencies, as well as file claims to private health plans.

Non-Covered Services

A service and/or supply (not a covered service) for which there is no provision for either partial or total benefit/payment under the subscriber contract/certificate.

Prefix

A three-digit prefix to the member's identification number that identifies the BCBS Plan or the national account in which the member is enrolled.

Provider Payment Register

A claims summary identifying all claims paid and denied that is provided to providers with payment, either electronically or by mail.

Subscriber/Member

Employees or individuals (also known as members) and their enrolled eligible dependents covered under a Blue Cross subscriber contract/certificate who are entitled to receive dental care and treatment and health care Benefits as defined in and pursuant to a subscriber contract/certificate.

Subscriber Contract/Certificate

Any Blue Cross contract/certificate or health benefit plan issued or administered by Blue Cross, its subsidiaries and affiliates, or another Blue Cross and Blue Shield Plan with which Blue Cross has a participating or reciprocal agreement, entitling members to receive dental care and treatment and health care Benefits as defined in and pursuant to a subscriber contract/certificate.

Summary of Changes

Below is a summary of changes to the Blue Cross and Blue Shield of Louisiana Dental Network Manual. Minor revisions not detailed in the summary include modifications to the text for clarity and uniformity, grammatical edits, and updates to web links referenced in the document.

January 2023

Quick Reference Guide

- Provider Credentialing & Data Management – updated description of Vantage Health Plan partnership, updated instructions for accessing credentialing packets and finding more information on the Blue Cross credentialing and data management process

Section 5: Appeals

- Independent External Review – removed indication that IRO process only applies for medical services under the member's medical benefits, added indication that IRO process only applies to stand-alone dental benefits for claims over \$250



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