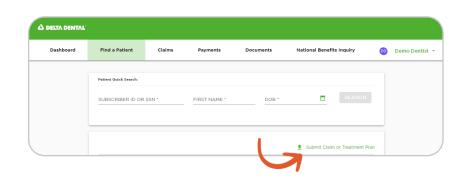


To submit a claim, pull up a patient using either **Patient Quick Search** from the dashboard or through the **Find a Patient** tab.

🛆 DELTA DE	NTAL'							
Dashboa	rd	Find a Patient	Claims	Payments	Documents	National Benefits Inquiry	DD	Demo Dentist 👻
		Welcome to your n	ew Dentist Acco	unt! For tips and res	ources on navigating y	our account, click here.		
		Patient Quick Search:					-	

Click Submit Claim or Treatment Plan.

2



 $\Delta$  delta dental°

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

fit Ve	erification Number <sup>⑦</sup> 336
	Treatment Plan?
7	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.
Ĩ	Payer Information:
	PRIMARY PAYER:
	Delta Dental of Kansas

## 🛃 How to Submit a Claim

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.

Treatment Plan?		
Check here if you are only submitting valid for a period of 180 days followi	g a treatment plan and not a claim. Treatment plan ng submission.	s are
Payer Information:		
PRIMARY PAYER: Delta Dental of Kansas		
Additional Coverage Information: Patient has other Coverage?		
	GROUP NUMBER: *	
Patient has other Coverage?	GROUP NUMBER: * SUBSCRIBER ID: *	
Patient has other Coverage? CARRIER NAME: *		
Patient has other Coverage? CARRIER NAME: * GROUP NAME: *	SUBSCRIBER ID: *	

5

4

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: *	<b>*</b>
BILLING / BUSINESS NPI: *	*

## 🖈 How to Submit a Claim

6	The form will auto populate a patient and subscriber information based on the patient you	4	Patient Information NAME: DOB: ADDRESS 1: *	ID: GENDER: * Female
	had pulled up when you selected <b>Submit</b> <b>Claim or Treatment</b> <b>Plan.</b>		ADDRESS 1: ADDRESS 2: CITY: * Hutchinson	
			STATE: * KS	
	(If this is not a patient you are needing to submit		ZIP: * 67501	
	a claim for, simply return to the <b>Patient</b> <b>Quick Search</b> and	4	Subscriber Information	ID:
	search for a patient you want to submit a		ADDRESS 1: *	GENDER: * Male
	claim for.)		ADDRESS 2:	
			CITY: * Hutchinson	
			STATE: * KS ZIP: *	
			67501	

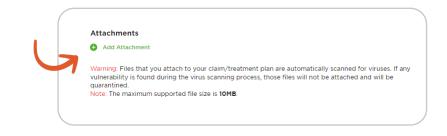
7

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:	

### 🖌 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

10

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.

Attachments	
File name	Attachment Type *
Claim.rtf	Biopsy report
	Chart notes
Add More Attachments	
Note: Attachment Type is a required field. Please select an appropmenu.	<sub>ria</sub> Narrative
	Periodontal charting
Warning: Files that you attach to your claim/treatment plan a	re
vulnerability is found during the virus scanning process, those guarantined.	e fil X-Rays
Note: The maximum supported file size is <b>10MB</b> .	Photo image

To begin listing your procedure codes click Add Procedure.



### 🖈 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.

DATE OF SERVICE:	TOOTH:	*	AREA:	SURFACE:
	-	1	Entire Oral Cavity	Buccal
PROCEDURE CODE: *	DESCRIPTIO	2	Maxillary Area	Distal
		3	Mandibular Area	Facial
FEE: *		4	Other Area of Oral Cavity	🗌 Incisal
\$		5	Upper Right Quadrant	Lingual
		6	Upper Left Quadrant	Mesial
		× Remove	Due e e duue	



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



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 contractural 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.

#### 🛃 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.

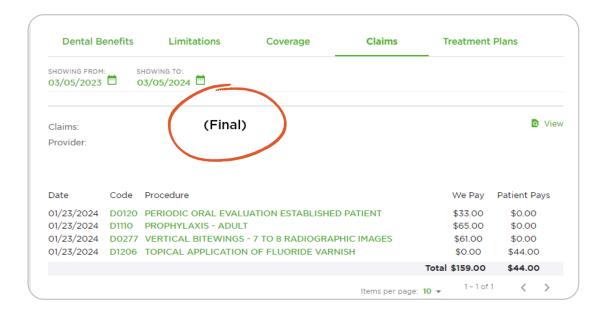
Dental Be	enefits	Limitations	Coverage	Claims	Treatment	t Plans
HOWING FROM: 02/16/2023		HOWING TO: 02/16/2024	_			
Claims: Provider:		(In Pro	ocess)			Edit/Void
Date	Code	Procedure			We Pay	Patient Pays
01/23/2024	D0120	PERIODIC ORAL EVAL	UATION ESTABLISHE	D PATIENT	\$33.00	\$0.00
01/23/2024	D1110	PROPHYLAXIS - ADUL	т		\$65.00	\$0.00
01/23/2024	D0277	VERTICAL BITEWINGS	- 7 TO 8 RADIOGRA	PHIC IMAGES	\$61.00	\$0.00
01/23/2024	D1206	TOPICAL APPLICATION	N OF FLUORIDE VAR	NISH	\$0.00	\$44.00
					Total \$159.00	\$44.00
				Items per page	1-1 of	1 < >

#### 🖌 How to Submit a Claim



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.



## 🖈 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.

				E	Benef	fit Ver	rificat	tion I	Numł	oer 🤊	366					
					De	ental	Bene	efits		Lir	nitati	ions	Coverage	Claims	Treatment F	Plans
				-	HOW	NG FRO	- M.		SHOW	/ING TC						
					HOWI	NOPRO			SHOW	ING TO	·					
ΔD	ELTA DEN	TAL.					C	HEC	CK D	ISBU	RSEM	1ENT				
lta De	ntal of Kans	as													(	Q View
											02/13,					
ubscribe	er Name	Subscriber	ID	Provider II	)/Loc	Chec Patient I	k NO: Name	Interes	st	Amoun	t: \$336. Claim No					
Te	oth or Date of Service vity	Submitted	Contract Allowance	Plan Allowana	n Ded.	Over Hex	c08	Plan Coins 35	Plan Pays	Patient Pays	Prov Adjus					
0110	02/08/2024		\$65.00 \$33.00	\$65.00 \$33.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	100%	\$65.00 \$33.00	\$0.00 \$0.00	\$42.00 \$31.00				We Pay	Patient Pays
0274	02/08/2024 02/08/2024 TOTAL	\$64.00 \$75.00 <b>\$246.00</b>	\$42.00 \$40.00	\$42.00 \$140.00	\$0.00 \$0.00 \$0.00	\$0.00	\$0.00 \$0.00 \$0.00	100%	\$42.00 \$140.00	\$0.00 \$0.00	\$33.00		ATION ESTABLISHED	PATIENT	\$33.00	\$0.00
Te	er Name	Subscriber	Contract	Provider II		Patient I	Name	Interes Plan		1	Claim No				\$65.00	\$0.00
Code C	or Date of Service vity	Submitted	Allowance	Plan Allowand	n Ded.	Over Hex	008	Coine X	Plan Pays	Patient Pays	Prov Adjus	t Massage Code(s)	7 TO 8 RADIOGRAP OF FLUORIDE VARN		\$61.00 \$0.00	\$0.00 \$44.00
	02/09/2024 5 02/09/2024	\$35.00	\$0.00 \$20.00	\$0.00 \$20.00	\$0.00 \$20.00	\$0.00	\$0.00 \$0.00	100% 100%	\$0.00 \$0.00	\$0.00 \$20.00	\$112.00 \$15.00	25	OF FLOORIDE VARIA	lion	Total \$159.00	\$44.00 \$44.00
0230 1 ubscribe	8 02/09/2024 TOTAL	\$30.00 \$177.00 Subscriber	\$17.00 \$37.00	\$17.00 \$37.00 Provider II	\$17.00 \$37.00		\$0.00 \$0.00	100%	\$0.00 \$0.00	\$17.00 \$37.00	\$13.00 \$140.00 Claim No					
Te	oth pate of Service	Submitted	Contract	Provider II.	Ded.	Over Nex	cos	Plan Coine %	Plan Paya	Petient Pays	Prov Adjus			Items per page	e: 10 ▼ 1-1 of 1	< > )
	02/06/2024	\$107.00	\$65.00	\$65.00	\$0.00	\$0.00	\$0.00	100%	\$65.00	\$0.00	\$42.00					
0120	02/06/2024 02/06/2024	\$45.00	\$33.00 \$0.00	\$33.00 \$0.00	\$0.00 \$0.00	\$0.00	\$0.00 \$0.00	100% 100%	\$33.00 \$0.00	\$0.00 \$45.00	\$31.00 \$0.00	15, M-320				
ubscribe	r Name	\$216.00 Subscriber	\$98.00	\$96.00 Provider II	\$0.00	\$0.00 Patient I	\$0.00 Name	Interes	\$98.00 st	\$45.00	\$73.00 Claim No					
Code	or Date of Service vity	Submitted	Contract Allowance	Plan Allowans	e Ded	Over Hex	<b>cce</b>	Coine X	Plan Pays	Petient Pays	Prov Adjus	t Heesege Code(s)	$\boldsymbol{\nu}$			
01110	02/09/2024	\$107.00 \$64.00	\$65.00 \$33.00	\$65.00 \$33.00	\$0.00 \$0.00		\$0.00 \$0.00		\$65.00 \$33.00	\$0.00 \$0.00	\$42.00 \$31.00					
	TOTAL	\$171.00	\$98.00	\$98.00 Total Subm	\$0.00		\$0.00	Tot	\$98.00 al Paid: \$3	\$0.00	\$73.00					
IESSA	GE CODE E	(PLANAT	TION:													
-320	Patient not el Deductible A		vice due to a	age limitation	s specified	J in this plan	n. Please ai	dvise pati	ent of resp	oonsibility fo	or fee.					
	Non-covered	charge(s)														
-38	P-This proces the patient or	dure is a comp nly the amour	ponent of th nt indicated	e completed as Patient Pa	procedure ys.	i and may r	not be bille	d separat	ely. Partic	ipating dent	ists have ag	greed to charge				

Submitting a Claim Watch Video

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