dental bulletin

december 2008

Arkansas Blue Cross and Blue Shield and BlueAdvantage Administrators of Arkansas are continually working with our dental claims administrator to improve the speed and efficiency of our claims processing system. The following information will help ensure your paper and electronic claims are processed in a timely manner.

NPI Updates

The majority of dentists in Arkansas have established their Type 1 National Provider Identifier (NPI), as required by the Centers for Medicare and Medicaid Services (CMS), but there has been some confusion about who needs a Type 2 NPI.

There are two types of NPIs:

Type 1: If you registered with CMS as an individual dentist or a sole proprietor, you used your Social Security number or individual tax identification number (TIN) to receive a Type 1 NPI.

Type 2: If you have an incorporated business (Inc.), a professional corporation (PC) or a limited liability company (LLC), and have an employee identification number, you should register your business for a Type 2 NPI.

Having both types of NPIs distinguishes the dentist providing the services from the practice billing the service. This will ensure that tax responsibilities are properly assigned.

Applying for Your NPI

There are three ways for you to apply for an NPI:

1. The most efficient way to receive an NPI is to log on to the National Plan and Provider Enumeration System (NPPES) Web site at https://nppes.cms.hhs.gov and apply online.
2. You may print a paper application from the NPPES Web site and mail it to the address on the application.
3. You also may call for a copy of the application at 1-800-465-3203 or TTY 1-800-692-2326.

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Filling out the Application

You will need the following information prior to registration:

- Social Security number
- Tax identification number
- Employer ID (if applying for Type 2)
- License number and state of issue (for each registering dentist if Type 2)
- Other provider ID numbers may include an Arkansas Blue Cross billing number, unique provider identification number (UPIN), Medicare and Medicaid.

Reporting Your NPI

If you have not reported your NPI to us please do so by sending a copy of your NPPES validation notice and a Change of Data form (enclosed) to:

Arkansas Blue Cross
and Blue Shield
Provider Network Operations
P.O. Box 2181
Little Rock, AR 72203

Or you can fax the information to 501-378-2465.

The NPI replaces the use of Arkansas Blue Cross provider identifiers, UPIN, and all other payers' unique provider numbers. Having an NPI does not guarantee reimbursement by health plans, enroll providers in health plans, make providers covered entities, require providers to conduct electronic transactions, nor eliminate credentialing / enrollment requirements.

The NPI is not designed to replace your TIN and it does not correspond to the TIN. You can find out more information about the NPI at the NPPES Web site, https://nppes.cms.hhs.gov.

Submitting Member Identification Numbers

For Arkansas Blue Cross members whose ID cards begin with XCD, (examples include XCD970012345, XCDJ12345, or XCDJA1234), the prefix "XCD" should be omitted when submitting the claim.

For BlueAdvantage members whose ID cards end in 00, 01, 02, etc., (examples include M1244123400 or M1244123401), the last two digits of the ID number should be omitted when submitting the claim.

This interim solution should avoid delays in processing claims. We are working on a solution that will allow you to submit claims with the IDs exactly as they appear on the card.

Claims Submission Address

Please be sure all claims are filed on the most current version of the ADA claim form (2006). **Claims should be submitted through your electronic vendor or directly to:**

Dental Claims Administrator
P.O. Box 1206
Elk Grove Village, IL
60009-1206

Federal Employee Plan Claims

Please continue to send all FEP claims to:

FEP Dental Claims
P.O. Box 2181
Little Rock, AR 72203

The Customer Service number for FEP is 1-800-482-6655.

Remember all FEP claims must be typed on a 2006 ADA Claim Form.

Submitting a Claim

Arkansas Blue Cross now requires an NPI on all dental claims submitted, including electronic (837D) and paper claims. The 2006 American Dental Association (ADA) claim form includes a space to accurately report your NPI on the dental claim. This claim form is the preferred format for all paper claims.

Section 49 identifies the billing dentist or entity. **Section 54** identifies the servicing dentist. If you are an individual or sole proprietor, the NPI in both sections will be the same. If you have a PC, LLC or Inc., use section 49 for your Type 2 NPI and section 54 for the servicing dentist's Type 1 NPI.

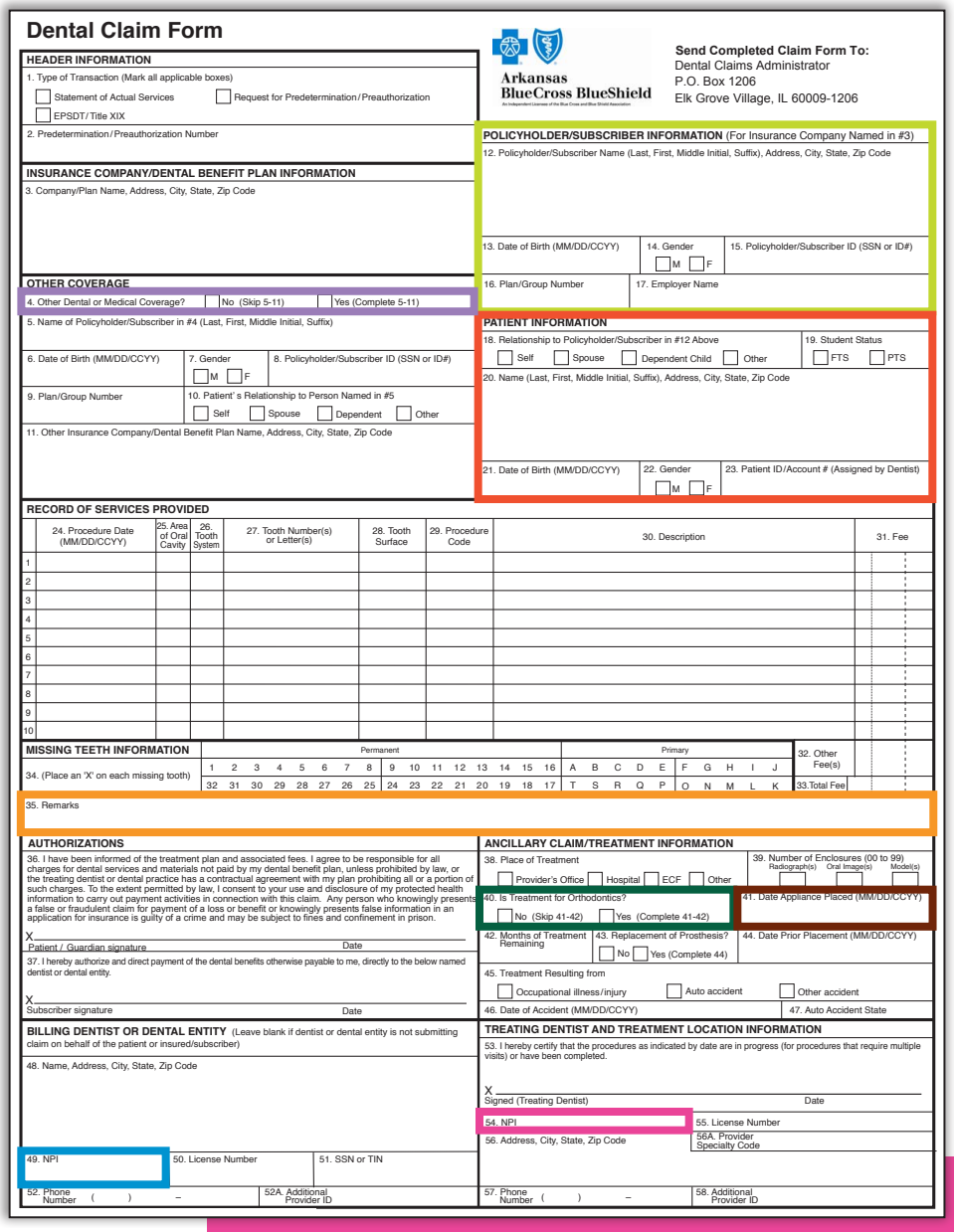
Please ensure the following information is complete for Arkansas Blue Cross and BlueAdvantage members:

- Member information (**sections 12-17**)
- Patient information (**sections 18-23**) for the member or covered dependent.

When applicable, you should include Other Coverage information (**section 4**). Please exhaust all efforts to determine the primary carrier for the patient's claim. The claim should not be submitted to the secondary carrier until the Explanation of Benefits (EOB) is received from the primary carrier. Once received, the EOB should be included as an attachment to the claim submitted to the secondary carrier. Claims may be denied if they are submitted without the primary carrier's EOB or if we must determine the order of benefits.

Orthodontic Claims

When filing orthodontic claims, in addition to the applicable coding and charges, please fill in Remarks (**section 35**) by indicating the total charge for treatment, the number of months the treatment will encompass, as well as any payment made by the member. In **section 40**, indicate "Yes" if the treatment is for orthodontics. In **section 41**, indicate the date the member received the appliance. After this information is received, an initial payment will be made — followed by monthly installments — until the orthodontic benefit is exhausted.



Dental Claim Form

Arkansas BlueCross BlueShield

Send Completed Claim Form To:
Dental Claims Administrator
P.O. Box 1206
Elk Grove Village, IL 60009-1206

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination / Preauthorization
☐ EPSDT / Title XIX
2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

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

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION
34. (Place an 'X' on each missing tooth)
Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
Primary: A B C D E F G H I J / T S R Q P O N M L K
32. Other Fee(s)
33. Total Fee
35. Remarks

AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
X _____ Patient / Guardian signature _____ Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X _____ Subscriber signature _____ Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)
48. Name, Address, City, State, Zip Code
49. NPI | 50. License Number | 51. SSN or TIN
52. Phone Number ( ) – | 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X _____ Signed (Treating Dentist) _____ Date
54. NPI | 55. License Number
56. Address, City, State, Zip Code | 56A. Provider Specialty Code
57. Phone Number ( ) – | 58. Additional Provider ID

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P.O.Box 2181
Little Rock, AR 72203-2181

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arkansasbluecross.com

good for you.

Dental Provider Relations

Customer Service 1-877-203-9921

Linda Duelmer
Phone: 1-501-378-2195

Debbie Jines
Phone: 1-501-378-3296

Fax: 1-501-378-2465
Toll Free: 1-800-843-1329

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