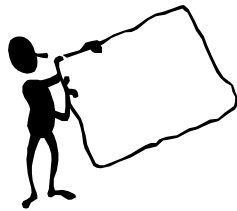


# **Banta Consulting**

Insurance  
Strategies That Work!



# **Insurance Strategies That Work!**

Sponsored by  
Buffalo Dental Meeting

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# **Insurance Strategies That Work!**

Presented by  
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## **Key Topics:**

- The Employee Dental Benefit Book
- Effective Claim Submission Techniques
- Narratives and Other Secrets
- The Claim Form
- Insurance Company Strategies



**INSURANCE INFORMATION STICKER SAMPLE**

Today's Date		Employee Name			©2001Banta Consulting, Inc.	
Employer				SS#		
Insurance Company			Spoke with			
Maximum	Deductible	Coverage year	%coverage/flat fee		Eff date	
Preventative		X-rays				
Restorative		CT				
Major		X-rays				
Frequency:Exams	Prophy	BWX	FMS	Fluoride		
Other Exclusions			Dental Coverage?		What age?	
Missing tooth clause?	NonDup clause?	Coord Ben?	Wait Periods?			

**NEW PATIENT INFORMATION STICKER SAMPLE**

Name		Date	Date of Appt	
Street	City	State	Zip	
Home Phone	Work Phone	Cell Phone		
Appointed for	Referred by			
Previous DDS	Phone	©2001Banta Consulting, Inc.		
Last dental visit	X-rays available?	Date of request		
Medical problems		Pre Med?		
Allergies	Dental problems			
DENTAL INSURANCE?	Employer & address			
Carrier & address		SS#		

## **Effective Claims Submittal Techniques**

1. Ask for alternate benefits
  
  
  
  
  
  
  
  
  
  
2. Bill and code for what you do
  
  
  
  
  
  
  
  
  
  
3. Document, document, document
  
  
  
  
  
  
  
  
  
  
4. Emergency visits and coding
  
  
  
  
  
  
  
  
  
  
5. Supporting documentation guidelines
  
  
  
  
  
  
  
  
  
  
6. Using the correct code for the procedure – don't commit fraud

1. What to write on the narrative – two words...OBNOXIOUS DETAIL!

## 2. Getting the insurance company to accept same day pre estimate or FAX

### 3. Electronic claims

### Open & Report Narrative Sample

#\_\_\_\_\_ had gross caries. We removed all decay. #\_\_\_\_\_ had small exposure. We placed a medicated base (direct pulp cap) and placed a temporary filling. #\_\_\_\_\_ will most likely need endo soon.

### Perio Narrative Sample

Note: patient exhibits continued pocketing (5mm or greater) in this area, even after past scaling & root planing. This area was scaled & root planed again and a “perio chip”- chemotherapeutic agent was placed in an effort to reduce the sub gingival flora.

**Narrative Sample for insurance claim**

Date\_\_\_\_\_

Patient\_\_\_\_\_

Insurance Co.\_\_\_\_\_

Group # \_\_\_\_\_

ID# \_\_\_\_\_

Dear Dental Consultant:

A \_\_\_\_\_ has been prescribed for restoration of tooth #\_\_\_\_\_ because:

- \_\_\_\_\_ 1. The \_\_\_\_\_ cusp(s) has/have been destroyed by caries or fracture and require restoration.
- \_\_\_\_\_ 2. The \_\_\_\_\_ cusp(s) has/have been undermined by caries and/or previous restorations.
- \_\_\_\_\_ 3. The tooth has a symptomatic crack or fracture on the \_\_\_\_\_ surface(s).
- \_\_\_\_\_ 4. The tooth has had endodontic treatment.
- \_\_\_\_\_ 5. There is recurrent decay under the present \_\_\_\_\_.
- \_\_\_\_\_ 6. Other: \_\_\_\_\_

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

Note: Prosthesis/or restoration is/is not an initial placement.

Date of prior placement \_\_\_\_\_.

Extraction date \_\_\_\_\_.

A Bitewing \_\_\_\_\_, or periapical(s) \_\_\_\_\_ xray(s) is /are enclosed.

Sincerely,

\_\_\_\_\_  
Attending Dentist



1. How to use the claim form properly – Know your form!
2. When to submit an x-ray and/or photographs with the claim
3. When you should use a medical claim form
4. College student status information

**XYZ Dental Office  
1111 James Street  
Anytown, USA 55555  
(555) 555-5555**

**Financial Agreement for:**

Patient Name \_\_\_\_\_ Guarantor Name \_\_\_\_\_

Previous Balance: \_\_\_\_\_

Estimate Total Treatment: \_\_\_\_\_

Estimate Insurance Payment: \_\_\_\_\_

Estimate Total Amount Financed: \_\_\_\_\_

\_\_\_\_\_ due each month for 3 months. The first payment is due at start of treatment. Payment dates are as follows:  
\_\_\_\_\_ due \_\_\_\_\_, \_\_\_\_\_ due \_\_\_\_\_ and final payment of \_\_\_\_\_ due \_\_\_\_\_.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent or Guardian Signature (if pt minor)*

\_\_\_\_\_  
*Date*

**Please note: Any changes in the amount paid or date payment is received will cancel this agreement and the entire balance becomes due effective immediately.**

# **Banta Consulting, Inc.**

*Seminar Materials*

## **90-Day reply letter**

Date

BALANCE DUE: \$ \_\_\_\_\_

Name

Address

City, State Zip

Dear \_\_\_\_\_,

Normally, at this time, because your account is long past due, it would be placed with our collection attorney which could possibly affect your credit by placing a lien on property or garnishment of wages. However, we would prefer to hear from you regarding your preference in this matter.

PLEASE INDICATE YOUR CHOICE AND RETURN THIS FORM:

( ) 1. Please find enclosed my payment in full.

( ) 2. Please charge the balance owed to my VISA, MASTERCARD, DISCOVER CARD. (Circle which Card.)

ACCOUNT NUMBER \_\_\_\_\_

EXPIRATION DATE OF CARD \_\_\_\_/\_\_\_\_/\_\_\_\_

AUTHORIZING SIGNATURE \_\_\_\_\_

( ) 3. I will have payment in full in your office within two weeks.

( ) 4. I will call this week to make payment arrangements.

( ) 5. I do not feel I owe the amount billed. If you do not feel you owe the amount billed please explain below.

( ) 6. I do not intend to pay the bill. Please turn my account over for collection. FAILURE TO RETURN THIS FORM OR TO MAKE PAYMENT WITHIN TWO WEEKS WILL INDICATE YOU DO NOT INTEND TO MAKE PAYMENT.

( ) 7. COMMENTS:

Please do not hesitate to call if you have any questions regarding this matter.

Sincerely,

Financial Administrator for:

**SAMPLE TREATMENT PLAN**

**Treatment Plan**

**Patient name**

**Date**

**Treatment Goals:**

- 1 - Life long oral health & comfort
- 2 - Preventive and periodontal treatment
- 3 - Control of tooth decay
- 4 - Replacement of missing teeth
- 5 - Cosmetic Dentistry

**Preventive and Periodontal Treatment:**

**Restorative Treatment:**

Upper Right:

Lower Right:

Upper Left:

Lower Left:

Upper anterior (front):

Lower Anterior (front):

**Replacement of Missing Teeth:**

**Estimate Total: \$**

***Please note: fees quoted are valid for 90 days from date of consult and actual treatment rendered may change.***

## **Cross Coding – is an Art**

1. What procedures cross code?
  
  
  
  
  
  
  
  
  
  
2. Why send medical claims?
  
  
  
  
  
  
  
  
  
  
3. How to get around that “first denial” “we need information from the other insurance company” ...stumbling block.
  
  
  
  
  
  
  
  
  
  
4. When is it ok to use a dental form?
  
  
  
  
  
  
  
  
  
  
5. When must you use a medical claim form?

## 1. Knowing how the insurance company thinks

## 2. How to prevent denials and get paid faster

### 3. How to resubmit a claim for appeal

#### 4. The insurance company “stall” tactics – are they real?

Checklist for insurance claims on major restorations:

1. For build-up, more than 50% of tooth structure needs to be involved to be an allowable claim on most dental plans.
2. It is best to list how many millimeters of tooth structure is involved in the restoration.
3. Keep in mind that a diagnostic film is not always 100% conclusive. Draw a picture of the tooth and draw arrows to the surface(s) involved ...obnoxious detail is crucial!
4. Utilize an intra-oral photo or digital photo image to reveal the most detailed evidence of needed dentistry. i.e.; for a cracked tooth, shine the composite light behind the crack...it illuminates it and creates a neon sign for why restoration was necessary.
5. Make sure to list prior placement date of previous crown/bridge if treatment is for replacement of major dentistry
6. Make sure to identify date of extraction. Most insurance companies now need an exact date of extraction, not an estimated date to approve benefit.
7. Utilize my narrative form, this provides the best "obnoxious detail" on claims.
8. Submit copy of perio charting for DSRP claims.
9. Remember, the narrative on a claim form must mirror the documentation notes on the treatment rendered page.

**Sample Disclaimers:**

I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.

I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.

I assign dental benefit payments to be paid directly to Dr. John Doe from my insurance company.

I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.