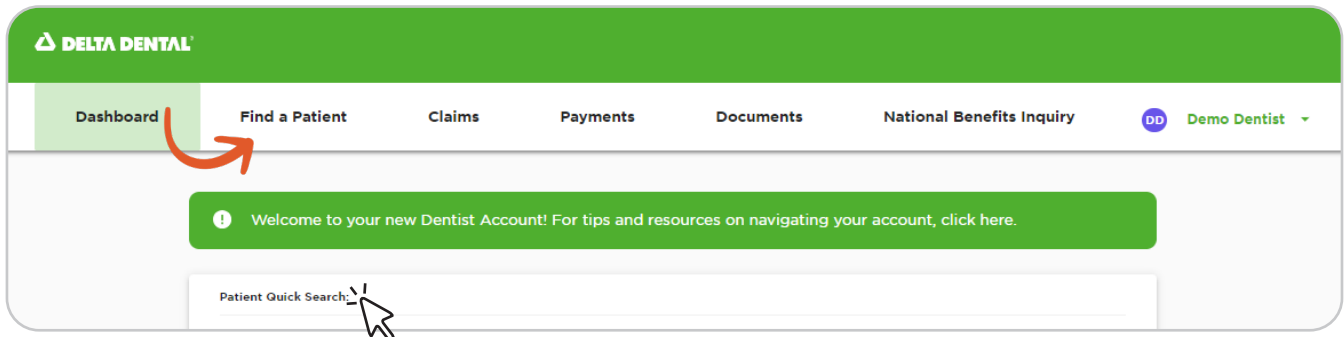


# Submitting a Claim

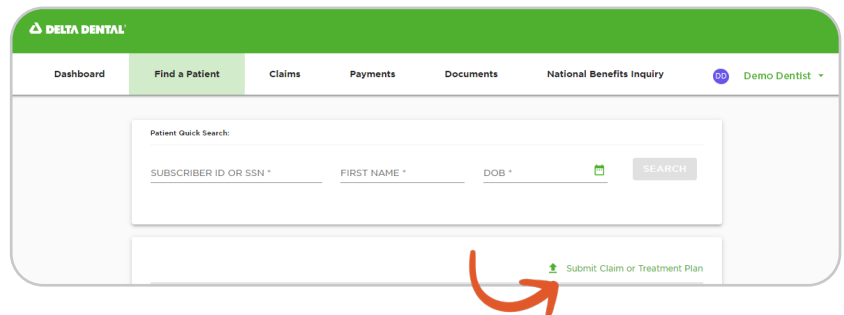
## Online Dentist Account

### ★ How to Submit a Claim

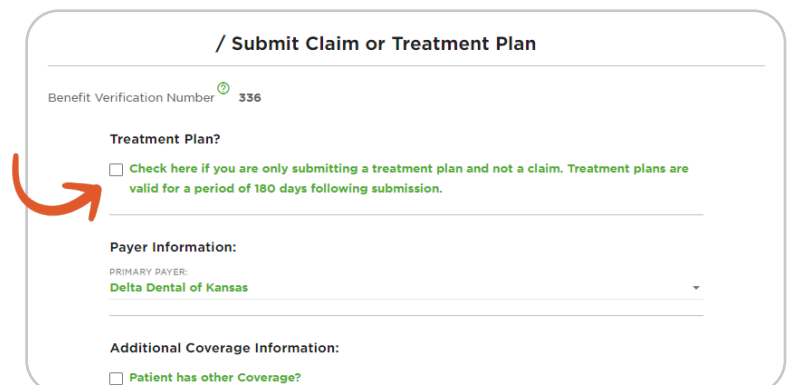
- 1 To submit a claim, pull up a patient using either **Patient Quick Search** from the dashboard or through the **Find a Patient** tab.



- 2 Click **Submit Claim or Treatment Plan**.



- 3 Since this is an in-for-payment claim, be sure to leave **Treatment Plan** unchecked.



# Submitting a Claim

## Online Dentist Account

### ★ How to Submit a Claim

- 4 If the patient has secondary insurance coverage, including if Delta Dental of Kansas is not the patient's primary insurance, check **Patient has other Coverage?** under Additional Coverage Information. This will open fields for information concerning the patient's other insurance policy information.

**/ Submit Claim or Treatment Plan**

Benefit Verification Number 336

**Treatment Plan?**

Check here if you are only submitting a treatment plan and not a claim. Treatment plans are valid for a period of 180 days following submission.

**Payer Information:**

PRIMARY PAYER:  
Delta Dental of Kansas

**Additional Coverage Information:**

Patient has other Coverage?

CARRIER NAME: \*      GROUP NUMBER: \*

GROUP NAME: \*      SUBSCRIBER ID: \*

FIRST NAME: \*      LAST NAME: \*

DATE OF BIRTH: \*      GENDER \*

RELATIONSHIP TO SUBSCRIBER \*

- 5 Select the Treating Dentist and Business from the drop-down menus. These fields are required to submit, even if your office only has one dentist and one office location.

**Dentist Information:**

TREATING DENTISTS NPI: \*

BILLING / BUSINESS NPI: \*

# Submitting a Claim

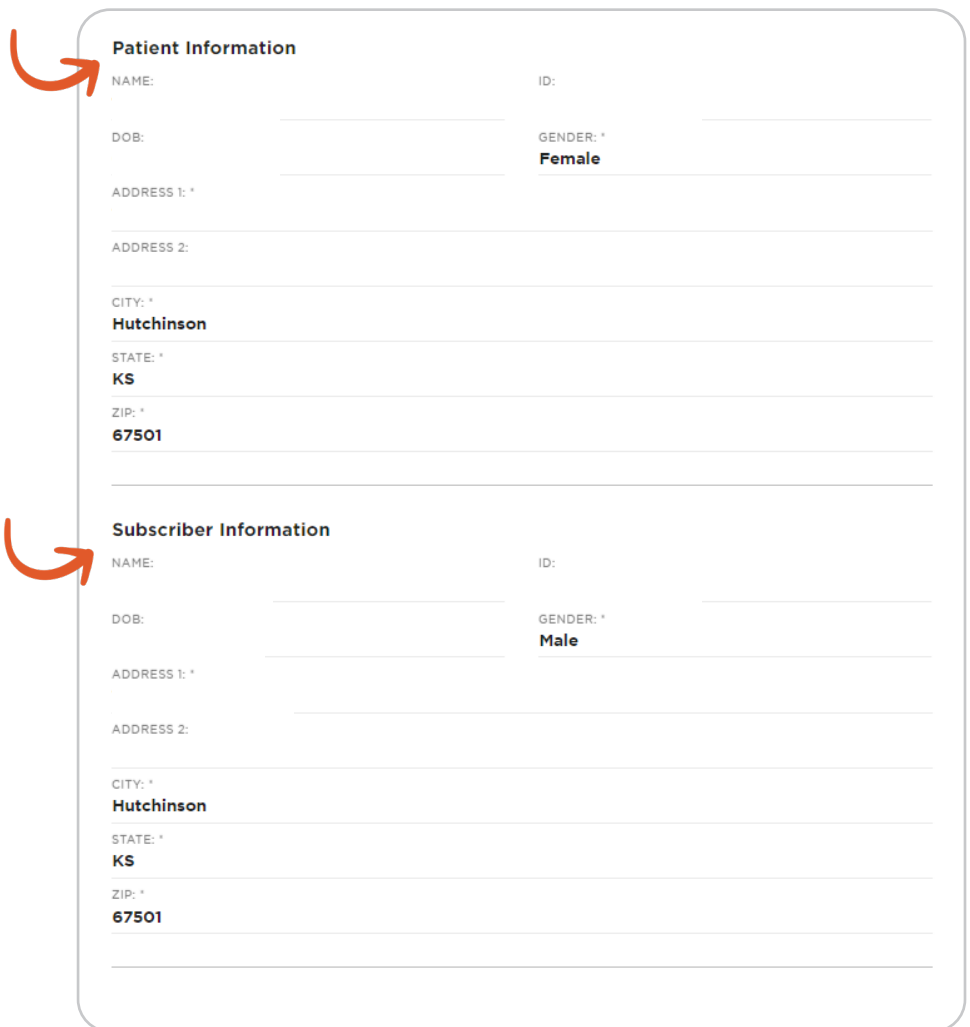
## Online Dentist Account

### How to Submit a Claim

6

The form will auto populate a patient and subscriber information based on the patient you had pulled up when you selected **Submit Claim or Treatment Plan**.

*(If this is not a patient you are needing to submit a claim for, simply return to the **Patient Quick Search** and search for a patient you want to submit a claim for.)*



**Patient Information**

NAME: \_\_\_\_\_ ID: \_\_\_\_\_

DOB: \_\_\_\_\_ GENDER: \*  
**Female**

ADDRESS 1: \* \_\_\_\_\_

ADDRESS 2: \_\_\_\_\_

CITY: \*  
**Hutchinson**

STATE: \*  
**KS**

ZIP: \*  
**67501**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Subscriber Information**

NAME: \_\_\_\_\_ ID: \_\_\_\_\_

DOB: \_\_\_\_\_ GENDER: \*  
**Male**

ADDRESS 1: \* \_\_\_\_\_

ADDRESS 2: \_\_\_\_\_

CITY: \*  
**Hutchinson**

STATE: \*  
**KS**

ZIP: \*  
**67501**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7

Below **Subscriber Information** box is a set of fields where you can list the NEA number, Additional Remarks and ICD 10 codes for the claim. *Please know that Delta Dental of Kansas does **not** require ICD 10 codes.*



**Additional Claim Information**

NEA NUMBER: \_\_\_\_\_

ADDITIONAL REMARKS: \_\_\_\_\_

ICD-10 CODES: \_\_\_\_\_

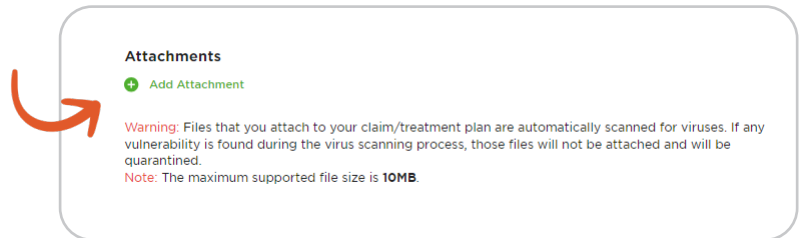
# Submitting a Claim

## Online Dentist Account

### ★ How to Submit a Claim

8

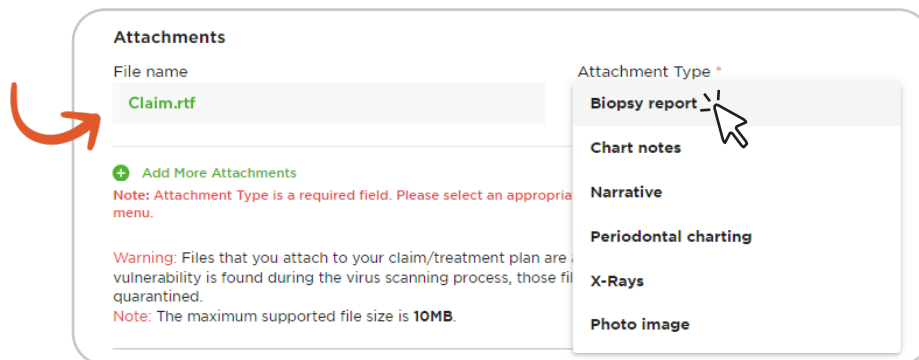
Click **Add Attachment**. A box will open allowing you to select a file to attach from your computer. Once you have selected the necessary files, click the **Open** to attach the file.



9

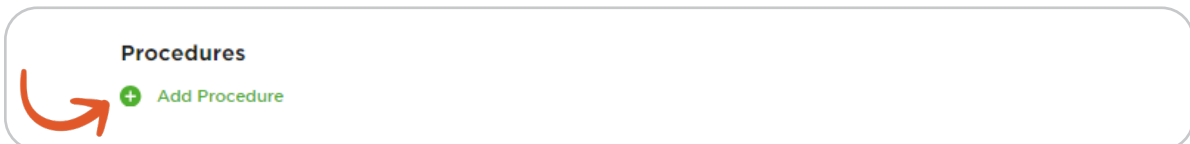
Two boxes will appear for each attachment listing the **File name**. Next, select an **Attachment Type**.

*Please note if you add any attachments, that the program will not allow you to submit the claim until an attachment type is listed for each attachment.*



10

To begin listing your procedure codes click **Add Procedure**.



# Submitting a Claim

## Online Dentist Account

### ★ How to Submit a Claim

- 11 Since this is an in-for-payment claim, the date field will be blank. Add the date the patient received the treatment under **Date of Service**. You will see fields for the Procedure Code, Tooth, Area, Surface and your office Fee. Complete all relevant fields for the CDT codes you are submitting.

**Procedures**

DATE OF SERVICE: \_\_\_\_\_

TOOTH: \_\_\_\_\_

AREA: \_\_\_\_\_

SURFACE: \_\_\_\_\_

PROCEDURE CODE: \*

DESCRIPTION

FEE: \*

\$ \_\_\_\_\_

Entire Oral Cavity

Maxillary Area

Mandibular Area

Other Area of Oral Cavity

Upper Right Quadrant

Upper Left Quadrant

Buccal

Distal

Facial

Incisal

Lingual

Mesial

- 12 If the Claim is for Orthodontic treatment, check the **Is Treatment for Orthodontics** in the Ancillary Treatment Information section.

**Ancillary Treatment Information:**

**Is treatment for orthodontics?**

DATE OF PLACEMENT: \*

ESTIMATED TREATMENT TIME (IN MONTHS): \_\_\_\_\_

\$ INITIAL BANDING FEE: \*

- 13 Review the Legal section and check the boxes noting that you have reviewed these sections.

Click **Submit** to submit the claim for processing. If the Submit button remains gray, review the claim for any fields highlighted with red text that require information for submission.

**Legal:**

I have informed the patient of the treatment plan and associated fees and they agree to be responsible for all charges for dental services and materials not paid by the dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with the plan prohibiting all or a portion of such charges.

I hereby certify that procedures indicated by date are in progress (for procedures that require multiple visits) or have been completed, or procedures with no date are being submitted for predetermination. The fees submitted are the actual fees I have charged and intent to collect for those procedures.

# Submitting a Claim

## Online Dentist Account

### ★ How to Submit a Claim

14

Once you click **Submit**, you will be brought back to that patient's Claims tab.

You will see the claim status in parenthesis next to the claim number. Claim statuses you will see are Denied, In Process, Final, and Paid. Denied claims are claims that all services on the claim were denied. For claims still In Process you can Edit or Void the claim by selecting the Edit or Void button.

Dental Benefits    Limitations    Coverage    **Claims**    Treatment Plans

SHOWING FROM: 02/16/2023    SHOWING TO: 02/16/2024

Claims: **(In Process)** [Edit/Void](#)

Provider:

Date	Code	Procedure	We Pay	Patient Pays
01/23/2024	D0120	PERIODIC ORAL EVALUATION ESTABLISHED PATIENT	\$33.00	\$0.00
01/23/2024	D1110	PROPHYLAXIS - ADULT	\$65.00	\$0.00
01/23/2024	D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	\$61.00	\$0.00
01/23/2024	D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	\$0.00	\$44.00
<b>Total</b>			<b>\$159.00</b>	<b>\$44.00</b>

Items per page: 10    1 - 1 of 1

# Submitting a Claim

## Online Dentist Account

### ★ How to Submit a Claim

15

Claims that are Final have been processed and will be paid in the next payment cycle.

*If your office is set up for EFT payments, the claim should process to pay by the next business day. If your office is set up for check payments, the claim will be processed to pay in the next weekly payment cycle.*

Dental Benefits	Limitations	Coverage	Claims	Treatment Plans
SHOWING FROM: 03/05/2023		SHOWING TO: 03/05/2024		
Claims: (Final) <a href="#">View</a>				
Provider:				
Date	Code	Procedure	We Pay	Patient Pays
01/23/2024	D0120	PERIODIC ORAL EVALUATION ESTABLISHED PATIENT	\$33.00	\$0.00
01/23/2024	D1110	PROPHYLAXIS - ADULT	\$65.00	\$0.00
01/23/2024	D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	\$61.00	\$0.00
01/23/2024	D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	\$0.00	\$44.00
			<b>Total \$159.00</b>	<b>\$44.00</b>
Items per page: 10 1 - 1 of 1				

# Submitting a Claim

## Online Dentist Account

### ★ How to Submit a Claim

15 Paid claims have already been processed to pay. Click **View** to view the EOP for the claim. All applicable reference codes will be listed on the Explanation of Payments (EOP) for the claim.

The screenshot displays the 'CHECK DISBURSEMENT' page for Delta Dental of Kansas. At the top, it shows the 'Benefit Verification Number' as 366 and a 'Submit Claim or Treatment Plan' button. Below this are tabs for 'Dental Benefits', 'Limitations', 'Coverage', 'Claims', and 'Treatment Plans', with 'Claims' currently selected. A 'View' button is circled in orange. The main content area is divided into two sections: a summary table and a detailed table.

Subscriber Name	Subscriber ID	Provider ID/Loc	Patient Name	Interest	Claim No							
<b>Check NO: 02/13/2024</b> <b>Amount: \$336.00</b>												
Code	Tooth or Date of Service	Submitted	Contract Allowance	Plan Allowance	Del.	Over Max	COB	Plan Code %	Plan Pays	Patient Pays	Prev Adjust	Message Code(s)
D110	02/06/2024	\$107.00	\$65.00	\$65.00	\$0.00	\$0.00	\$0.00	100%	\$65.00	\$0.00	\$42.00	
D020	02/06/2024	\$64.00	\$33.00	\$33.00	\$0.00	\$0.00	\$0.00	100%	\$33.00	\$0.00	\$31.00	
D0274	02/06/2024	\$75.00	\$42.00	\$42.00	\$0.00	\$0.00	\$0.00	100%	\$42.00	\$0.00	\$33.00	
<b>TOTAL</b>		<b>\$246.00</b>	<b>\$140.00</b>	<b>\$140.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>		<b>\$140.00</b>	<b>\$0.00</b>	<b>\$106.00</b>	

Subscriber Name	Subscriber ID	Provider ID/Loc	Patient Name	Interest	Claim No	
<b>DATE ESTABLISHED PATIENT</b>						
<b>7 TO 8 RADIOGRAPHIC IMAGES OF FLUORIDE VARNISH</b>						
<b>WE PAY</b> <b>PATIENT PAYS</b>						
<b>\$33.00</b> <b>\$0.00</b>						
<b>\$65.00</b> <b>\$0.00</b>						
<b>\$61.00</b> <b>\$0.00</b>						
<b>\$0.00</b> <b>\$44.00</b>						
<b>Total</b>		<b>\$159.00</b>	<b>\$44.00</b>			

Items per page: 10 | 1 - 1 of 1

### ▶ Submitting a Claim Watch Video

Watch this video to learn how to submit a claim on your new online Dentist Account.