LOUISIANA BLUE

DENTAL NETWORK OFFICE MANUAL



2027

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Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

Blue Cross and Blue Shield of Louisiana
Dental Network Office Manual

This Dental Network Office Manual is designed to be a reference guide for Blue Cross and Blue Shield of Louisiana (Louisiana Blue) network dentists and office staff. It includes information you need 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 section.

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.lablue.com/providers >Resources).

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

LOUISIANA BLUE

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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 of 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	Please mail appeals and disputes to: **United Concordia** Dental Claims Administrator P.O. Box 69441 Harrisburg, PA 17106-9441
Blue365	To become a provider in the Blue365 Dental Solutions program, contact DenteMax: **email:** customerservice@dentemax.com **phone:** (248) 327-5405
Claims	Mail claims and written inquiries to: **Advantage Plus or Advantage Plus 2.0 Dental Network Claims** United Concordia Dental Claims Administrator P.O. Box 69441 Harrisburg, PA 17106-9441 **FEP Preferred Dental Claims** Louisiana Blue – FEP Preferred Dental Claims P.O. Box 98028 Baton Rouge, LA 70898-9028 **Louisiana Blue Oral Surgery Claims** Blue Cross and Blue Shield of Louisiana P.O. Box 98029 Baton Rouge, LA 70898-9029 **Out-of-State Claims** Refer to the member ID card.
Customer Care Center	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: • iLinkBlue (www.lablue.com/ilinkblue) • Interactive Voice Recognition (IVR) - 1-800-922-8866 • HIPAA 27x Transactions - 1-800-716-2299, option 3 Network providers may call the Customer Care Center for all other inquiries. Please have your National Provider Identifier (NPI), the member ID number, patient date of birth and the date of service when calling. **phone:** 1-800-922-8866

EDI Services	Claims may be submitted electronically to Louisiana Blue directly from your office or through a Louisiana Blue-approved clearinghouse. For more information about filing claims electronically and/or approved clearinghouse locations, please contact our Electronic Data Interchange (EDI) Services: **email:** EDIservices@lablue.com **phone:** 1-800-716-2299, option 3
Electronic Funds Transfer (EFT)	All providers must be part of our EFT program. With EFT, Louisiana Blue deposits your payment directly into your checking or savings account. For more information, visit the EFT section of the Provider page at www.lablue.com/providers >Electronic Services >Electronic Funds or contact us: **email:** PCDMstatus@lablue.com **phone:** 1-800-716-2299, option 2
Eligibility	To obtain verification of coverage, benefit information or to inquire about a claim, please call: United Concordia for Advantage Plus and Advantage Plus 2.0 questions 1-866-445-5338 FEP Customer Service Unit for FEP questions 1-800-272-3029
iLinkBlue	iLinkBlue (www.lablue.com/ilinkblue) is a free online provider tool that includes services such as: • Eligibility verification • Benefits (copayments, deductible and coinsurance) • Claims status (paid, rejected and pended) • Allowable charges • Action requests • Payment registers • Medical policies • Authorization requests For questions regarding iLinkBlue issues please contact our EDI Services: **email:** EDIservices@lablue.com **phone:** 1-800-716-2299, option 3 For iLinkBlue training please contact Provider Relations: **email:** provider.relations@lablue.com

Provider Credentialing & Data Management	Credentialing packets and criteria are available on our Provider page at www.lablue.com/providers >Network Enrollment >Join Our Network >Professional Providers >Join Our Networks. The Provider Credentialing & Data Management (PCDM) team handles demographic changes. To change your address, phone number, Tax Identification Number, etc., please visit www.lablue.com/providers, choose "Resources," then "Forms." Select a link based on the type of change you are making to access the applicable update form. For more information on our credentialing and data management process, including frequently asked questions, visit www.lablue.com/providers, choose "Network Enrollment," then "Join Our Networks" and select "Professional Providers" or "Facilities and Hospitals." For PCDM status inquiries: **email:** PCDMstatus@lablue.com **phone:** 1-800-716-2299, option 2, option 1 For recredentialing inquiries: **email:** recredentialing@lablue.com **phone:** 1-800-716-2299, option 2, option 2
Provider Contracting	Provider Contracting supports inquiries related to your provider agreement(s). **email:** provider.contracting@lablue.com **phone:** 1-800-716-2299, option 1
Provider Identity Management Team (PIM)	PIM is a dedicated team that helps establish and manage system access to our secure electronic services, including the setup process for administrative representatives. **email:** PIMteam@lablue.com **phone:** 1-800-716-2299, option 5

Provider Page	Our Provider page is designed to serve provider needs. Use this page to help locate important information such as: • Authorizations • Credentialing • Resources • Newsletters • Office of Group Benefits (OGB) • Pharmacy Management • Provider Tools • Quality Blue **website:** www.lablue.com/providers
Provider Relations	Provider Relations representatives assist network providers and office staff with information about Louisiana Blue and its programs and procedures. Provider Relations representatives do not handle routine claim inquiries and benefit questions. **email:** provider.relations@lablue.com

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Section 1: Dental Network Overview

INTRODUCTION

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

Freedom to Choose

Louisiana Blue 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 Louisiana Blue.

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

Louisiana Blue 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 Louisiana Blue.

NETWORK PROVIDER RESPONSIBILITIES

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

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

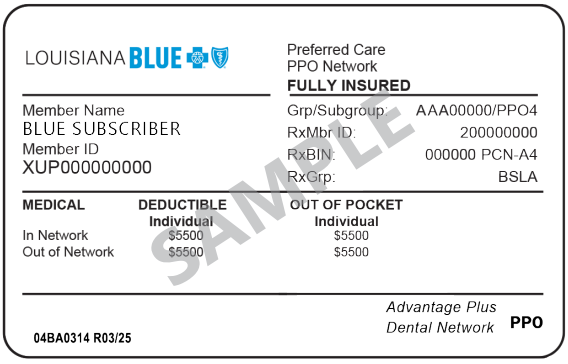
Please be aware that member benefit plans have different maximums, deductibles and percentage of benefits payable. If you have questions about benefits or eligibility, use iLinkBlue or call the dental number on the member ID card.

OUR DENTAL NETWORKS

Members with dental benefits have the applicable dental network indicated on their Louisiana Blue 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.

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

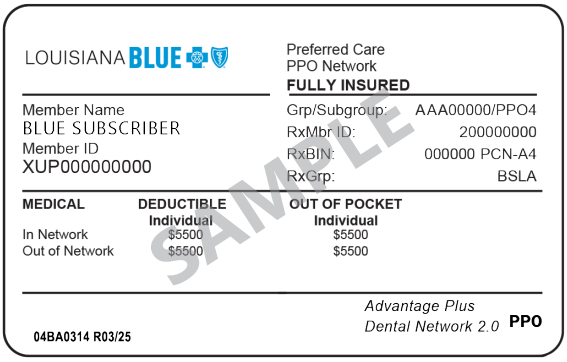
There is a Louisiana Blue-dedicated customer service unit for benefits, authorizations and claims administered by UCD on behalf of Louisiana Blue Advantage Plus. Dental claims should be filed directly with UCD.

Essential Health Benefits for members under age 19:
Louisiana Blue 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.

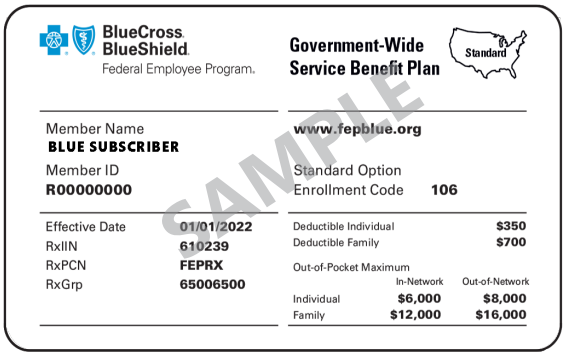
FEP Preferred Dental Network

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 begins 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 Louisiana Blue 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

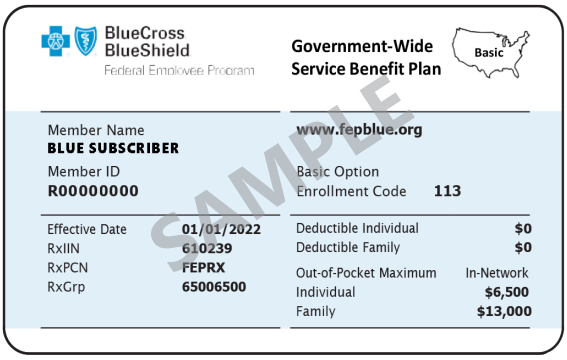
- Greater benefits.
- Louisiana Blue reimburses FEP Preferred Dentists up to the FEP fee schedule amount.
- Member pays the difference between the Fee Schedule Amount and the maximum allowable charge (MAC)*.

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

FEP Basic Option

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

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



Note: There are certain Louisiana Blue 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.

Louisiana Blue Dental Network

Louisiana Blue and HMO Louisiana no longer offer members dental benefits that directly access the Louisiana Blue Dental Network. However, we have maintained our Louisiana Blue 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 Louisiana Blue. Benefits, authorizations and claims are handled directly by Louisiana Blue.

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 Louisiana Blue 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 and Advantage Plus 2.0, you may find the information at www.lablue.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 visit www.lablue.com/providers, choose "Resources," then "Forms." Select a link based on the type of change you are making to access the applicable update form.

Section 2: Dental Billing Guidelines

The following billing guidelines are to assist you with filing dental claims. Please follow these guidelines regardless of whether the claim pays under the member's 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 Occupational Safety and Health Administration (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.
- Coverage is not available for care provided to members outside of an established provider-patient relationship as defined by the Plan. The stipulation of a required provider-patient relationship does not apply to healthcare services provided in Urgent Care Centers, Emergency Room Departments, imaging services, pathology/laboratory services and/or services provided while the member(patient) is in a facility.

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. 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.

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 – first 15 minutes
D9243	intravenous moderate (conscious) sedation/ analgesia – each subsequent 15 minute increment

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, Louisiana Blue may recode the procedures and apply the appropriate allowable charge.

ORTHODONTIA WORK IN PROGRESS

Louisiana Blue 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

Louisiana Blue 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 Louisiana Blue. Louisiana Blue 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

Louisiana Blue uses CDT, a systematic listing and coding of procedures and services performed by dentists, for processing claims. Each procedure or service is identified by 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.** Louisiana Blue 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)

All covered entities must use their NPI when filing claims. All providers who apply for Louisiana Blue 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 Louisiana Blue of your NPI(s) prior to filing claims using your NPI(s).**

Notifying Louisiana Blue of your NPI

If your NPI changes, please notify Louisiana Blue as soon as possible. To do so, you may use the National Provider Identifier (NPI) Change Form located in the "Resources" section on the Provider page.

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 Louisiana Blue 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 Louisiana Blue. For more information, including **whom should apply** for an NPI and **how to obtain** your NPI, visit the CMS site at www.cms.gov/medicare/regulations-guidance/administrative-simplification. If you have any questions about the NPI relating to your Louisiana Blue participation, please contact Provider Credentialing & Data Management.

ELECTRONIC CLAIMS

Dental Claims may be submitted electronically to Louisiana Blue directly from your office or through Louisiana Blue 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 (hard copy) should submit the claim to the Blue Plan named on the member ID card. **Louisiana Blue 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 Louisiana Blue 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 Louisiana Blue. 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 Louisiana Blue 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.
- BlueCard recommends 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 Louisiana Blue 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 Louisiana Blue, 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 Louisiana Blue.
- Providers should call Louisiana Blue 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

Louisiana Blue 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 High Deductible Health Plan (HDHP) plan, like Blue*Saver. Allowable charges are provided to Louisiana Blue dentists to help avoid refund situations.

Examples of what to collect from members:

1) Member's Total Deductible $2000
   Member's Deductible Paid $2000
   Allowable Charge $100
   Amount to be collected from member $0
   Plan Payment $100

   } Member Has Met Deductible

2) Member's Total Deductible $2000
   Member's Deductible Paid $1000
   Allowable Charge $100
   Amount to be collected from member $100

   } Member Has NOT Met Deductible

3) Member's Total Deductible $2000
   Member's Deductible Paid $2000
   Allowable Charge $100
   Member's Coinsurance (20%) $20
   Amount to be collected from member $20
   Plan Pays $80

   } Member with Coinsurance

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, Louisiana Blue 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, Louisiana Blue 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 (Louisiana Blue payment)	- $ 9
	FEP Member Liability (amount you should collect from your patient)	= **$29**

*The total combined amount a FEP Preferred Dentist can collect from Louisiana Blue 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 Louisiana Blue 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 Louisiana Blue 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 and follow 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 Louisiana Blue 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 *provider writes off $20 above allowable amount*	$100
Member Cost Share	$20 *coinsurance*
Dental Claim Payment Amount	**$80**

Medical Plan

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

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 *provider writes off $20 above allowable amount*	$100
Member Cost Share	$20 *coinsurance*
Dental Claim Payment Amount	**$80**

Medical Plan

Total Charge	$120
Contracted Dental Allowable *provider writes off $20 above allowable amount*	$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, Louisiana Blue 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 Louisiana Blue regarding covered services. An appeal is a written request from the member to change a prior decision that Louisiana Blue 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.

Louisiana Blue 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 the Employee Retirement Income Security Act of 1974 (ERISA), and non-federal government insurance plans. Louisiana Blue 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 Louisiana Blue at 1-800-376-7741 or (225) 293-0625. Members and providers are encouraged to provide Louisiana Blue 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 Louisiana Blue Customer Care. Providers will be notified of appeal results only if the provider filed the appeal.

PEER TO PEER

Louisiana Blue has a process that allows providers to discuss utilization management decisions with our medical directors. A peer to peer is the provider's telephone request to speak to a medical director or peer reviewer on a member's behalf about a utilization management decision that Louisiana Blue has made. A peer to peer may also include submission of additional information prior to or after the peer-to-peer discussion. A peer to peer is available once and only for initial or concurrent review determinations that are requested within 10 days of the denial.

APPEALS PROCESS FOR NON-ERISA MEMBERS (MNRO)

Louisiana Blue 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 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 Louisiana Blue after 180 days of the denial will not be considered.
- We will investigate the member's concerns. Healthcare professionals, including a physician or other healthcare 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 days of the member's preservice appeal request or within 60 days of the member's post-service appeal request. 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 Louisiana Blue 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 healthcare 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 Louisiana Blue. 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 healthcare 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, Louisiana Blue 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 healthcare 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 healthcare 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 **healthcare 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 Louisiana Blue 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 Louisiana Blue 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 healthcare 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 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 the 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, Louisiana Blue 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 preservice 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 Louisiana Blue 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 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 Louisiana Blue 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 Louisiana Blue within 60 days of the member's receipt of a level one denial. Requests submitted to Louisiana Blue 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 Louisiana Blue, unless the parties agree to a longer period. The IRO will notify the member or their authorized representative and the member's healthcare 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 of 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 Louisiana Blue Dental Network work?

The Louisiana Blue Dental Network only exists to process medical policy benefits when medical services are rendered to a member by a dental professional. The Louisiana Blue 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 Louisiana Blue member for covered medical services are processed and paid through the Louisiana Blue 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 Louisiana Blue 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 Louisiana Blue 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?

Louisiana Blue 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 Louisiana Blue 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 Louisiana Blue 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 Louisiana Blue does not restrict your right to determine how much you should charge or how often to increase your fees. However, you agree to charge Louisiana Blue 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 Louisiana Blue and FEP Preferred Dental networks are not Medicare or Medicaid programs. Each pertains to your Louisiana Blue patients only, which includes members whose contracts are underwritten and/or administered by Louisiana Blue.

What claim form do you accept?

Louisiana Blue accepts the ADA Dental Claim Form approved by the American Dental Association, or a CMS-1500 claim form for Louisiana Blue 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 Louisiana Blue members know I'm an Advantage Plus, Advantage Plus 2.0 or FEP Preferred network dentist?

Louisiana Blue 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.lablue.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 Louisiana Blue on a CMS-1500 claim form.

Where do I send dental claims for FEP members?

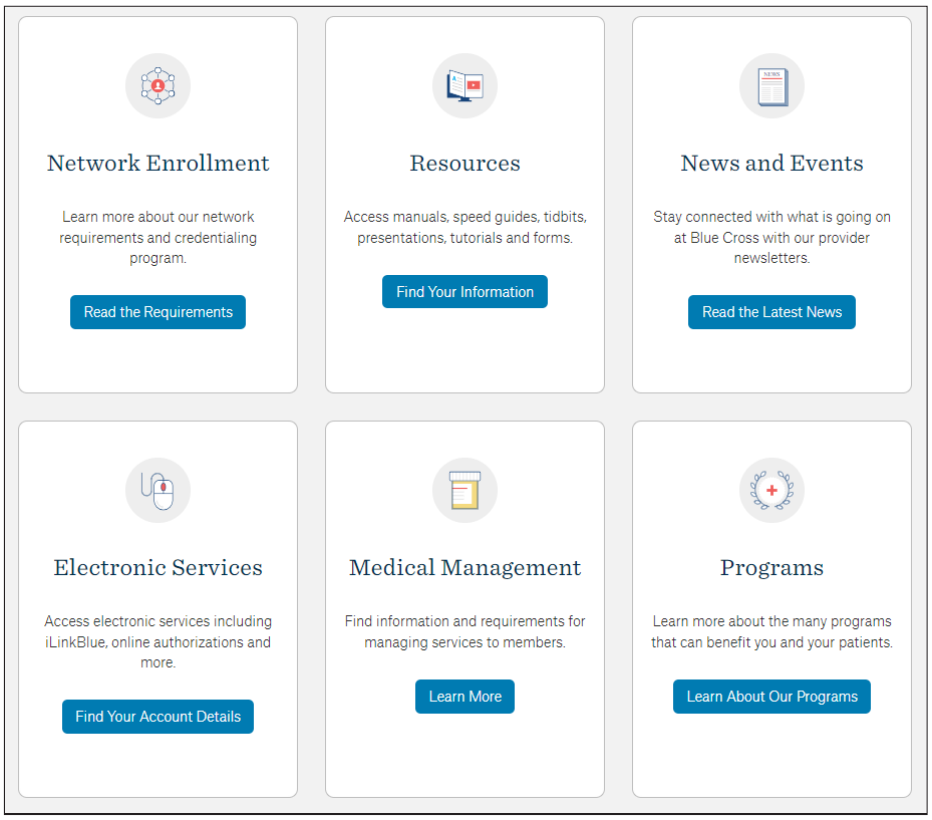
Dental claims for FEP members, whether dental or medical, should be filed directly to Louisiana Blue.

Appendix I - Online Resources

Louisiana Blue 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

Louisiana Blue's provider website serves our providers' needs



www.lablue.com/providers

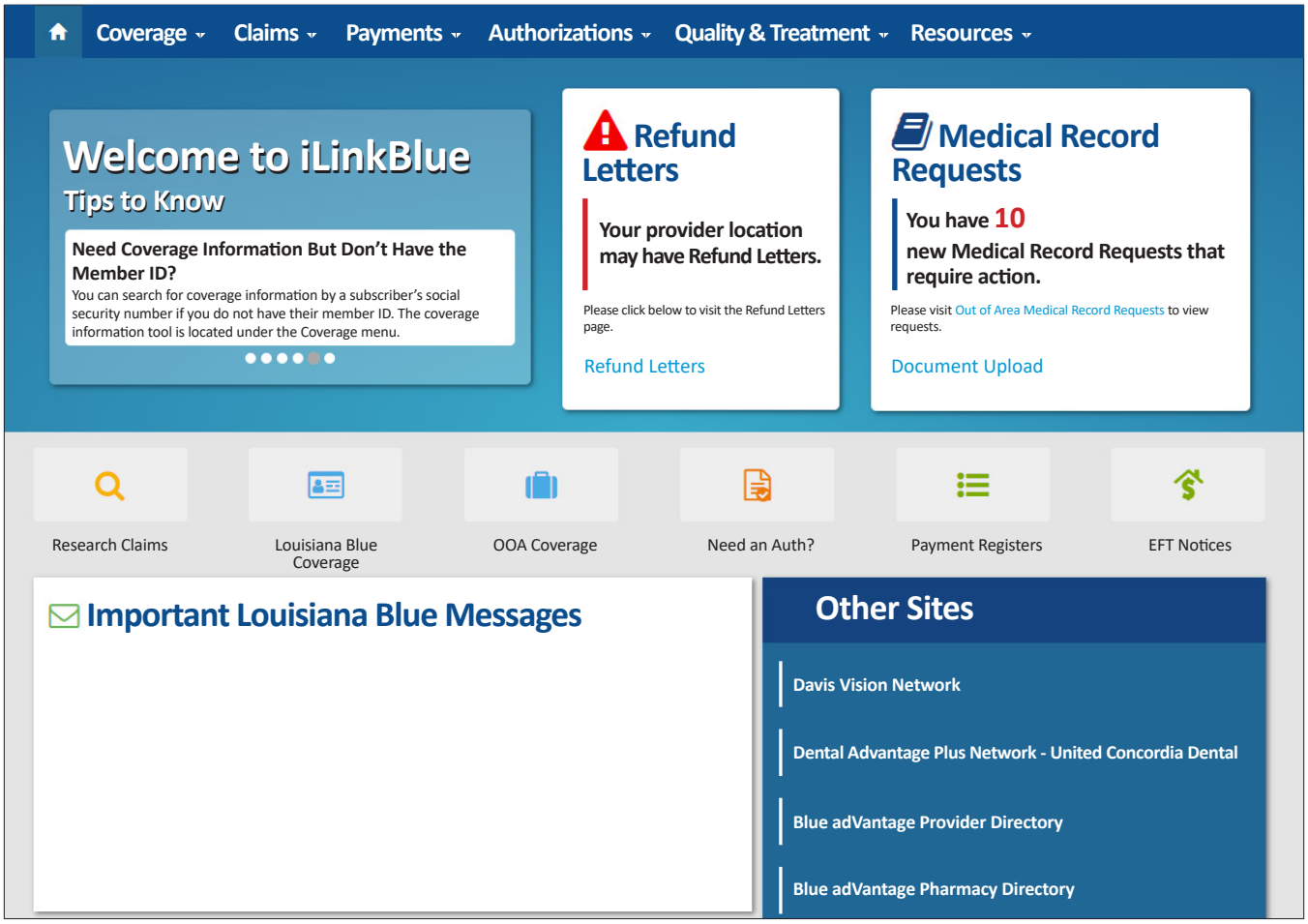
Find information on:

- Network Enrollment
  - Credentialing
  - Provider Support
- Resources
  - Manuals
  - Speed Guides
  - Tidbits
  - Workshops & Webinars
  - Forms for Providers
- News and Events
  - Network News
  - Product Enhancements
  - Blue Advantage Insight
  - Past Newsletters
- Electronic Services
  - Learn about iLinkBlue
  - Clearinghouse Services
  - Administrative Representatives
  - Electronic Funds
- Medical Management
  - Authorizations
  - Medical Policies
  - Lab Management
  - Care Management
  - Pharmacy
- Programs
  - Blue Distinction
  - Quality Blue
  - Specialty Care Insight

iLinkBlue

Louisiana Blue's iLinkBlue is our secure online tool for facility and professional healthcare 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.



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.lablue.com/ilinkblue

Sample Weekly Provider Payment Register

(Page 1 of 1)

Date: 04/24/2023

BLUE CROSS BLUE SHIELD OF LOUISIANA

Family Dentistry Clinic

WEEKLY PROVIDER PAYMENT REGISTER

Page: 1 of 1

1 Patient Name	2 Contract Number	3 Patient Acct	4 Performing Provider	5 Days/ Units	6 Admt/ Dis Dt	7 Claim Number	8 CPT4 Rev	9 Drg	10 Total Charges	11 Above Allow Amt	12 COB OC Pay	13 OC Code	14 Not Covered Ded-Coin-Inel	15 Amount Paid
ERD, LIZ	DZV1234567890	123456789011	123456789	1	3/27/2023 3/27/2023	123456789011	9921325		$80.00	$6.30	$0.00		$35.00	$38.70
			Sais, Simon							$6.30 PXN-CO			$35.00 CPY-PR	
					** CPT4 9921325									
ERD, LIZ	DZV1234567890	123456789011	123456789	1	3/27/2023 3/27/2023	123456789011	D7210		$388.00	$0.00	$0.00		$388.00	$0.00
			Sais, Simon										$388.00 345-PR	
					** CPT4 D7210									
ERD, LIZ	DZV1234567890	123456789011	123456789	1	3/27/2023 3/27/2023	123456789011	D9222		$268.00	$18.00	$0.00		$0.00	$250.00
			Sais, Simon							$18.00 PXN-CO				
					** CPT4 D9222									
ERD,, LIZ	DZV1234567890	123456789011	123456789	1	3/27/2023 3/27/2023	123456789011	D9223		$268.00	$218.00	$0.00		$0.00	$50.00
			Sais, Simon							$218.00 PXN-CO				
					** CPT4 D9223									
ERD, LIZ	DZV1234567890	123456789011	123456789	5	3/27/2023 3/27/2023	123456789011	D7240		$2,495.00	$808.30	$0.00		$0.00	$1,686.70
			Sais, Simon							$808.30 PXN-CO				
					** CPT4 D7240									
ERD,, LIZ	DZV1234567890	123456789011	123456789	1	3/27/2023 3/27/2023	123456789011	D9610		$144.00	$103.85	$0.00		$0.00	$40.15
			Sais, Simon							$103.85 PXN-CO				
					** CPT4 D9610									
16 Totals:				10					$3,643.00	$1,154.45	$0.00		$423.00	$2,065.55

PR - This is the amount determined by Blue Cross to be the responsibility of the Patient.
CO - This Amount is determined by Blue Cross to be the responsibility of the Provider.
345 - This service is not covered under the member's contract.
PXN - The charge exceeds the allowed amount for this service.
CPY - Copay

Note: All charges and codes are examples only.

Federal regulation 42 CFR part 2 prohibits unauthorized disclosure of these records. You are prohibited from making any further disclosure of information in this record that identifies a member as having had, currently having, or having been referred for treatment of a substance use disorder unless you obtain express written consent of the member.

Family Dentistry Clinic
PO Box 1234567
Anytown, LA 70000-0000

Blue Cross Blue Shield of Louisiana
Post Office Box 98029
Baton Rouge, Louisiana 70898-9029
1-800-495-2583
(225) 295-2145

17 ILB ID: 12345
17 PAID PROV: 123456789
18 DATE: 04/24/2023
19 EFT NO: 123456789

Provider Payment Register Explanation

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

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

Louisiana

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

18NW1061 R1/17

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.



HEALTH INSURANCE CLAIM FORM

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



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

CARRIER

PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES 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? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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 QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

SAMPLE

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 this field 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
b. Signature on file
c. On file
d. Benefits assigned
e. Assigned
f. Pay provider

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. Louisiana Blue 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 Louisiana Blue/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 Louisiana Blue 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 #

NPI - 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, Diagnostic Radiology Center, Laboratory and Diagnostic Services and Retail Health Clinic providers do not have to enter a physician NPI in this block. Please enter the facility NPI in blocks 32A and 33A as instructed. Beginning Jan. 1, 2026, Emergency Room Physicians and Urgent Care Center providers are required to file the rendering provider NPI and taxonomy code.

Taxonomy – Enter the 10-digit taxonomy code if required by the payer for adjudication.

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. Enter the 10-digit taxonomy code that corresponds with the provider's type. The taxonomy code is used to determine the specialty of the provider and is required when we are unable to locate a single match for the NPI entered.

Block 33 Billing Provider Info & Ph # - Enter complete name, address, telephone number for the billing provider.

Block 33A NPI - Enter the NPI for the billing provider listed in Block 33.

Block 33B Other ID # - The non-NPI number of the billing provider refers to the payer-assigned unique identifier of the professional.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

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 (alll dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) | 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of 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

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

©2024 American Dental Association
J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

To reorder call 800.947.4746 or go online at ADAstore.org

Sample

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 Louisiana Blue.

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 healthcare. 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 #.

Louisiana

United Concordia
Dental Claims Administrator
PO Box 69441
Harrisburg, PA 17106-9441

ATTENDING DENTIST'S STATEMENT

CHECK ONE:
❑ **DENTIST'S PRE-TREATMENT ESTIMATE**
❑ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

CARRIER-NAME AND ADDRESS:

PATIENT SECTION

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE SELF | SPOUSE | CHILD | OTHER | 3 SEX M | F | 4. PATIENT BIRTHDATE MO | DAY | YEAR | 5. IF FULL TIME STUDENT SCHOOL | CITY

6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST | 7. EMPLOYEE SSN/ SUBSCRIBER BLUE CROSS AND BLUE SHIELD OF LOUISIANA CONTRACT NUMBER

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS | 9. NAME OF GROUP DENTAL PROGRAM

CITY, STATE, ZIP | 10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NUMBER | 12. LOCATION (LOCAL) | 13. ARE OTHER FAMILY MEMBERS EMPLOYED? ❑ YES ❑ NO EMPLOYEE NAME SSN | 14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO | DENTAL PLAN NAME | UNION LOCAL | GROUP NUMBER | NAME AND ADDRESS OF CARRIER

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

DENTIST SECTION

16. DENTIST NAME | 24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES

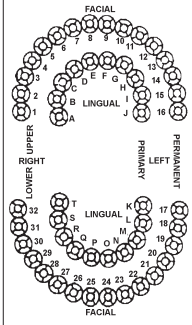
17. MAILING ADDRESS | 25. IS TREATMENT RESULT OF AUTO ACCIDENT? 26. OTHER ACCIDENT? NO | YES

CITY, STATE, ZIP | 27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? NO | YES

18. DENTIST SSN OR T.I.N. | 19. DENTIST PROVIDER NO. | 20. DENTIST PHONE NO. | 28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO | YES | (IF NO. REASON FOR REPLACEMENT) | 29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT OFFICE | HOSP | ECF | OTHER | 23. RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY? | 30. IS TREATMENT FOR ORTHODONTICS? NO | YES | IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED | MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN -- LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY THE DATE HAVE BEEN COMPLETED.

X _____ _____
DENTIST SIGNATURE DATE

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

Form Approved by the Council on Dental Programs of the A.D.A.

01MK5389 R01/18

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and is incorporated as Louisiana Health Service & Indemnity Company.

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 healthcare 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 Louisiana Blue 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.

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 healthcare benefit programs and paying benefits in accordance with established guidelines when members are eligible for benefits under more than one healthcare 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 Louisiana Blue 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 Louisiana Blue 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 Blue Shield Plans as accepted practice for treatment of the condition. Note: Louisiana Blue 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 healthcare benefits plan designed for personnel employed by the federal government.

FEP Preferred Dental Network
A network of dentists who have signed contracts with Louisiana Blue 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 healthcare providers and for such providers to use in reporting to Louisiana Blue those services rendered to the member.

Identification Number
The number assigned to the member and all of his/her Louisiana Blue 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 healthcare providers, designed to help you quickly complete important functions such as claims entry, authorizations and billing information.

Louisiana Blue
Refers to Blue Cross and Blue Shield of Louisiana.

Louisiana Blue 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 Louisiana Blue pertaining to payment for covered services rendered to members.

Medical Necessity
Those healthcare 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 healthcare 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 Blue Cross Blue Shield Plan or the national account in which the member is enrolled.

Provider-Patient Relationship

A valid provider-patient relationship is established between a member and a provider, including, without limitation, a physician, an allied health provider or other provider type, as defined by Plan, when the member and the provider engage in a healthcare encounter that includes a fully documented clinical assessment (in-person or telemedicine) of the member (patient). For physicians, physician assistants and nurse practitioners, this initial documentation must include, at a minimum, pertinent history, pertinent examination and medical decision making (MDM). MDM may include making a specific diagnosis(es), providing a clinical recommendation(s) and/or medical plan of care, and providing other specific services such as order(s) for ancillary services (e.g., imaging and labs), diagnostic or therapeutic tests, issuance of a prescription(s), and/or the delivery of healthcare item(s) (i.e., any substance, product, device, equipment, supplies or other tangible good or article) when medically necessary and meets the standard of care. For all others, the documentation must conform to the accepted standards of that provider type.

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 Louisiana Blue subscriber contract/certificate who are entitled to receive dental care and treatment and healthcare benefits as defined in and pursuant to a subscriber contract/certificate.

Subscriber Contract/Certificate

Any Louisiana Blue contract/certificate or health benefit plan issued or administered by Louisiana Blue, its subsidiaries and affiliates, or another Blue Cross and Blue Shield Plan with which Louisiana Blue has a participating or reciprocal agreement, entitling members to receive dental care and treatment and healthcare 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 2027 - *Indicated changes current as of Jan.1, 2027*

Quick Reference Guide

- Customer Care Center – Updated phone number listed for HIPAA 27X transactions.
- Provider Credentialing & Data Management – Updated directions for accessing the professional or facility credentialing sections of the provider website and added contact options for PCDM status and recredentialing inquiries.
- Table of Contents – Changed name of Informal Reconsideration section to Peer Review

Dental Network Overview

- How to Find Participating Dentists – Added Advantage Plus 2.0 to the provider directory reference for finding dental network participation information.

Filing Claims

- National Provider Identifier (NPI) – Updated section to remove historical information about NPI legislation and updated how to notify Louisiana Blue of an NPI change.

Reimbursement

- Allowable Charges – Updated allowable charges plan reference to use High Deductible Health Plan (HDHP).

Appeals

- Peer to Peer – Removed Informal Reconsideration subsection and replaced with subsection describing the Louisiana Blue peer-to-peer process.
- Appeals Process for Non-ERISA Members (MNRO) – Updated description of Investigational Appeals process and updated First Level of Internal Appeal timeframes for notifying the member and provider of an upheld denial to within 30 days of the member's preservice appeal request or within 60 days of the member's post-service appeal request.
- Appeals Process for ERISA Members – Updated description of Investigational Appeals process

Appendix I - Online Resources

- iLinkBlue – updated sample image of iLinkBlue homescreen.

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