OFFICE REFERENCE MANUAL

Underwritten by Dental Care Plus, Inc. 1.21

PARTICIPATING DENTIST ADMINISTRATIVE MANUAL

Welcome to The Dental Care Plus Group
A DentaQuest Company

This manual is intended to serve as an administrative guide to you and your office personnel for our dental plans. Changes and supplements to this manual will be posted on our website.

WHAT IS THE DENTAL CARE PLUS GROUP?

The Dental Care Plus Group (DCPG) is owned and operated by DentaQuest and is committed to a provider-friendly approach to offering managed care plans to the market. The goal of DCPG is to protect the fee-for-service practice of dentistry. DCPG offers a suite of products to meet the needs of employers large and small:

1. **Dental Care Plus** is a dental health maintenance organization (DHMO) product offering high value benefits through a dedicated network of providers,

2. **Dentaselect Plus** is a dental preferred provider organization (DPPO) product offering high value benefits that are available from dentists in- or out-of-network,

3. **Dentapremier Plus** is a dental indemnity product offering high value benefits without a network so members can seek services from any dentist they choose.

The Dental Care PLUS GROUP
A DentaQuest Company

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SECTION 1

THE DENTAL CARE PLUS GROUP PRODUCTS AND NETWORKS

Dental Care PLUS

DHMO PRODUCT

Patients are required to use a Dental Care Plus DHMO network provider in order for benefits to be payable. This option generally provides the lowest out-of-pocket expense for patients.

DentaSelect PLUS

DPPO PRODUCT

Benefits are structured to afford the patient the lowest out-of-pocket expense by utilizing a contracted network provider. Patients may receive services from providers who are not in the network, but their out-of-pocket expense may be greater.

The DentaSelect Plus product can be paired with the traditional DentaSelect Plus DPPO network or with DCPG's narrow network offering, the Balanced Value (BV) network.

DentaPremier PLUS

INDEMNITY PRODUCT

Allows patients to see any dentist they wish. Providers are not required to sign a contract to participate in this plan. This option generally provides the highest out-of-pocket expense for the patient.

SECTION 2

DENTIST PARTICIPATION

A. DENTIST RESPONSIBILITY

As a dentist participating in our network(s), you have agreed to the following regarding your DHMO and/or DPPO patients:

1. Accept our Members as patients and provide needed services as long as your office is accepting new patients regardless of insurance coverage.

2. Refer our Members only to other DCPG participating dentists. Please be sure to consult the Provider Directory available on the DCPG website at www.dentalcareplus.com, or call the Customer Service Department to check on the participating status of a dentist.

3. Maintain such records as are necessary to fully disclose the extent of the services provided to our Members, and submit claims on the most current, approved American Dental Association (ADA) Claim Form. Claims must be submitted within one year from the date of service to be considered for payment.

4. Seek compensation solely from DCPG (except for copayments and deductibles for all Covered Dental Services). You agree **not** to bill the Member for charges exceeding the maximum allowable fee or withhold amounts (withhold amounts apply to DHMO and DPPO).

   You agree to bill **only** for copayments, deductibles and those services not covered by the Member's plan, including amounts which exceed the annual or lifetime maximums of the Member's plan.

5. Cooperate fully with any utilization review, quality assurance or any other program established by DCPG to promote quality dental care.

B. INFORMATION UPDATE

It is essential that DCPG is informed of all changes of address, telephone numbers, additional office sites, and dentists coming into or leaving established dental practices to make certain our records are accurate for payment. All changes should be submitted on the Standard Updates Request form available on DentaQuest.com on the Dentists page. Completed forms should be emailed or faxed to Standardupdates@dentaquest.com or faxed to 262-241-4077 as directed on the form.

Please include the following information:

- Dentist Name
- Current Address
- City, State Zip
- Telephone
- Fax
- Email
- The Type of Change
- The Effective Date of the Change
- Remit Name and Address (if different than above)
- Tax ID / Social Security Number
- W-9 (if the tax ID is changing)

Please call the Provider Engagement Team with any questions concerning the above information.

SECTION 3

MEMBER ELIGIBILITY

A. THE MEMBER IDENTIFICATION (ID) CARD

Each subscriber receives an ID card listing all covered family members (new ID cards will list only the subscriber but can be used for all covered family members. Note: some members may still have the ID card that lists all members though since we are not re-carding all existing members). The Member Number is the unique identification number of the employee as well as any eligible dependents.

The ID card should be presented by the Member each time services are rendered. If the Member is unable to provide their ID card, the dentist's office may wish to confirm Member eligibility and verify copayments and deductible amounts, if any. Member eligibility can be confirmed on the provider portal https://govservices.dentaquest.com or by calling customer service at 800-367-9466 or 513-554-1100.

The information commonly listed on the majority of Member ID cards is:

Member name

Be sure to register the Member and covered dependents in your system with their name as printed on the Member ID card.

Member #

Plan #

Effective date

Product logo

Claims address

Claims & Customer Service phone #

Electronic payer ID #

Web address

NOTE: For new Members, who have not yet received their Member ID card, eligibility can be verified on the provider portal or by calling customer service at 800-367-9466.

B. VERIFICATION OF MEMBER ELIGIBILITY

1. **Provider Portal** – Participating dentists may verify patient eligibility by accessing the provider portal at https://govservices.dentaquest.com/.

2. **Customer Service** - The dental office may also verify eligibility by calling customer service at the number listed on the back of the Member's ID card.

NOTE: Member eligibility information is subject to change and is based on a member's eligibility on the date of service and when a claim is received.

SECTION 4

DESCRIPTION OF BENEFITS

A. COVERED DENTAL SERVICES

This is a **general** outline of Covered Dental Services for most benefit plans. However, Covered Dental Services are always determined by the benefit plan in which the subscriber and eligible dependents are enrolled. Therefore, some of the dental services listed in each section below may not be covered under every plan or may be subject to different limitations than those described in each section. Certain groups may also add additional Covered Dental Services to those listed. Member benefits can be verified by visiting the provider portal at https://govservices.dentaquest.com/.

PREVENTIVE BENEFITS

Preventive & Diagnostic Services	Limitation
Routine oral examinations	limited to two visits each year
Prophylaxis (cleaning)*	limited to two each year
*For purposes of prophylaxis, a child is considered anyone 14 years of age or younger.	
Topical application of fluoride	limited to two treatments each year to children under age 18
Bitewing X-rays	limited to one set of four each year
Vertical bitewing X-rays	limited to once every three years (7-8 films)
Periapical X-rays	limited to five films per year
Full mouth X-rays	limited to once every three years (complete series or panoramic)

BASIC BENEFITS

Emergency Services	Limitation
Emergency/limited oral examinations	
Office visit after hours - for emergencies only	
Emergency palliative treatment	

Diagnostic Services	Limitation
Extraoral X-rays	
Referral consultations and examinations performed by a specialist	

Sealants & Preventive Resin Restorations	Limitation
Permanent molar teeth only	limited to children under 15 years of age, once every five years per tooth

BASIC BENEFITS CONT.

Space Maintainers	Limitation
Fixed band type, unilateral	limited to children under 19 years of age
Distal shoe space maintainer - fixed, unilateral	limited to children under 8 years of age

Oral Surgery (Includes local anesthesia and routine post-operative care)	Limitation
Extractions:	
Simple single tooth extractions	
Root removal - exposed roots	
Surgical Extractions:	
Removal of an erupted tooth (uncomplicated)	
Other Oral Surgery:	
Incision and drainage of abscess	
Biopsy and examination	
General Anesthesia or intravenous sedation	only when necessary and provided in connection with oral surgery

Periodontic Services (Includes local anesthesia and routine post-operative care)	Limitation
Emergency treatment (periodontal abscess, acute periodontitis, etc.)	
Periodontal scaling and root planing	limited to four quadrants each year as a definitive treatment when pocket depths of at least 4mm are demonstrated.
Scaling in presence of generalized moderate or severe gingival inflammation	limited to once in a 24 month period when clinical documentation demonstrates that 30% or more of teeth are involved.
Surgical periodontics	limited to two additional recalls in the first year following complex surgery (including post-surgical visit)
Gingivectomy	
Osseous and muco-gingival surgery	
Gingival grafting	
Guided tissue regeneration	
Periodontal maintenance procedure	limited to two each year following a history of periodontal disease

Endodontic Services (Includes local anesthesia and routine post-operative care, excluding Sargenti)	Limitation
Root canal therapy, traditional	
Retreatment of previous root canal	must be at least three years following previous root canal treatment on the same tooth
Recalcification and apexification	

BASIC BENEFITS CONT.

Restorative Services (Includes local anesthesia. Multiple restorations on a single surface will be considered as a single restoration.)

	Limitation
Restorations (amalgam, composite, sedative fillings and core buildups)	limited to once every two years per tooth (same surfaces only)
Pins - pin retention as part of restoration when used instead of gold or crown restoration	
Stainless steel crowns when teeth cannot be adequately restored with filling material	
Recementation of inlays, onlays, crowns, bridges, and space maintainers	
Repairs to crowns and bridges	

Prosthodontic Services	**Limitation**
Full and partial denture repairs	
Repair broken complete or partial dentures	
Replacement of broken teeth on complete or partial denture	
Additions to partial denture to replace extracted natural teeth	

MAJOR BENEFITS

Restorative Services	**Limitation**
(Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.)	
Inlays, onlays, crowns, post & cores	limited to once in five years on same tooth

Oral Surgery (Includes local anesthesia & routine post-operative care)

Surgical Extractions	**Limitation**
Removal of impacted tooth - soft tissue	
Removal of impacted tooth - partially bony	
Removal of impacted tooth - completely bony	
Removal of impacted tooth - completely bony, with complications	
Surgical removal of residual roots	

MAJOR BENEFITS CONT.

Pre-Prosthetic Oral Surgery	Limitation
Alveoloplasty and vestibuloplasty	

Prosthodontic Services	Limitation
Fixed bridge	limited to one original or replacement prosthesis every five years
Complete upper or lower denture	limited to one original or replacement prosthesis every five years
Partial upper or lower denture	limited to one original or replacement prosthesis every five years
Relining and rebasing	limited to once every three years

ORTHODONTIC BENEFITS

Coverage includes orthodontic procedures under a treatment plan that has been evaluated through Pre-treatment Review by DCPG, such as:

Comprehensive Orthodontic Treatment

- Other Orthodontic Treatment (limited to one appliance per individual)
- Appliance for tooth guidance
- Appliance to control harmful habits
- Orthodontic retention appliance

Benefits other than for the initial payment will be made in installments beginning when appliances are inserted. The payments will be issued monthly for the length of the estimated treatment plan. The first Member payment for the initial charge will be at the discretion of the dentist. Under the program, only 25% of the total treatment cost may be recognized as the initial charge. DCPG's payment will be determined by the benefit level specified in the schedule of benefits.

If a Member is receiving orthodontic treatment which was covered under another company's benefit plan(s) prior to the effective date of DCPG's benefit plan(s), DCPG will deduct the payments made by the other Company's Benefit Program(s) from the DCPG lifetime maximum. All benefits paid toward orthodontic services by all previous benefit plan(s) will be applied to the DCPG lifetime maximum.

B. EXCLUSIONS

This is a **general** outline of excluded dental services. **The dental plan exclusions vary by employer group.** The following are services specifically excluded from coverage under most benefit plans. The Member is financially responsible for the full charge for any service that is excluded/not covered under the plan.

1. Services performed for cosmetic reasons, including personalization or characterization of prosthetic devices and the bleaching of teeth, unless the schedule of benefits specifically provides for coverage of the bleaching of teeth.
2. Services or supplies which are considered experimental according to standard dental practice.
3. Charges which are incurred before the Member's effective date of coverage or after the date a Member's coverage terminates.

4. Services or procedures started prior to the effective date of the Member's coverage, with the exception of orthodontic services if covered by the plan. Prosthetic devices and crowns will not be covered if final impressions were taken before the effective date of coverage. If final impressions were taken while coverage is in effect, but the prosthetic device or crown is installed more than thirty (30) days after the coverage terminates, then charges for the prosthetic device or crown will not be covered, unless stated otherwise elsewhere.
5. Dentures, implants and bridgework (including crowns and inlays forming their abutments) if in replacement of natural teeth which were extracted while the individual was not covered under the plan.
6. Porcelain coverage on posterior crowns.
7. Missed appointment charge.
8. Completion of claim forms.
9. Replacement of lost, stolen, or broken prosthetic devices or appliance unless it is after the limitation date.
10. Analgesics, nitrous oxide, non-intravenous conscious sedation and other drugs and prescriptions.
11. Localized delivery of antimicrobial or chemotherapeutic agents.
12. Hospital related charges.
13. Appliances, restorations, and procedures other than full dentures, for the primary purpose of increasing vertical dimension, restoring the occlusion or treatment of bruxism.
14. Veneers or similar properties of crowns and pontics.
15. Services for educational purposes.
16. Splinting (if tooth does not otherwise need to be restored).
17. Services related to or arising out of employment, including self-employment, if the Member is eligible for benefits under any workers' compensation act or similar law.
18. Surgical implants or transplants of any type (including prosthetic devices, such as crowns, attached to them) and all related services, unless the schedule of benefits specifically provides for coverage of implants. If the schedule of benefits provides for the coverage of implants, all implant or transplant services which are outside the covered dental services and limitations described in the schedule of benefits are excluded from coverage.
19. Services performed by other than a licensed dentist, except for legally delegated services to a licensed hygienist or licensed expanded functions auxiliary.
20. Treatment for temporomandibular joint disease (TMJ) or myofacial pain dysfunction syndromes (MPD).
21. X-rays for TMJ.
22. Orthognathic surgery.
23. Services or supplies rendered, or furnished in connection with, any duplicate appliance.
24. Services or supplies which are not medically necessary.
25. Expenses incurred for more than two oral examinations and/or prophylaxis treatments during a benefit year.
26. Expenses incurred for the replacement of amalgams, composites, sedative fillings and/or core buildups more often than once in any two (2) year period.
27. Expenses incurred for the replacement of fixed bridgework, crowns, gold restorations and jackets more often than once in any five (5) year period.
28. Expenses incurred for the replacement of partial or full dentures more often than once in any five (5) year period.

29. Expenses incurred for replacement of an existing denture which is or can be made satisfactory.
30. Expenses incurred for relining of dentures more often than once in any three (3) year period.
31. Expenses incurred for a temporary full denture.
32. Expenses incurred for the retreatment of root canals if it has not been at least three (3) years since the previous root canal treatment.
33. Expenses incurred for bone replacement grafts for ridge preservation.
34. Expenses incurred for a core buildup if an amalgam, composite restoration and/or sedative filling was completed within a two (2) year period on the same tooth.
35. Services which are determined to be eligible expenses under any medical plan in which the Member is enrolled.
36. House calls.
37. Dental services or supplies for a condition resulting from civil disobedience, active participation in a riot or in the commission of a felony, self-inflicted injury, non-accidental injury, or an act of war.
38. Any services not specifically listed as a Covered Dental Service.
39. Treatment by a Member of the immediate family or a resident in the covered employee's home; self-treatment.
40. Acid etches.
41. Expenses for the completion of periodontal charting.
42. Asepsis.
43. Claims that are not received by DCPG within one calendar year from the date of service.
44. Charges for services received after a Member has reached the annual or lifetime maximum benefits payable under the plan.
45. Expenses for gold restorations and crowns, except when used as treatment for decay or traumatic injury when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

C. ALTERNATIVE BENEFIT POLICY

Many dental conditions can be treated in more than one way. Every DCPG plan has an "Alternative Benefit Policy" which governs the amount of benefits the plan will pay for treatments covered under the plan. If two or more alternative treatments are both Covered Dental Services under the plan, and the patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the Covered Dental Service that provides professionally satisfactory results at the most cost-effective level. The patient will pay the difference in cost. To apply the Alternative Benefit Policy:

- The dental office must have the patient sign an Informed Consent prior to the treatment, acknowledging the patient's understanding of the benefit and that he/she will be billed directly and will be financially responsible for the **difference** in cost of the treatment.
- The dental office will bill DCPG the cost of the Covered Dental Service. Participating Dentists must seek compensation solely from DCPG for all Covered Dental Services, except copayments, deductibles and charges that exceed maximum benefit levels.

NOTE: Covered Dental Services also include services which are part of the complete dental procedure and are considered components of, and are included in, the fee for the complete procedure.

EXAMPLE:

A gold or metallic crown (D2792) on a molar tooth is a Covered Dental Service. However, if a patient chooses the porcelain crown (D2752) on a molar tooth and signs an Informed Consent, with full knowledge of the difference in price, services may be provided and a claim submitted.

If the Participating Dentist's normal billed charge for a porcelain crown (D2752) is $900 and the normal billed charge for a metallic crown (D2792) is $800, the claim should be submitted to DCPG as follows:

DCPG – D2792 crown - full cast noble metal

Billed charge	$800.00
DCPG allowed	$725.00
Write-off	$75.00
Withhold	$72.50
Paid amount*	$652.50

*The paid amount equals the DCPG payment plus any patient responsibility (deductible, co-payment, charges that exceed maximum benefit levels) up to the DCPG allowed amount.

PATIENT is billed directly	$100.00 (difference between D2752 & D2792)
DENTIST receives	$752.50

This example is for illustration purposes only. The actual benefits adjudicated in Windward may vary.
The following codes are not eligible for the application of the Alternative Benefit Policy:

EXCLUDED CODE RANGES

Category of Service	Code Series
Diagnostic	D0100 – D0999
Preventive	D1000 – D1999
Endodontics	D3000 – D3999
Periodontics	D4000 – D4999**
Implant Services	D6000 – D6199
Oral Surgery	D7000 – D7999
Orthodontics	D8000 – D8999
Adjunctive General Services	D9000 – D9999

**When Alloderm is requested by a patient, the Alternative Benefit Policy will apply to the Alloderm but not to the procedure itself.

INFORMED CONSENT

For Alternative Benefit

My dental practitioner has advised me and fully explained the dental treatment program considered a cost effective, professionally accepted course of treatment for my dental care. In addition, alternative benefits in the course of treatment have been explained. After review with my dentist, I agree to be billed directly for additional benefit alternatives by the dentist.

I further agree to reimburse the dentist directly for these charges.

Service

Fee Charged to Patient

Patient Signature

Dentist Signature

Date

SAMPLE

SECTION 5

CLAIMS

A. PRE-TREATMENT REVIEW OF DENTAL SERVICES

When a proposed treatment plan for a DCPG Member exceeds **$400.00**, a pre-treatment review may be obtained from DCPG prior to the initiation of the treatment.

To submit services for a pre-treatment review, send DCPG the most current ADA Claim Form listing the proposed treatment along with appropriate CDT codes.* Check the "Request for pre-determination/pre-authorization" box. Enclose X-rays and other diagnostic aids which are required for an accurate determination of benefits. A listing of the most Frequently Requested Items can be found later in this section.

DCPG, through its consulting dentists, will manage the pre-treatment review process. After the review is complete, you will be provided with an estimate of benefits payable (if any), based on the Member's plan. Pre-treatment review does not constitute a guarantee of payment. When the services have been rendered, send the most current ADA Claim Form listing the completed treatment to DCPG for processing.

*Current Dental Terminology © American Dental Association

B. CLAIMS SUBMISSION

After rendering services to an eligible DCPG Member, the dentist's office is responsible for preparing and submitting a claim form directly to DCPG.

1. **Payer IDs**
   - Group – 04356
   - Individual – CX014

2. **Paper Claims Submission**
   Paper claims for services must be submitted on the most current ADA Dental Claim Form. Please complete the claim form in its entirety and review carefully so that errors will be minimized. Please use the following addresses for submitting paper claims:

   - Group
     PO Box 502
     Milwaukee WI 53201-0502

   - Individual
     PO Box 2906
     Milwaukee WI 53201-2906

3. **Electronic Claims Submission**
   - DCPG offers participating dentists the ability to submit electronic claims - including attachments - free of charge via the provider portal.

   - You may also submit electronic claims by using the clearinghouse of your choice through your practice management system.

     Payor ID numbers are located on the back of the Member's ID card or you may contact Customer Service for assistance. Please note that Payor ID numbers differ for Group members vs Individual plan members.

C. FREQUENTLY REQUESTED ITEMS

For the following services please include the requested items with your original claim.

Description of Service	Requested Item(s)
Crowns, Inlays/Onlays, Bridges	Pre-operative X-rays and if replacement, provide date of original placement
Crown Buildups/Post and Cores	Pre-operative X-rays
Crown Repair	Crown repair narrative and type of material
Complete Dentures, Partial Dentures	Pre-operative full-mouth X-rays, and if initial placement, provide dates of extractions of all missing teeth, or if replacement, provide date of original placement
Periodontal Scaling, Osseous Surgery	Pre-operative full-mouth X-rays and periodontal charting
Crown Lengthening	Pre-operative full-mouth X-rays and clinical notes
Gingivectomy — Quadrant	Narrative and periodontal charting
Gingivectomy — Per Tooth	Clinical notes
Orthodontic Procedures	Provide the entire treatment plan when initially submitting for payment
Pulp Cap	Description of materials used
Root Canal Retreatment	Provide date of original root canal
Extraction of Impacted Teeth	Pre-operative full-mouth X-rays
Unspecified Procedures (All codes ending in 999)	Provide narrative of procedure performed

D. IMPORTANT CLAIM FILING TIPS

The **seat date** (completion date), is considered the date of service for all prosthodontic procedures such as crowns, bridges and dentures. DCPG considers services for payment **only** after completion.

- Do not bill with the hygienist's name. Always bill with the supervising dentist's name.
- Claims should be submitted as soon as possible after services are rendered.
- Claims which are not received by DCPG within one calendar year from the date of service will be denied for payment.
- Always bill DCPG your usual and customary fee for the service rendered to a Member. Fees charged to DCPG should not exceed your fee for the same services rendered to other patients in your practice.
- When submitting a claim to DCPG as the secondary payer, please provide the payment information from the primary payer (a copy of the explanation of benefits is required) including the legend of explanation codes.

E. COORDINATION OF BENEFITS (COB)

"Coordination of Benefits" is the process used to pay dental care expenses when a patient is covered by more than one plan. DCPG follows rules established by state law to decide which plan pays first and how much the other plan must pay.

When a DCPG Member is covered by another dental insurance plan, be sure to indicate this on the claim form. Please provide the name of the company, employee, and any other information pertaining to the coverage.

SECTION 6

REIMBURSEMENT

A. PROVIDER REMITTANCE ADVICE

Reimbursement for services provided to eligible DCPG Members will be issued directly to the participating dentist via Electronic Funds Transfer (EFT) or paper check. A single payment with a corresponding Remittance Advice identifying each claim and patient included in the remit will be sent to the dental office. Payments are issued weekly.

The amount paid by DCPG is to be considered payment in full. The Member can only be billed for applicable deductibles, co-payments and those services not covered by their plan.

B. MAXIMUM ALLOWABLE FEES

Maximum Allowable Fees are established based upon independent actuarial analysis of DCPG service and charge data. This process is reviewed annually. Maximum allowable fees are established for each CDT* procedure code. The maximum allowable fee for a procedure may vary depending on whether the procedure is performed by a general dentist or a dental specialist.

Charges which exceed the Maximum Allowable Fee cannot be billed to the Member.

*Current Dental Terminology © American Dental Association

C. DENTIST FEE WITHHOLD

All fees paid to the dentist, are subject to a 10 percent withhold amount, as outlined in The Dental Care Plus Group Participating Dentist Agreement.

The withhold amount cannot be billed to the Member.

D. MEMBER FINANCIAL RESPONSIBILITY

The Member is financially responsible for copayments, deductibles and any service not covered by the plan:

1. **Copayments** are a fixed dollar amount or a percentage of the maximum allowable fee.
2. **Deductibles** are the amount a Member is required to pay before benefits are payable under the DCPG benefit plan (usually applied to Basic and Major Services only).
3. **Non-covered services** include (but are not limited to) the following:
    - a) any service specifically listed as an exclusion in the patient's benefit plan.
    - b) any service not covered by DCPG due to a specified limitation listed in the patient's benefit plan.
    - c) any service that is denied by DCPG because a patient has exceeded the Annual or Lifetime Maximum benefits payable under the patient's benefit plan.

E. REIMBURSEMENT RESOURCES

If you would like to enroll in EFT, please visit https://dentaquest.com/dentists/ and complete and return the Standard Updates Request Form (under "Update Your Provider Information" heading. You may return this form by e-mail to Standardupdates@dentaquest.com or by fax to 262-241-4077.

If you have a question regarding the reimbursement of a claim, you may contact Customer Service at 800-367-9466, Monday through Friday from 8:00 am until 4:30 pm EST.

F. DIRECT DEPOSIT

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account. To receive claims payments through Direct Deposit, Providers must:

- Complete and sign the Direct Deposit Form found on the website.
- Attach a voided check to the form. The authorization cannot be processed without a voided check.
- Return the Direct Deposit Form and voided check to DentaQuest.
- Via Fax – 262-241-4077

The Direct Deposit Form must be legible to prevent delays in processing. Providers should allow up to six weeks for Direct Deposit to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Form. Changes to bank accounts or banking information typically take 2 -3 weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in Direct Deposit are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the PWP at https://govservices.dentaquest.com/

2. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.

3. Log in using your password and ID

4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".

5. The remittance will display on the screen.