Dental Providers
Administrative Office Manual
Introduction

Established in 1946 in Greenville, SC, BlueCross BlueShield of South Carolina is a mutual insurance company headquartered in Columbia, SC. We have major offices in Columbia, Florence, Surfside Beach, Greenville, Charleston and Camden, SC; Dallas, Texas; Augusta, GA; and Nashville, TN – all serving multiple lines of business.

BlueCross offers health insurance to individuals, small groups and large groups in South Carolina. It also provides administrative services for larger, self-funded group health plans in South Carolina and nationwide.

BlueCross’ subsidiary companies offer products related to other types of insurance, such as life and behavioral health benefits. Our largest subsidiaries administer federal Medicare and TRICARE contracts. Some subsidiaries are technology-focused, offering back office claims processing, cloud hosting and other services to outside companies in our data centers.

For all lines of business, 851 million claims and 20.4 billion transactions were processed in 2014.

The only South Carolina-owned and operated health insurance carrier, BlueCross is a major supporter of community and charitable causes in all its locations. It also supports health care-related research, education and service in South Carolina through the BlueCross BlueShield of South Carolina Foundation.

BlueCross is an independent licensee of the Blue Cross and Blue Shield Association. A.M. Best’ (www.ambest.com), the world’s oldest and most authoritative insurance rating and information source, has rated our group of companies at A+ (Superior). This high rating is held by only a few health insurance companies in the nation.

BlueCross BlueShield of South Carolina is committed to providing quality service, education and problem resolution to the health care community. This Administrative Office Manual for Dental Providers is part of that commitment. We developed this manual to guide you through claim filing and enhance our partnership with you when providing services to our members.

We have put great effort into making sure the information in these pages is accurate. In the event of any inconsistency between information contained in this manual and the agreement(s) between you and BlueCross, the terms of such agreement(s) shall govern. Also, please note that BlueCross, and other Blue Cross and/or Blue Shield Plans, may provide available information concerning an individual’s status, eligibility for benefits and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, presentation of BlueCross identification cards in no way creates, nor serves to verify an individual’s status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

We will make annual revisions and updates to this manual. We will also update provider information in the Education Center of our website at www.SouthCarolinaBlues.com as needed. Please send all suggestions for enhancements to this manual to:

Provider Relations and Education Department
BlueCross BlueShield of South Carolina
I-20 at Alpine Road, AX-624
Columbia, SC 29219
Provider.Education@bcbssc.com

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Section 1
General Information

1. Website
Visit the Provider page of www.SouthCarolinaBlues.com for educational information, news, updates, resources and forms.

1.1 News and Updates
We have many informational publications for providers, including this manual. These publications are available on our website. By placing our publications on the website, we can provide you with important information quickly and accurately.

1.2 Resources
We’ve developed several resources to make your interactions with BlueCross easy and efficient. Document types include instructional manuals, user guides, managed care magazines, quick reference guides and educational handouts. Resources are available to view online or to print. You can find these documents:

• Administrative Office Manual for Dental Providers
• BlueNews for Providers newsletter
• Dental presentation
• My Insurance Manager User Guide
• My Remit Manager User Guide
• Provider Web Tools presentation
• News Bulletins

1.3 Forms
All forms are available to download and print on the Forms page of www.SouthCarolinaBlues.com. Many are also available in Spanish. Some of the forms you may find most useful are:

• Other Health/Dental Insurance Questionnaire – Ask your patients to update this information annually or when a change occurs in other health and/or dental coverage, including Medicare, that the subscriber or any covered dependent may have.

• Electronic Funds Transfer (EFT) and Electronic Remit Advice (ERA Enrollment form) – Complete these forms if you want to participate in the EFT program and/or do not currently receive an ERA. The authorized person who signs this form must sign the EFT Terms and Conditions. You can fax completed forms to 803-870-8065, Attn: EFT Coordinator, or email to provider.eft@bcbssc.com. An authorized person in your company must sign the required EFT Terms and Conditions Form and submit it along with the EFT and ERA Enrollment forms. The authorized person who signs this form must also sign the EFT and ERA Enrollment forms.

• Overpayment Refund Form – Complete this form when sending BlueCross unsolicited (voluntary) refund checks.

• South Carolina Dental Credentialing Application – Complete this form for initial credentialing and recredentialing.

• Dental Provider Reconsideration Form – Use this form to request review of a claim that has processed with an adverse determination.

There are several additional forms available to make changes to your dental provider information as needed.

2. Registering for Trainings
As part of our service efforts, we have created Palmetto Provider University. This curriculum educates new and experienced providers and their staffs on our business objectives and processes.

From the Provider page of www.SouthCarolinaBlues.com, select the Provider Training link from the Education Center drop-down menu. View a complete list of current course offerings and descriptions from the Palmetto Provider University page. Choose the link to complete the registration form. Submit the registration.

You will receive a confirmation email from provider.education@bcbssc.com that includes instructions for logging on for the selected webinar.
### 3. Contact Us

We direct all phone calls and emails to a central distribution center and assign them to the provider advocate who can most efficiently handle the request. The provider advocate who responds to your inquiry may not be the one dedicated to your county, but is available to respond to your inquiry.

#### 3.1 Provider Advocates

Our Provider Relations and Education staff focuses on providing training and support to health care professionals. Staff members serve as liaisons between BlueCross and the dental community to promote positive relationships through continued education and problem resolution. The staff is available for on-site office training and participation in regional practice manager meetings.

If you have a training request or question about a topic – such as compliance requirements, electronic claim filing updates and changes or problem identification/resolution – please contact the Provider Education department by calling 803-264-4730, emailing your provider advocate or using the Provider Advocate Contact Form available on www.SouthCarolinaBlues.com.

Our provider advocates cover the state of South Carolina and contiguous counties in Georgia and North Carolina. We will route your inquiry to the appropriate staff member for resolution.

<table>
<thead>
<tr>
<th>Name</th>
<th>Counties Served or Service Specialty</th>
<th>Telephone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Ann Shipley</td>
<td>Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg</td>
<td>Toll Free 800-288-2227, ext. 4730</td>
<td><a href="mailto:mary.ann.shipley@bcbssc.com">mary.ann.shipley@bcbssc.com</a></td>
</tr>
<tr>
<td>Ashlie Graves</td>
<td>Abbeville, Aiken, Anderson, Edgefield, Greenwood, Greenville, McCormick, Oconee, Pickens, Georgia (Augusta area)</td>
<td></td>
<td><a href="mailto:ashlie.graves@bcbssc.com">ashlie.graves@bcbssc.com</a></td>
</tr>
<tr>
<td>Jada Addison</td>
<td>Clarendon, Dillon, Florence, Georgetown, Horry, Marion, Marlboro, Williamsburg</td>
<td></td>
<td><a href="mailto:jada.addison@bcbssc.com">jada.addison@bcbssc.com</a></td>
</tr>
<tr>
<td>Sandy Sullivan</td>
<td>Calhoun, Chesterfield, Darlington, Kershaw, Lancaster, Lee, Lexington, Richland, Sumter</td>
<td></td>
<td><a href="mailto:sandy.sullivan@bcbssc.com">sandy.sullivan@bcbssc.com</a></td>
</tr>
<tr>
<td>Bunny Temple</td>
<td>Cherokee, Chester, Fairfield, Laurens, Newberry, Saluda, Spartanburg, Union, York, North Carolina (Charlotte area)</td>
<td></td>
<td><a href="mailto:bunny.temple@bcbssc.com">bunny.temple@bcbssc.com</a></td>
</tr>
<tr>
<td>Shamia Gadsden</td>
<td>Medicare Advantage and Quality Education</td>
<td></td>
<td><a href="mailto:shamia.gadsden@bcbssc.com">shamia.gadsden@bcbssc.com</a></td>
</tr>
<tr>
<td>Contessa Struckman</td>
<td>Quality Education</td>
<td></td>
<td><a href="mailto:contessa.struckman@bcbssc.com">contessa.struckman@bcbssc.com</a></td>
</tr>
<tr>
<td>Sharman Williams</td>
<td>BlueCard® Program and Ancillary Education</td>
<td></td>
<td><a href="mailto:sharman.williams@bcbssc.com">sharman.williams@bcbssc.com</a></td>
</tr>
<tr>
<td>Elizabeth Duvall</td>
<td>Internal Education</td>
<td></td>
<td><a href="mailto:elizabeth.duvall@bcbssc.com">elizabeth.duvall@bcbssc.com</a></td>
</tr>
<tr>
<td>Jamie Self</td>
<td>Internal Education</td>
<td></td>
<td><a href="mailto:jamie.self@bcbssc.com">jamie.self@bcbssc.com</a></td>
</tr>
<tr>
<td>Teosha Harrison</td>
<td>Provider Relations and Education Management</td>
<td></td>
<td><a href="mailto:teosha.harrison@bcbssc.com">teosha.harrison@bcbssc.com</a></td>
</tr>
</tbody>
</table>
3.2 Lines of Business

Use this contact information for our dental networks:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Description</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jonathan Todd</td>
<td>Dental Provider Contracting</td>
<td><a href="mailto:jonathan.todd@bcbssc.com">jonathan.todd@bcbssc.com</a></td>
</tr>
<tr>
<td>Sarah Turner</td>
<td>Commercial Dental Operations</td>
<td><a href="mailto:sarah.turner@bcbssc.com">sarah.turner@bcbssc.com</a></td>
</tr>
<tr>
<td>Bonnie Tucker</td>
<td>State Dental Plan Operations</td>
<td><a href="mailto:bonnie.tucker@bcbssc.com">bonnie.tucker@bcbssc.com</a></td>
</tr>
<tr>
<td>Belinda Stokes</td>
<td>Commercial Dental Operations</td>
<td><a href="mailto:belinda.stokes@bcbssc.com">belinda.stokes@bcbssc.com</a></td>
</tr>
<tr>
<td>Sherry Lawson</td>
<td>FEP BlueDental</td>
<td><a href="mailto:sherry.lawson@bcbsa.com">sherry.lawson@bcbsa.com</a></td>
</tr>
</tbody>
</table>

3.3 Other Service Areas

Use this contact information for other helpful resources:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Description</th>
<th>Telephone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Data Interchange (EDI)</td>
<td>Problems submitting claims electronically</td>
<td>N/A</td>
<td><a href="mailto:edi.services@bcbssc.com">edi.services@bcbssc.com</a></td>
</tr>
<tr>
<td>Electronic Data Interchange Gateway (EDIG)</td>
<td>Enroll your practice or billing service as a recipient of electronic data</td>
<td>N/A</td>
<td><a href="mailto:edig.services@bcbssc.com">edig.services@bcbssc.com</a></td>
</tr>
<tr>
<td>Provider Certification</td>
<td>Credentialing, provider updates, network status</td>
<td>803-264-4795 (Fax)</td>
<td><a href="mailto:provider.cert@bcbssc.com">provider.cert@bcbssc.com</a></td>
</tr>
<tr>
<td>Technology Support Center</td>
<td>Password reset for encrypted emails</td>
<td>855-229-5720</td>
<td>N/A</td>
</tr>
<tr>
<td>Web Technology Support</td>
<td>Technical problems with My Insurance Manager</td>
<td>800-868-2505</td>
<td>N/A</td>
</tr>
</tbody>
</table>

4. Provider Credentialing

4.1 Network Participation

We credential each new dental provider who wishes to join our dental network. Participating in our dental network opens your doors to nearly 500,000 South Carolina members, including those enrolled with private employers, Dental Plus, FEP BlueDental, FEP’s Basic and Standard plans, wishing to seek services from a network provider.

It also includes members enrolled with Companion Life. Life and dental insurance is offered by Companion Life. Because Companion Life is a separate company from BlueCross, Companion Life will be responsible for all services related to dental and life insurance.

Blue Cross and Blue Shield Plans around the nation have developed a network allowing dentists to treat patients from other participating Blue Cross and Blue Shield Plans at the local Plan reimbursement levels. We call this program GRID. GRID is an independent company that offers a dental network on behalf of BlueCross. BlueCross’ participating dental providers have access to GRID members nationwide living or traveling in South Carolina seeking dental services.

BlueCross gives potential network applicants the South Carolina Dental Credentialing Application, specific network contracts and professional agreements for network participation. The South Carolina Dental Credentialing Application is available in the Providers area of the website. Select Forms, then select Credentialing/Provider Updates. For contract or professional agreements, email provider.cert@bcbssc.com with your name, mailing address and the specific network contracts you need.

To apply for network participation, you must complete the application, attach the required documentation and submit the entire package to BlueCross. We will notify you of any missing or incomplete information. The average processing time for credentialing is 90 business days from when we receive a completed package. Any missing or incomplete information will delay the credentialing process.
You must submit these documents with your application:

- State license(s)
- Current DEA certificate
- Proof of malpractice coverage, including supplemental coverage
- Board specialists’ certificate, if applicable
- Electronic Claims Filing Requirement form (page 10 of the SCUCA application)
- NPI National Plan and Provider Enumeration System (NPPES) confirmation letter or email
- Appropriate IRS documentation (letter 147C, CP 575 E or tax coupon 8109-C)
- A signed contract signature page for each network to which you wish to apply

Note: You only need to submit one SCDCA application, regardless of the number of networks for which you are applying.

Please email your completed application and documentation to provider.cert@bcbssc.com or fax to 803-264-4795.

4.2 Provider File Updates

To maintain accurate participating provider directories and also for reimbursement methods, providers are contractually required to report all changes of address or other practice information electronically. Changes may include:

- Provider name
- Federal tax ID number
- NPI
- Physical and billing addresses
- Telephone number, including daytime and 24-hour numbers
- Fax number
- Email address
- Hours of operation
- Practice URL (website)
- Name changes, mergers or consolidations
- Languages spoken
- Accepting new patients
- Age range and gender of patients accepted
- Group affiliations
- Practice Management System

Find the applicable form to report any provider file updates by visiting the Forms page of www.SouthCarolinaBlues.com.

5. Health Insurance Portability and Accountability Act (HIPAA) and Electronic Data Interchange (EDI) Services

HIPAA became law in 1996. HIPAA portability provisions ensure that insurance companies do not deny individuals health insurance coverage under pre-existing conditions when the individual moves from one employer group health plan to another. HIPAA includes provisions for administrative simplification. These provisions improve the efficiency and effectiveness of health care transactions by standardizing the electronic exchange of administrative and financial data, as well as protecting the privacy and security of individual health information that insurance companies maintain or transmit electronically.

HIPAA administrative simplification imposes stringent privacy and security requirements on health plans, health care providers and health care clearinghouses that maintain and/or transmit individual health information in electronic form. In addition, HIPAA mandates that EDI complies with the adoption of national uniform transaction standards and code sets, and requires new, unique provider identifiers.

5.1 HIPAA Transactions

The BlueCross Gateway processes these ASC X12N Version 4010A1 transactions HIPAA requires:

- 270 (Health Care Eligibility/Benefit Inquiry)
- 271 (Health Care Eligibility/Benefit Response)
- 276 (Health Care Claim Status Request)
- 277 (Health Care Claim Status Response)
- 278 (Health Care Services Review)
- 834 (Benefit Enrollment and Maintenance)
- 835 (Health Care Payment/Advice)
- 837 (Health Care Claim-Professional)
- 837 D (Dental Claims)
- 837 I (Health Care Claim-Institutional)
5.2 Trading Partner Agreements

Trading Partner Agreement. In general, a trading partner is any organization that enters into a business arrangement with another organization and agrees to exchange information electronically. Typically, the two organizations develop a contract or agreement to describe this arrangement. BlueCross requires providers or their vendors to complete a Trading Partner Agreement (TPA). You can find the TPA application at www.HIPAACriticalCenter.com under Enrollments and Agreements.

Companion Guide. Companion Guide clarifies the specifics about the data content a provider transmits electronically to a specified health plan. For example, it may clarify what identification number is needed for the Payer Identifier data element. We call our companion guides “Supplemental Implementation Guides” (SIGs), since they supplement the HIPAA Implementation Guides. These guides address the situational fields that HIPAA allows for and explain how we use these fields. You can find all our guides at www.HIPAACriticalCenter.com.

Supplemental Implementation Guide (SIG). There are data elements we require in all cases (these are called “required”), and there are data elements we require only when the situation calls for them (these are called “situational”). Many situational data elements are related to the specialty of the physician. While you may choose to rely on your vendor to provide you with the necessary upgrade to capture the applicable data, it may be prudent to validate that the vendor has supplied all the necessary data for these reasons:

- It is the provider’s responsibility to be compliant. If you are not compliant, you risk having us return claims or even fine you for non-compliance.

- Vendors are not covered entities under HIPAA. Most vendors will do the best they can to assist their clients to become HIPAA-compliant, but it is critical for you to ensure that your software upgrade meets the HIPAA requirements.

- The capture of additional data usually means changes in business processes. You may need to change procedures or alter workflow. By understanding the new data you need to capture, you can determine what changes are necessary in your office.

Understanding the data requirements, however, is not easy. You may want to consider getting expert assistance, especially if you are a multi-specialty practice. If you decide to begin the task of validating your data requirements yourself, you should get a copy of the SIGs.

5.3 Electronic Funds Transfer (EFT)

EFT deposits payments directly into your bank accounts, allowing you to receive funds before BlueCross mails checks. EFTs are generated based on your NPI number. The EFT payment will show the NPI instead of the Tax ID.

5.4 Electronic Remittance Advice (ERA)

Dental providers with electronic file transfer capabilities can choose to receive the 835 ERA containing their Provider Payment Registers. Once you download the remittance files at your office, you can upload the files into an automated posting system. This eliminates a number of manual procedures.

If you are adding or changing billing services or clearinghouses, please complete the ERA Addendum-Billing Services and Clearinghouse or ERA Addendum-Corporate Headquarters found on www.HIPAACriticalCenter.com. You will not need the BlueCross EDIG Trading Partner Enrollment form when you only request 835 transactions for existing trading partners.

Remittance advices are available in My Insurance Manager and My Remit Manager.
6. My Insurance Manager

My Insurance Manager is an online tool providers can use to access these options:

- Benefits and Eligibility
- Claims Entry
- Pre-Treatment Estimate Entry and Status
- Graphical Tooth Chart
- Claims Status
- Remittance Information
- Your Mailbox
- EDI Reports

It is a valuable provider tool you can access after registering with a valid Tax ID number on our system. Secure encryption technology ensures any information you send or receive is completely confidential. My Insurance Manager can provide you with eligibility information and general benefits for members in Preferred Blue, Federal Employee Program, State Dental/Dental Plus Plans and Health Insurance Marketplaces. It also gives eligibility information and general benefits at the service-type level for BlueCard (out-of-area) members.

My Insurance Manager is not available during weekly maintenance on Sunday evenings from 5 p.m. until midnight.

How to register. Select the My Insurance Manager tab on www.SouthCarolinaBlues.com. Choose Create a Profile, and then enter your BlueCross Tax ID number. Create a username and password. Your profile administrator and each authorized user must have a unique username and password registered in My Insurance Manager. Submit the information. You are now ready to access My Insurance Manager.

7. My Remit Manager

My Remit Manager is an online tool dental providers can use to search remittances by patient, account number and check number. It is free to all dental providers who receive EFT payments and electronic remittance advices. It accepts 835s from all commercial BlueCross lines of business. It works independently of your practice management system or clearinghouse.

Use My Remit Manager to:

- View ERA information by file and see all details. You have the option of viewing the specific American National Standard Institute (ANSI) details the payer sends or the standardized information in a conventional format.
- Instantly see patient errors and denials. The system highlights any claims that have errors or that BlueCross has denied.
- View information categorized by check numbers or by patient. It clearly lists the name of each patient whose EOB is associated with an individual check or EFT.
- Print individual remits for a single patient. Eliminate the need to remove or black out other patient information on the remit.
- Print remits for selected patients. Print individual or group remits.
- Generate and analyze reports. Analyze claim, payment, subscriber, CPT code, etc., and specific data over a specific time period.

How to register. You can register to use My Remit Manager by completing our Provider Advocate Contact Form, by emailing provider.education@bcbssc.com or by calling Provider Education at 800-288-2227, ext. 44730.
Section 2
Product (Plan) Information

1. Benefit Structure
   Each BlueCross insurance plan offers a variety of coverage and differs by employer. Please verify eligibility and benefits before providing services.

   BlueEssentials™ plans no longer use the Participating Dental Network or include pediatric dental benefits. Individuals can purchase a separate dental plan if their Exchange plans do not offer dental benefits.

2. Identifying Members
   When members arrive at your office, remember to ask to see their current member identification (ID) cards at each visit. This will help you identify the product the member has and get dental plan contact information. It will also help you with filing claims. Please note that all ID cards do not look the same and are for identification purposes only. They do not guarantee eligibility or payment of your claim.

   **Important Facts about the ID Card Prefix**
   - Using the correct ID card prefix is critical for electronic routing of specific HIPAA transactions.
   - It is important to capture all ID card data at the time of service.
   - Do not assume that a member’s ID card number is his or her Benefits Identification Number.
   - Be sure all of your system upgrades accommodate the ID card alpha prefix and all characters that follow it.
   - Do not add, delete or change the sequence of characters or numbers in a member’s ID card number.
   - Make copies of the front and back of the ID card. Share this information with your billing staff.

3. Verifying Eligibility and Benefits
   Use My Insurance Manager to verify eligibility and benefits. Select the dental plan for which you want to review eligibility and benefits. Choose your eligibility view according to general benefits, service type or procedure code. Unless otherwise required by state law, the notice is not a guarantee of payment. Benefits are subject to all contract limits and the member’s status on the date of service. Accumulated amounts, such as deductible, may change as additional claims are processed.

   - For Commercial Dental Plan members, you can call the Provider Services Voice Response Unit at 800-222-7156 (Columbia center) or 800-922-1185 (Greenville center). The fax number is 803-264-7629.
   - For State Dental and Dental Plus members, you can call the State Dental Provider Services at 888-214-6230 (toll free) or 803-264-3702 (Columbia area). The fax number is 803-264-7739.
   - For FEP BlueDental members, you can call the FEP BlueDental Provider Service at 855-504-2583. The fax number is 843-763-0631.

4. Commercial Dental Plans
   Some commercial dental plans use a network of participating providers, and other plans do not. Members can visit any dental provider. An out-of-network provider, however, can balance bill for the difference in BlueCross’ allowable and actual charges.

   Levels of dental coverage for these plans include:
   - Preventive care
   - Restorative care
   - Major restorative care
   - Orthodontic care (optional)
4.1 How to Identify Members

The ID card shows the plan, member's identification number and plan code number. On the back of the card, you'll see the
customer service telephone number. Depending on the plan, coverage may be for dental only or offered in conjunction
with a member’s health benefits. These are examples of member identification cards from our commercial group plans that
offer dental benefits.

4.2 Sample Commercial ID Card(s)

Commercial Dental Only ID Card

![Commercial Dental Only ID Card](image)

Commercial Medical and Dental ID Card

![Commercial Medical and Dental ID Card](image)

5. Dental GRID

Dental GRID allows dentists to see members from other participating Blue Cross and Blue Shield Plans at local Plan
reimbursement levels. We consider you as an in-network dental provider to more patients that may be members of out-of-
state plans. Your reimbursement levels or provider agreements will not change. GRID is a separate company that offers a
dental network on behalf of BlueCross.

5.1 Participating Plans

These Plans are all independent licensees of the Blue Cross and Blue Shield Association.

- BlueCross BlueShield of South Carolina
- Blue Cross of California
- Blue Cross of Idaho
- Blue Cross Blue Shield of Nevada
- Blue Cross Blue Shield of Arizona
- Blue Cross Blue Shield of Colorado
- Blue Cross Blue Shield of Wyoming
- Blue Cross Blue Shield of North Dakota
- Blue Cross Blue Shield of Nebraska
- Blue Cross and Blue Shield of Kansas
- Blue Cross Blue Shield of Missouri
- Blue Cross Blue Shield of Wisconsin
- BlueCross BlueShield of Tennessee
- Blue Cross Blue Shield of Indiana
- Blue Cross Blue Shield of Kentucky
- Blue Cross Blue Shield of Ohio
- Blue Cross Blue Shield of Virginia
- Blue Cross and Blue Shield of North Carolina
- Blue Cross Blue Shield of Georgia
- Blue Cross Blue Shield of Maine
- Blue Cross Blue Shield of New Hampshire
- Blue Cross Blue Shield of Connecticut
- Empire Blue Cross Blue Shield
- Horizon Blue Cross Blue Shield
- CareFirst BlueCross BlueShield
- Capital Blue Cross
- CBA Blue
- Wellmark
- Excellus BlueCross BlueShield
- HealthNow New York
5.2 How to Identify Members

You should see “GRID” or “GRID+” on the member’s identification card. There will also be a customer service number to call with your benefit or eligibility questions.

A small number of participating Blue Cross and/or Blue Shield Plans may not immediately update their member ID cards to add the word “GRID.” If a member states he or she has the GRID network, but you don’t see “GRID” on his or her card, please verify participation by calling the provider service or customer service phone number on the ID card.

6. State Dental and Dental Plus Plans

BlueCross administers the State Dental and Dental Plus Plans. The dental benefits have four classes: diagnostic and preventive services; basic dental services; prosthodontics; and orthodontics. We pay covered services under the State Dental Plan based on its Schedule of Dental Procedures and Allowable Charges.

Dental Plus is a supplement to the State Dental Plan that provides a higher level of reimbursement for dental services the State Dental Plan covers. Members pay the entire premium with no contribution from the state. Dental Plus pays up to $1,000 for covered services in each benefit period for each covered member, in addition to the $1,000 maximum payment under the State Dental Plan.

Dental Plus does not cover services that are not covered under the State Dental Plan. Instead, it covers the same procedures and services (except orthodontics) at the same percentage of coverage as the State Dental Plan. The allowances are based on whether the provider participates in the BlueCross dental provider network.

6.1 How to Identify Members

The ID card displays the subscriber’s first and last name, the identification number, including the three-digit alpha prefix, and the plan name. The reverse side of the ID card gives a brief summary of benefits, the claims mailing address and the customer service telephone number.

6.2 Sample ID Card

Sample State Dental Plus ID Card

6.3 State Dental Plan Fee Schedule

Use the State Dental Plan fee schedule to determine if a service applies to dental or health benefits. You can find this fee schedule when you log in to My Insurance Manager and accept the State Dental Plan Fee Schedule Agreement.

7. FEP BlueDental

GRID Dental Corporation (GDC) is a separate company that administers FEP BlueDental on behalf of BlueCross. FEP BlueDental members use the GRID+ network as an in-network provider source. Participating providers now have access to FEP BlueDental members.

7.1 How to Identify Members

The ID card will indicate the provider network (GRID+), member’s identification number, group number and program name, and on the reverse side, claims filing address and the customer service telephone number. The top left corner on the back of the member’s ID card will display GRID+, indicating the use of the GRID+ network.

The ID card is for identification ONLY. The ID card is not a guarantee of eligibility or benefits. When a member provides your office with his or her FEP BlueDental ID card, it is important to also ask for his or her medical ID card. The medical ID card is important, because by law, the member’s medical plan is the primary carrier.
7.3 FEP Standard Option Dental Benefits

Under Standard Option, FEP pays for the following services, up to the amounts shown per service, as listed in the Schedule of Dental Allowances. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments or coinsurance. A member pays all charges in excess of the listed fee schedule amounts when using a non-preferred dentist. The member pays the difference between the fee schedule amount and the BlueCross Participating Dental Allowance when using a preferred dentist.

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>FEP Pays</th>
<th>Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral evaluations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic oral evaluation (up to two per person per calendar year)</td>
<td>$12 $8</td>
<td></td>
</tr>
<tr>
<td>Limited oral evaluation</td>
<td>$14 $9</td>
<td></td>
</tr>
<tr>
<td>Comprehensive oral evaluation</td>
<td>$14 $9</td>
<td></td>
</tr>
<tr>
<td>Detailed and extensive oral evaluation</td>
<td>$14 $9</td>
<td></td>
</tr>
<tr>
<td>Periodic oral evaluation (up to two per person per calendar year)</td>
<td>$12 $7</td>
<td></td>
</tr>
<tr>
<td>Limited oral evaluation</td>
<td>$14 $9</td>
<td></td>
</tr>
<tr>
<td>Comprehensive oral evaluation</td>
<td>$14 $9</td>
<td></td>
</tr>
<tr>
<td>Detailed and extensive oral evaluation</td>
<td>$14 $9</td>
<td></td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intraoral complete series</td>
<td>$36 $22</td>
<td></td>
</tr>
<tr>
<td>Intraoral periapical first image</td>
<td>$7 $5</td>
<td></td>
</tr>
<tr>
<td>Intraoral periapical each additional image</td>
<td>$4 $3</td>
<td></td>
</tr>
<tr>
<td>Intraoral occlusal image</td>
<td>$12 $7</td>
<td></td>
</tr>
<tr>
<td>Extraoral first image</td>
<td>$16 $10</td>
<td></td>
</tr>
<tr>
<td>Extraoral each additional image</td>
<td>$6 $4</td>
<td></td>
</tr>
<tr>
<td>Bitewing – single image</td>
<td>$9 $6</td>
<td></td>
</tr>
<tr>
<td>Bitewings – two images</td>
<td>$14 $9</td>
<td></td>
</tr>
<tr>
<td>Bitewings – four images</td>
<td>$19 $12</td>
<td></td>
</tr>
<tr>
<td>Vertical bitewings</td>
<td>$12 $7</td>
<td></td>
</tr>
<tr>
<td>Posterior-anterior or lateral skull and facial bone survey image</td>
<td>$45 $28</td>
<td></td>
</tr>
<tr>
<td>Panoramic image</td>
<td>$36 $23</td>
<td></td>
</tr>
<tr>
<td>Palliative treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative treatment of dental pain – minor procedure</td>
<td>$24 $15</td>
<td></td>
</tr>
<tr>
<td>Protective restoration</td>
<td>$24 $15</td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis – adult (up to two per person per calendar year)</td>
<td>– $16</td>
<td></td>
</tr>
<tr>
<td>Prophylaxis – child (up to two per person per calendar year)</td>
<td>$22 $14</td>
<td></td>
</tr>
<tr>
<td>Topical application of fluoride or fluoride varnish</td>
<td>$13 $8</td>
<td></td>
</tr>
<tr>
<td>Not covered: Any service not specifically listed above</td>
<td>Nothing Nothing</td>
<td>All charges</td>
</tr>
</tbody>
</table>
### 7.4 FEP Basic Option Dental Benefits

Under Basic Option, FEP provides benefits for the services listed. Members pay a $30 copayment for each evaluation, and FEP pays any balances up to the BlueCross Preferred Blue Participating Dental Allowance.

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>FEP Pays</th>
<th>Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral evaluations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic oral evaluation*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited oral evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive oral evaluation*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Benefits are limited to a combined total of two evaluations per person per calendar year

**Diagnostic imaging**

| Intraoral – complete series including bitewings (limited to one complete series every three years) | Preferred: All charges in excess of member’s $30 copayment | Participating/Non-participating: Member pays all charges |
| Bitewing – single image**                | Preferred: $30 copayment per evaluation | Participating/Non-participating: Member pays all charges |
| Bitewings – two images**                  | Preferred: $30 copayment per evaluation | Participating/Non-participating: Member pays all charges |
| Bitewings – four images**                 | Preferred: $30 copayment per evaluation | Participating/Non-participating: Member pays all charges |

** Benefits are limited to a combined total of four images per person per calendar year

**Preventive**

| Prophylaxis – adult (up to two per calendar year) | Preferred: All charges in excess of member’s $30 copayment | Participating/Non-participating: Member pays all charges |
| Prophylaxis – child (up to two per calendar year) | Preferred: $30 copayment per evaluation | Participating/Non-participating: Member pays all charges |
| Topical application of fluoride or fluoride varnish – for children only (up to two per calendar year) | Preferred: All charges in excess of member’s $30 copayment | Participating/Non-participating: Member pays all charges |
| Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only) | Preferred: $30 copayment per evaluation | Participating/Non-participating: Member pays all charges |

Not covered: Any service not specifically listed above

| Not covered: Any service not specifically listed above | Nothing | All charges |
1. **Electronic Claims Filing**

Submit claims electronically to BlueCross in the HIPAA 837D format. This is our preferred method of claim submission for all providers.

This table gives general guidance on filing requirements according to the dental plan.

<table>
<thead>
<tr>
<th>Dental Plan</th>
<th>Claims Filing Procedure</th>
<th>Timely Filing*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member’s ID card.</td>
<td>Varies (Verify when checking eligibility and benefits.)</td>
</tr>
<tr>
<td>Dental GRID</td>
<td>Send claims to the mailing address on the member’s ID card.</td>
<td>Varies</td>
</tr>
<tr>
<td>State Dental and Dental Plus</td>
<td>Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. Do not file a separate claim for Dental Plus members.</td>
<td>24 months from date of service</td>
</tr>
<tr>
<td>FEP BlueDental*</td>
<td>Submit all claims to the member’s primary medical plan first. See the member’s medical ID card for submission.</td>
<td>12 months from date of service</td>
</tr>
</tbody>
</table>

* Note: Timely filing limits are subject to change. You can verify timely filing limits by checking eligibility and benefits in My Insurance Manager.

* Service Benefit Plan (FEP) Medical Member claims should be submitted to the local Blue Cross Blue Shield Plan. Primary payment will be sent to you, and then FEP medical will forward the claim, along with the primary payment amount, to FEP BlueDental. The primary benefit will be coordinated on the claim received from the medical carrier and upon completion of coordination of benefits. FEP BlueDental will send the secondary payment to you.
2. Paper Claims Filing

2.1 American Dental Association (ADA) Claim Form

The ADA Claim Form J430D provides a common format for reporting dental services to a patient’s dental benefit plan. ADA policy promotes use and acceptance of the most current version of the ADA Dental Claim form by dentists and payers.

2.2 State Dental Plan Claim Form

The State Dental Plan has customized the current version of the ADA Claim form J430D. This helps dental providers submit the appropriate form to the correct plan for processing. You can find it at https://StateSC.SouthCarolinaBlues.com in the Member Resources section.

Sample State Dental Services Claim Form
2.3 Plan Addresses

Use this table to locate the claims address for the appropriate network.

<table>
<thead>
<tr>
<th>Dental Plan</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>[Locate the mailing address on the back of the member’s ID card.]</td>
</tr>
<tr>
<td>Dental GRID</td>
<td>[Locate the mailing address on the front or back of the member’s ID card.]</td>
</tr>
<tr>
<td>State Dental and Dental Plus</td>
<td>BlueCross BlueShield of South Carolina</td>
</tr>
<tr>
<td></td>
<td>State Dental Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 100300</td>
</tr>
<tr>
<td></td>
<td>Columbia, SC 29202-3300</td>
</tr>
<tr>
<td>FEP BlueDental</td>
<td>FEP BlueDental Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 75</td>
</tr>
<tr>
<td></td>
<td>Minneapolis, MN 55440-0075</td>
</tr>
</tbody>
</table>

3. Using the Correct Provider Identifier

Each dental provider should use his or her TIN or NPI when filing claims. This will ensure accurate and timely payment. An exception to this occurs if a dental provider does not have a TIN and uses his or her Social Security number to report income.

Place your provider number in the appropriate form indicator for the 837D when filing claims. Please also include the NPI of the rendering provider, if it is different from the NPI of the billing NPI.

4. Diagnosis Codes

Dental providers are exempt from billing with diagnosis codes, in general. However, if billing for medical services, dental providers should use a CMS-1500 claim form. An example of a dental service that is covered under a member’s medical benefit is the extraction of an impacted tooth. If a dental provider chooses to bill with a diagnosis code, use of International Classification of Diseases, 10th revision (ICD-10) coding is required.

5. Procedure Codes

BlueCross uses current dental terminology (CDT), a systematic listing and coding of procedures and services providers perform, for processing claims. Because dental nomenclature and procedural coding is a rapidly changing field, certain codes may be added, modified or deleted each year. Please make sure your office uses the current edition of the codebook when filing claims. BlueCross will reject claims containing invalid codes at the EDI Gateway and return paper claims to you.

6. Carrier Codes

BlueCross uses carrier codes (payer ID) to route electronic transactions to the appropriate line of business once the Gateway accepts the claim. Failure to use the correct electronic carrier code will result in misrouted claims or delayed payments. If you transmit through a clearinghouse, check with the clearinghouse to see if it requires a different carrier code for claim submission.

Use the following carrier codes for dental claim submission.

- 38520 – BlueCross BlueShield of South Carolina
- 77828 – Companion Life

7. Claim Status

You can submit claim status inquiries by visiting www.SouthCarolinaBlues.com and logging in to My Insurance Manager. You can also access claim status through the voice response unit by calling the appropriate plan.

- For Commercial Dental Plan members, call the Provider Services Voice Response Unit at 800-222-7156 (Columbia center) or 800-922-1185 (Greenville center).
- For State Dental and Dental Plus members, call State Dental Provider Services at 888-214-6230 (toll free) or 803-264-3702 (Columbia area).
- For FEP BlueDental members, call FEP BlueDental Provider Services at 855-504-2583.
8. Remittances

8.1 Remittance Types
Determine a claim’s submission channel by reviewing the BlueCross claim number. Electronic claims through the HIPAA X12N or web formats will result in faster reimbursement, reduced administrative costs and the elimination of keying errors.

- Electronic claim (claim you submit through clearinghouse)
  Example – T46G00011A0000
- Web claim (claim you submit through our website, www.SouthCarolinaBlues.com)
  Example – T46G000111W0000
- Superbill claim (claim you submit for professional providers who want to file multiple charges for one date of service)
  Example – 33000000P0000
- Hard copy claim (claim you mail hard copy)
  Example – T46G0001110000

8.2 Payments
We issue payments once per week. Patients are responsible for amounts shown in the Total Patient Liability column on your remit if you are a participating provider. You can view or print remittance advices by logging in to My Remit Manager or My Insurance Manager.

If you have an NPI for each location previously loaded to the BlueCross provider file, only minor changes are reflected on your remittances (i.e., the NPI number will be printed on your hard copy remits, and My Remit Manager [835s] will have the NPI number shown on them, as well.). If you did not get an NPI for each location, your remittances are summarized at the NPI level. You will no longer receive separate remittances for each location. Everything will be summarized by NPI.
Section 4
Provider Administration

1. Pre-Treatment Estimates
You can submit a Pre-Treatment Estimate using My Insurance Manager. Use it for more estimation of costly procedures such as crowns, wisdom teeth extractions, bridges, dentures, implants or periodontal surgery. All services are subject to any limitations or exclusions in the contract that are in effect at the time the patient receives services.

You can also check the status of a Pre-Treatment Estimate using My Insurance Manager.

2. Tooth Chart
View a member’s graphical tooth chart for primary and permanent teeth in My Insurance Manager.

3. Prior Authorizations

3.1 Prescription Drug
You should use the Prescription Monitoring Program known as the South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS). SCRIPTS requires dispensing practitioners and pharmacies to collect and report the dispensing activity of all category 2 through category 4 controlled substances.

Create an account to use SCRIPTS at https://southcarolina.pmpaware.net. When using SCRIPTS, you can view prescriber and dispenser information for these category prescriptions your patient has filled for a specified period. The South Carolina Boards of Medical Examiners, Dentistry and Nursing assert that SCRIPTS should be part of every patient’s initial evaluation and subsequent monitoring, and is considered the standard of care.

SCRIPTS use is required for all State Health Plan – including State Dental and Dental Plus – members who are being prescribed opioids beginning March 15, 2016.

Additional information about SCRIPTS use and access is available at www.scdhec.gov/Health/FHPF/DrugControlRegisterVerify/PrescriptionMonitoring/.

4. Provider Obligations
Each provider’s professional agreement lists the contractual responsibilities of both BlueCross and the provider. Here is a general summary of the professional agreement:

• The provider will file all claims for BlueCross members.

• BlueCross will reimburse the provider for covered services based on the member’s contract. Fee allowances are the lower of the provider’s charge for a procedure or the fee schedule of maximum allowances.

• The provider will accept BlueCross’ payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The provider will not bill the patient for more than his or her applicable patient liability amount, not to exceed the fee allowance.

• The provider agrees to cooperate fully with the utilization review procedures.

• The provider agrees to bill promptly for all services and in a manner BlueCross approves. Electronic claims submission (EMC) in the 837D HIPAA-compliant format is the preferred method of filing.

• For State Dental and Dental Plus, we pay based on the assignment indicators you file on the claim, regardless of network affiliation.
4.1 Provider Fee Allowances

The professional agreement states that a network provider will accept the fee allowance for covered services (defined as the provider’s normal charge or the fee schedule allowance, whichever is lower) as payment in full. The member is not financially responsible for anything other than applicable copayments, coinsurance and deductibles. You should not bill members for any amount that exceeds the fee allowance. You should not balance bill members or bill them up front for covered services.

4.2 Exceptions

The exception to this is when you bill a code and BlueCross applies an alternate procedure code when processing the claim. You can bill the member the difference between the allowance for the alternate procedure code and the code you filed. An example is:

You charge $100 for a procedure. The fee allowance for this procedure is $90. The fee allowance for the alternate procedure code is $80. The difference between the allowance for the procedure you file ($90) and the alternate procedure ($80) is $10. You would accept the difference in your charge and the allowance for the procedure filed, $10, as a write-off. The member is responsible for the difference in our payment and the fee allowance of $90.

If you have any questions about your fee schedule, please contact your contracting specialist.

5. Provider Reconsideration

BlueCross accepts provider reconsideration requests to review a claim that has processed with an adverse determination. An adverse determination is a denial or penalty that unfavorably affects the member (such as increased liability). Requests are reviewed in conjunction with our policies and the member’s benefit plan.

Provider reconsideration is a provider’s written request for review of a prior benefit decision. This is a voluntary process we offer to ensure the benefit decision was correct. Common reasons a provider may seek reconsideration of a claim include:

- It is believed we did not apply coding and payment rules correctly.
- There is disagreement with our interpretation of the member’s plan of benefits, such as the definition of dental necessity.
- There is disagreement with our denial of a claim with regard to provider versus member financial responsibilities.

Submitting Provider Reconsiderations. A dental provider can pursue provider reconsideration by using the Dental Provider Reconsideration Form. It can be found on the Forms page of www.SouthCarolinaBlues.com. Please be sure to complete the form in its entirety and attach all supporting documentation.

Provider reconsideration requests should include an explanation of the issue(s) to be reconsidered, such as seeking additional benefits, or why we should reconsider the service. We require you to include any supporting documentation, such as member’s office records, pre- and post-op X-rays, periodontal charting. We are unable to review requests that are submitted without supporting documentation.

Send the Dental Provider Reconsideration Form to the appropriate fax number or address, as provided on the form.

If a provider is found to consistently file provider reconsideration requests for inappropriate reviews, an education specialist may initiate a training session to discuss proper procedure.

Determinations. It generally takes BlueCross 30 days after we receive all supporting documentation to complete provider reconsideration reviews. After the review is complete, the appropriate service area will initiate claim adjustments or generate letters of denial to providers.

FEP BlueDental members. If you and your FEP BlueDental patient disagree with the initial decision of how dental services were processed, please encourage your FEP BlueDental patient to refer to his or her FEP BlueDental brochure on how to submit a reconsideration.
6. Coordination of Benefits
Dental providers can assist members needing to update their Other Health/Dental Insurance (OHI) information. We require our members to update this information yearly. You can make it easy by giving members computer access right in your office. Ask them to log in to My Health Toolkit® and update their information. Have the member follow a link to the Other Health/Dental Insurance Questionnaire. Or, you can print the OHI form from www.SouthCarolinaBlues.com and give it to your patient if he or she does not have access to our website.

FEP BlueDental members: The member’s medical coverage is always primary. FEP BlueDental is secondary. Submit all claims to the primary medical plan first. Refer to the back of the member’s medical ID card for submission. Submit pre-estimates of benefits directly to FEP BlueDental. Upon completion of the dental care, submit the claim to the primary medical plan.

7. Release of Office Records
There are times when BlueCross may request office records from you for a patient. We may request records in order to determine the necessity or the appropriateness of services performed. When you receive a request for records, please respond to the appropriate mailing address or fax number provided with the request.

You or any entity designated for such responsibilities should not charge BlueCross for the creation or submission of office records. As a participating provider, your contract states you agree to permit BlueCross or one of our business partners to inspect, review and acquire copies of records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment.
Section 5
Appendices

A. Glossary

**Adjustments** – The reprocessing of a claim to make changes to information submitted on the original claim.

**Benefit** – Services and supplies a dental plan pays for. The term may refer to the amount a dental plan will pay.

**Claim** – A billing record generated and submitted by a provider or member using either paper or electronic media.

**Coinsurance** – A provision in a member’s coverage that limits the amount of coverage by the Plan to a certain percentage (e.g., 80 percent). The member pays the remaining percentage.

**Copayment** – A cost sharing arrangement in which the member pays a specified amount for a specific service.

**Coordination of Benefits (COB)** – Provision ensuring that members receive full benefits and preventing double payment for services when a member has coverage from more than one source.

**Covered Service** – Specific services the Plan will pay for.

**Deductible** – A required payment from the member during a given time period before benefits become payable. It is usually a set amount or percentage determined by the member’s contract.

**Electronic Funds Transfer (EFT)** – Any transfer of funds, other than a transaction originated by cash, check or similar paper instrument that is initiated through an electronic terminal, telephone, computer or magnetic tape, for the purpose of ordering, instructing or authorizing a financial institution to debit or credit an account.

**Member** – Any person entitled to receive benefits under a Plan.

**National Provider Identifier (NPI)** – A unique 10-digit identification number issued to providers in the United States by the Centers for Medicare & Medicaid Services (CMS).

**Network** – Group of physicians, hospitals and other medical or dental care providers that a specific Plan has contracted with to deliver services to its members.

**Remittance (Remit)** – A statement to the member and/or provider that explains how and why benefit calculations were determined; also termed an Explanation of Benefits (EOB).

**Tax Identification Number (Tax ID)** – A unique nine-digit identification number assigned by the Internal Revenue Service to business entities operating in the United States for the purpose of identification; also referred to as Employer Identification Number (EIN).
B. Dental Provider Resources

B.1 Forms

- Dental Provider Reconsideration Form
  http://web.southcarolinablues.com/providers/forms/specialtiesother.aspx

- EFT and ERA Enrollment Form
  http://web.southcarolinablues.com/providers/forms/financialandappeals.aspx

- FEP Other Health Insurance Questionnaire
  http://web.southcarolinablues.com/providers/forms/specialtiesother.aspx

- Other Health/Dental Insurance Questionnaire
  http://web.southcarolinablues.com/providers/forms/specialtiesother.aspx

- Overpayment Refund Form
  http://web.southcarolinablues.com/providers/forms/financialandappeals.aspx

- South Carolina Dental Credentialing Application
  http://web.southcarolinablues.com/providers/forms/credentialingproviderupdates.aspx

B.2 Guides and Manuals

- Administrative Office Manual for Dental Providers
  http://web.southcarolinablues.com/providers/educationcenter/resources.aspx

- My Insurance Manager User Guides
  http://web.southcarolinablues.com/providers/educationcenter/providertools/myinsurancemanager.aspx

- My Remit Manager User Guide
  http://web.southcarolinablues.com/providers/educationcenter/providertools/myremitmanager.aspx

B.3 Presentations

- Credentialing Process
  http://web.southcarolinablues.com/providers/educationcenter/providertraining/workshops.aspx

- Dental Providers
  http://web.southcarolinablues.com/providers/educationcenter/providertraining/workshops.aspx

- Web Tools
  http://web.southcarolinablues.com/providers/educationcenter/providertraining/workshops.aspx