



Wyoming
Department
of Health

Dental Claims

Claim Submission

Course Content

- Dental Claim Overview
- Dental Claim Submissions
- Dental Claims with Third Party Liability (TPL)
- Dental Claims Tertiary Claim
- Dental Claim Attachments



Dental Claims Overview

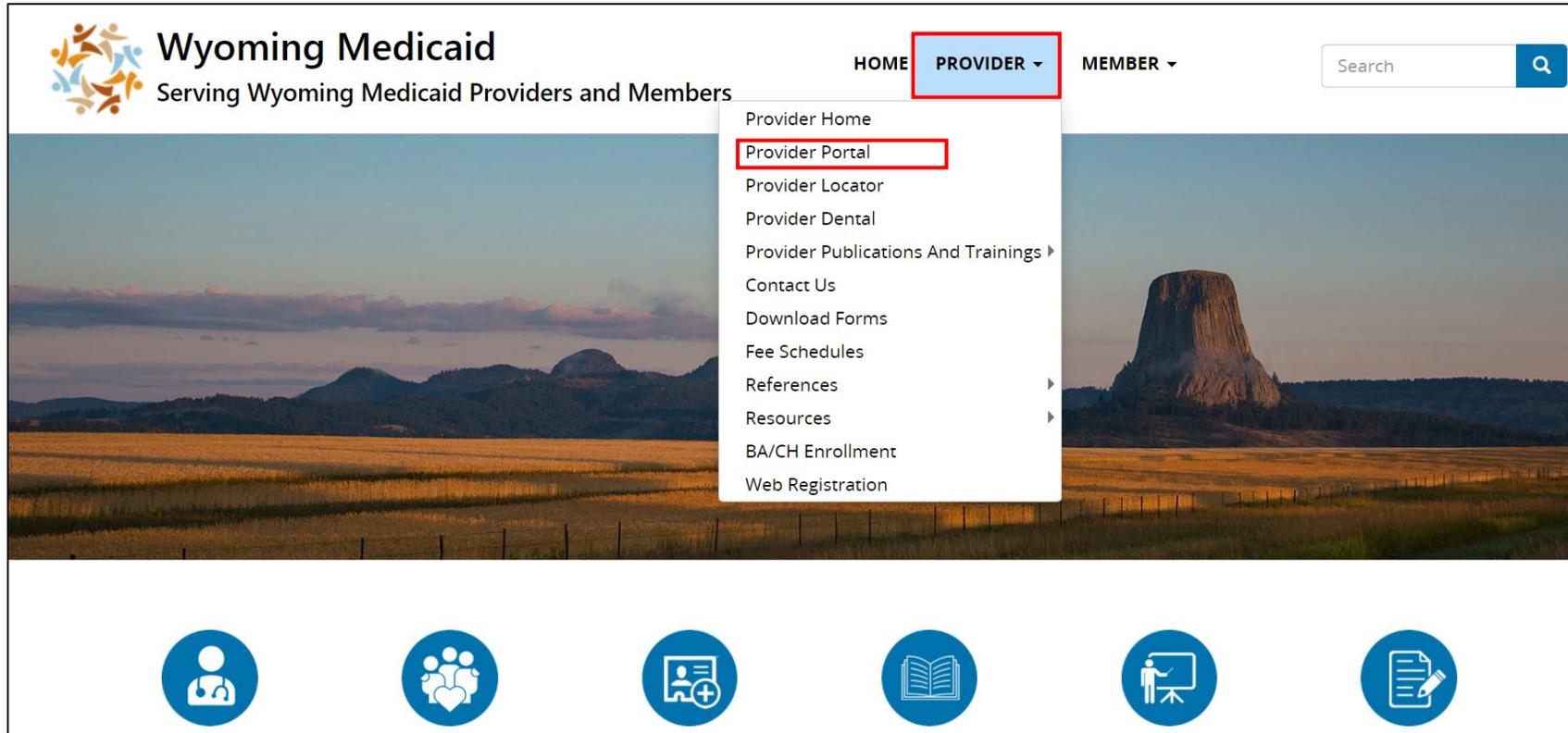
- Dental Claims are submitted by dentists and oral surgeons for dental services
 - Member receives a service
 - Provider submits a claim
 - Claims include information about the Member, Provider, and service
 - The claim is submitted to the State Medicaid Agency
 - The claim is approved and paid or denied



Dental Claims

How to complete the process of entering a Dental Claim

Dental Claims Submission



- Access the Medicaid Website at:
<https://www.wyomingmedicaid.com/>
- Select **Provider** at the top of the page. A drop-down list appears
- Select **Provider Portal** from the options in the menu

Dental Claims Submission

Wyoming
Department
of Health

Sign In - Non Production

Username

Password

Remember me

Sign In

OR

New users click here

Need Help Signing In?

Log in with Credentials

Log in to the BMS system:

- Log in to the Provider Portal with your Single Sign-On (SSO) username and password

After logging in, an authentication screen displays to authenticate access to the system.

Dental Claims Submission



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of Health



Receive a code via SMS to
authenticate

United States

Phone number

+1

Send code

Back to factor list



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Setup Okta Verify

Select your device type

iPhone

Android

Back to factor list



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Department
of Health



Setup Google Authenticator

Select your device type

iPhone

Android

Back to factor list

After logging in, the Multi-Factor Authentication (MFA) appears to authenticate access to the system:

Verify authentication based on your setup selection:

- Select **Send code** for SMS
- If you chose Google Authenticator, enter that code
- If you did an OKTA push, accept the push

Dental Claims Submission

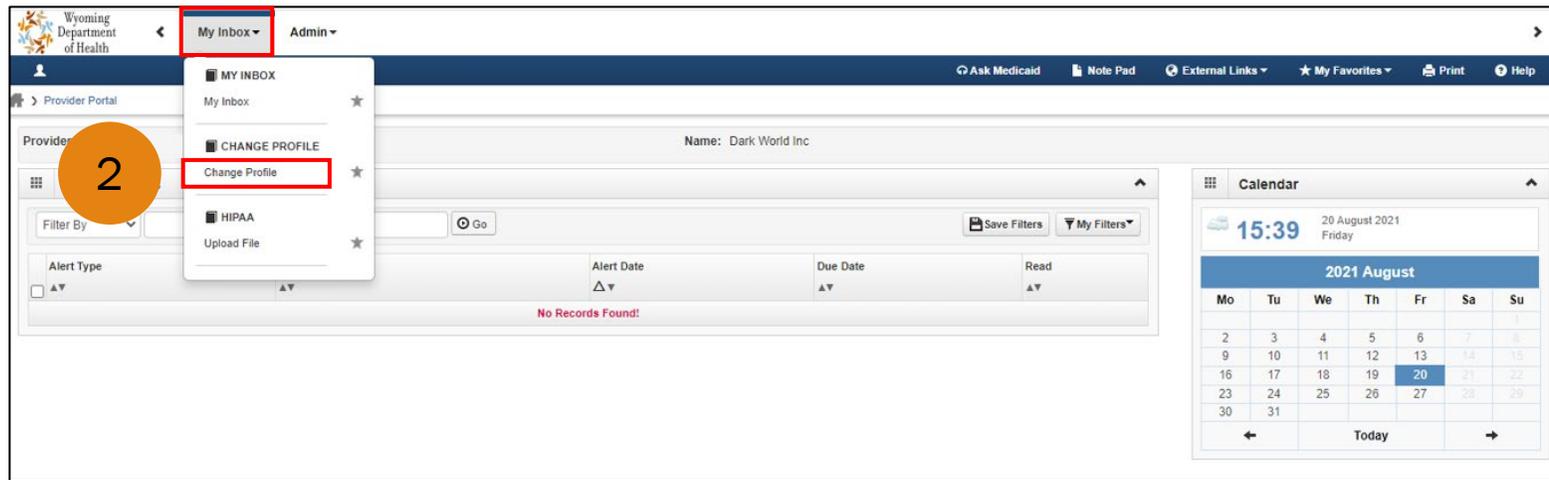
The screenshot shows the Wyoming Department of Health logo and the text "Wyoming Department of Health". Below the logo is a form with three dropdown menus and a button. The first dropdown menu is labeled "Domain" and has a red box around it. The second dropdown menu is labeled "Claims Access" and has a red box around it. The third dropdown menu is labeled "Select Favorite" and has a green box around the "Go" button. The "Go" button is labeled "Click Go".

Next, choose the domain and role:

- Select the applicable domain from the **Domain** drop-down list
- Select **Claims Access** from the **Profile** drop-down list
- Select **Go**

Dental Claims Submission

1

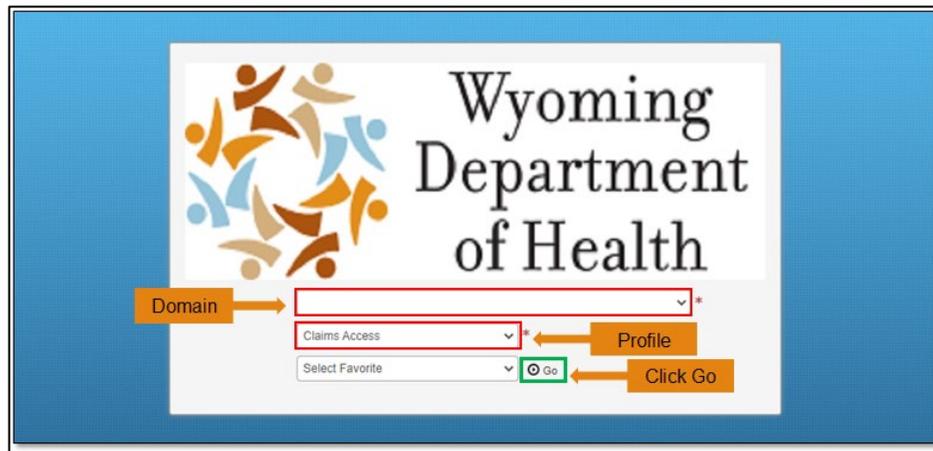


If you are already logged in to the Provider Portal, you can change your profile:

1. Select **My Inbox**.
2. Select **Change Profile**.

Next, choose the domain and role:

- Select the applicable domain from the **Domain** drop-down list
- Select **Claims Access** from the **Profile** drop-down list
- Select **Go**



Dental Claims Submission

1

The screenshot shows the Wyoming Department of Health Provider Portal. The 'Claims' dropdown menu is open, and 'Submit Dental' is highlighted with a red box. A second orange circle with the number '2' is placed over the 'Submit Dental' option. The main content area shows a search for 'Test BACH Test' with 'No Records Found!' displayed. A calendar for August 2021 is visible on the right side of the screen.

To enter Dental Claims in BMS:

1. Select **Claims**.
2. Select **Submit Dental**.

Dental Claims Submission

Note: Asterisks (*) denote required fields.

1 Provider ID: * Type: NPI Taxonomy Code: *

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

County: OTHER *

State/Province: OTHER *

Country: UNITED STATES *

Zip Code: * - * Validate Address

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

Select Validate Address

To enter Dental Claims information, required fields are indicated with an *.

1. Provider ID, National Provider Identifier (NPI), or Provider # is auto-populated. Confirm this is the correct NPI.
2. Enter in all caps the applicable Taxonomy Code associated with Provider.
3. For the address, enter Address Line 1 and Zip Code.
4. Select **Validate Address**.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

Close Submit Claim Save as Template Reset

Dental Claim

Note: Asterisks (*) denote required fields.

Basic Claim Info

Provider Beneficiary Claim Service

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI * Taxonomy Code: *

Address Line 1: 508 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

State/Province: WYOMING *
Country: UNITED STATES *

City/Town: Cheyenne *
County: Laramie *
Zip Code: 82007 * - 1996 Validate Address

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

BMS validates the address information and displays the following message:

“Address validation successful” message is displayed

- If a message displays “International Address,” change the Country to **United States** and re-validate.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

RENDERING PROVIDER

1 2 3

Provider ID: * Type: * Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Middle Initials: Suffix:

Date of Birth: mm dd yyyy * Gender: *

Does the beneficiary have insurance other than Medicaid? Yes No

If the Rendering Provider is not the Billing Provider, enter information as follows:

1. Enter the NPI.
2. Select the type from the **Type** drop-down list—NPI.
3. Enter the Taxonomy Code of Rendering Provider.

If care is a result of a referral, enter referring Provider's information.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

Close Submit Claim Save as Template Reset

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Suffix:

Date of Birth: mm dd yyyy * Gender: *

Does the beneficiary have insurance other than Medicaid? Yes No

Other Insurance

Under Beneficiary Information, required fields are indicated with an *:

1. Enter **Beneficiary ID**. This is the Member's Medicaid ID. These numbers begin with 0600/0800/00000.
2. Enter **First and Last Name, Date of Birth (DOB), and Gender**.
- If other insurance besides Medicaid, select **Yes**.

Dental Claims Submission

The screenshot shows a web form titled "OTHER INSURANCE INFORMATION" with a sub-section "Other Subscriber Information". The form contains several fields, some of which are marked as required with an asterisk (*). Two orange circles with numbers "1" and "2" highlight the "Payer Responsibility Code" and "Payer ID Number" fields, respectively. A red box highlights the "Add Another" button at the bottom right of the form. An orange arrow points from the "Add Another" button to a text box labeled "Add Another".

Does the beneficiary have insurance other than Medicaid? Yes No

1

2

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator:

Remittance Date: mm dd yyyy

Subscriber Member ID:

First Name: [] (State Code): [] Suffix: []

Beneficiary's Relationship:

Total COB Payer Paid Amount:

Add Another

Under **Other Insurance Information** section, required fields are indicated with an *.

1. Select **Primary** from the **Payer Responsibility Code** drop-down list.
2. If the **Payer ID** number is not known, then enter **99999**. There are no system validations for the Payer ID and Group/Policy Number fields.

Complete all required fields indicated with an *.

- To add Secondary Payer Information, select **Add Another**.

Dental Claims Submission

CLAIM DATA

Patient Account No.:	<input type="text"/> *								
Place of Service:	<input type="text"/> *	Appliance Placement Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy				
Service Start Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy	*	Service End Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy	*

1

2

3

Under **Claim Information**, required fields are indicated with an *:

1. Enter the **Patient Account No.** to identify the Member.
2. Select the applicable location from **Place of Service** drop-down list.
3. Enter the **Service Start** and **End Dates**.

Dental Claims Submission

The screenshot shows a web-based form for submitting dental claims. A red box highlights the 'PRIOR AUTHORIZATION/REFERRAL NUMBER' section, which includes the following fields and questions:

- Prior Authorization Number:
- Agency PA: Yes No
- Referral Number:
- DELAY REASON:
- CLAIM NOTE:
- Is this claim accident related? Yes No
- Does this claim have backup documentation? Yes No
- Does this claim require a diagnosis code? Yes No

Below the highlighted section is the 'BASIC LINE ITEM INFORMATION' section, which includes fields for Service Date, Appliance Placement Date, Treatment Start Date, Treatment Completion Date, Place of Service, Area Of Oral Cavity, Tooth Number/Letter, Procedure Code, and Procedure Description.

If your claim requires a Prior Authorization (PA), complete the fields for the PA information:

1. Enter the PA number in the **Prior Authorization Number** field.
2. For **Agency PA**, select **Yes** or **No**.
3. Under the **Claim Note** section, answer the questions as applicable, select **Yes** or **No**.

If the claim has back up documentation, select **Yes**. This suspends the claim for 30 days for processing.

Dental Claims Submission

Does this claim require a diagnosis code? Yes No

DIAGNOSIS

Diagnosis Code Category: ICD-10-CM *

Diagnosis Codes: 1: R059 * 2: F402 3: F487

When answer is **Yes** to “Does this claim require a diagnosis code?”, required fields are indicated with an *:

1. The only option for **Diagnosis Code Category** is **ICD-10-CM**.
2. Enter the applicable codes in the **Diagnosis Codes** fields.

Do not place additional characters (.) when adding information as the system will not recognize the diagnosis code as valid.

For example: Enter F402 instead of F4-02.

When diagnosis codes are added, diagnosis pointers will be needed in Basic Claim Information.

Dental Claims Submission

BASIC SERVICE LINE ITEMS

Service Date: *

Appliance Placement Date:

Treatment Start Date:

Treatment Completion Date:

Place of Service:

Area Of Oral Cavity:

Tooth Number/Letter: Surface: 1: 2: 3: 4: 5: Fees: *

Procedure Code: *

Quantity:

Procedure Description:

Diagnosis Pointers: 1: 2: 3: 4:

Characters Remaining: 80

Prior Authorization Number:

Agency PA: Yes No

Referral Number:

Rendering Provider ID (if different from header):

Type:

Taxonomy Code:

Supervising Provider ID (if different from header):

Type:

Add Service Line Item

Complete the **Basic Service Line-Item** information, required fields are indicated with an *:

1. Enter the service date from in the **Service Date** fields.
2. Enter **Procedure Code, Fees and Units/Quantity**.
 - Place of Service is not needed.
3. Enter **Diagnosis Pointers**.
 - Prior Authorization only needs entered at the header of the claim, unless line specific.
4. Select **Add Service Line Item**.
 - The claim automatically returns to the top of the claim.

Dental Claims Submission

Close Submit Claim Submit Claim

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code: Modifiers: 1: 2: 3: 4:

Service Date: mm dd yyyy
 HCPCS Description:

Last Date of Service: mm dd yyyy
 Characters Remaining:

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

Non-covered Line Charges:

Type:

Type:

Type:

Type:

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

- At the bottom of the Claims page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**
- A pop-up window opens with claim information and the option to attach documents, if needed

Dental Claims Submission

Submitted Claim Details

TCN:	Billing Provider ID:	Beneficiary ID:
Total Number of Lines:	Billing Provider Name:	Beneficiary Name:
Total Claim Charge:	Date of Service:	

Cover Sheet

Please select the document(s) to be mailed/faxed:

<input type="checkbox"/> Hysterectomy Forms	<input type="checkbox"/> Medical Documentation	<input type="checkbox"/> Forms
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Predictive Modeling	<input type="checkbox"/> NDC Drug Dosing and Cost Info
<input type="checkbox"/> Reports	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Voluntary Sterilization Forms
<input type="checkbox"/> EOB Insurance	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Diagnostic Tests
<input type="checkbox"/> Notes		
<input type="checkbox"/> Other <input type="text"/>		

Once the submitted information is validated in BMS, the system displays the Dental **Submitted Claim Details** page.

Dental Claims Attachment

The screenshot shows a web application interface for managing dental claims. At the top, there are 'Print' and 'Help' icons. Below is a section titled 'Submitted Professional Claim Details' with fields for TCN, Billing Provider ID, Beneficiary ID, Total Number of Lines, Billing Provider Name, Beneficiary Name, Total Claim Charge, and Date of Service. The next section is 'Cover Sheet' with a list of document types to be mailed/faxed, including Hysterectomy Forms, History and Physical, Reports, EOB Insurance, Notes, Other, Medical Documentation, Predictive Modeling, Anesthesia Records, Ambulance, Forms, NDC Drug Dosing and Cost Info, Voluntary Sterilization Forms, and Diagnostic Tests. There are 'Generate Coversheet' and 'Reset' buttons. Below this is the 'Additional Documents' section, which has a 'Save' button (circled in red and labeled '2') and a 'Delete' button. A table with columns for Document Type, Document Name, File Name (Size < 30 MB), Remarks, and TCN is shown. The 'File Name' column has a 'Choose File' button with a paper clip icon (circled in red and labeled '1'). A 'Close' button is at the bottom right.

Select the type of electronic document to attach from the options listed or choose a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the paper clip icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Dental Claims with TPL

How to complete the process of entering a Dental Claim with Third Party Liability (TPL)

Dental Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223
 - Within the IVR, say **Report TPL** or **Update insurance** to speak with someone.
- TPL can be direct billed, through a clearing house or from Medicare, if applicable
- An EOB or Explanation of Benefits, is a document that is acquired from a primary insurance that explains what was paid and what reason or adjustment codes were applied to the overall payment

Dental Claims Submission

1

The screenshot shows the Wyoming Department of Health Provider Portal interface. The 'Claims' dropdown menu is open, and the 'Submit Dental' option is highlighted with a red box. A second orange circle with the number '2' is placed over the 'Submit Dental' option. The main content area shows a search for 'Test BACH Test' with 'No Records Found!' displayed. A calendar widget for August 2021 is visible on the right side of the screen.

To enter Dental Claims in BMS:

1. Select **Claims**.
2. Select **Submit Dental**.

Dental Claims Submission

Note: Asterisks (*) denote required fields.

1 Provider ID: * Type: NPI Taxonomy Code: *

2 Taxonomy Code: *

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

County: OTHER *

State/Province: OTHER *

Country: UNITED STATES *

Zip Code: * - * Validate Address

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

To enter Dental Claims information, required fields are indicated with an *.

1. Provider ID, National Provider Identifier (NPI), or Provider # is auto-populated. Confirm this is the correct NPI.
2. Enter in all caps the applicable Taxonomy Code associated with Provider.
3. For the address, enter Address Line 1 and Zip Code.
4. Select **Validate Address**.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

Close Submit Claim Save as Template Reset

Dental Claim

Note: Asterisks (*) denote required fields.

Basic Claim Info

Provider Beneficiary Claim Service

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI Taxonomy Code: *

Address Line 1: 508 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

State/Province: WYOMING *

Country: UNITED STATES *

City/Town: Cheyenne *

County: Laramie *

Zip Code: 82007 * - 1966 Validate Address

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

Address validation successful

BMS validates the address information and displays the following message:

“Address validation successful” message is displayed

- If a message displays “International Address,” change the Country to **United States** and re-validate.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

1 2 3

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Middle Initials: Suffix:

Date of Birth: mm dd yyyy * Gender: *

Does the beneficiary have insurance other than Medicaid? Yes No

If the Rendering Provider is not the Billing Provider, enter information as follows:

1. Enter the NPI.
2. Select the type from the **Type** drop-down list—NPI.
3. Enter the Taxonomy Code of Rendering Provider.

If care is a result of a referral, enter referring Provider's information.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

Close Submit Claim Save as Template Reset

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Suffix:

Date of Birth: mm dd yyyy * Gender: *

Does the beneficiary have insurance other than Medicaid? Yes No

Other Insurance

Under Beneficiary Information, required fields are indicated with an *:

1. Enter **Beneficiary ID**. This is the Member's Medicaid ID. These numbers begin with 0600/0800/00000.
 2. Enter **First and Last Name, Date of Birth (DOB), and Gender**.
- If other insurance besides Medicaid, select **Yes**.

Dental Claims Submission

The screenshot shows a web form titled "OTHER INSURANCE INFORMATION" with a sub-section "Other Subscriber Information". The form contains several fields, some of which are marked as required with an asterisk (*). Two orange circles with numbers 1 and 2 highlight specific fields. A red box highlights the "Add Another" button at the bottom right. An orange arrow points from the "Add Another" button to a label "Add Another" below it.

Does the beneficiary have insurance other than Medicaid? Yes No

1

2

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator: *

Remittance Date: mm dd yyyy

Subscriber Member ID:

First Name: [State Code]: Suffix:

Beneficiary's Relationship:

Total COB Payer Paid Amount: *

Add Another

Under **Other Insurance Information** section, required fields are indicated with an *.

1. Select **Primary** from the **Payer Responsibility Code** drop-down list.
2. If the **Payer ID** number is not known, then enter **99999**. There are no system validations for the Payer ID and Group/Policy Number fields.

Complete all required fields indicated with an *.

- To add Secondary Payer Information, select **Add Another**.

Dental Claims Submission

CLAIM DATA

Patient Account No.:	<input type="text"/> *								
Place of Service:	<input type="text"/> *	Appliance Placement Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy				
Service Start Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy	*	Service End Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy	*

1

2

3

Under **Claim Information**, required fields are indicated with an *:

1. Enter the **Patient Account No.** to identify the Member.
2. Select the applicable location from **Place of Service** drop-down list.
3. Enter the **Service Start and End Dates**.

Dental Claims Submission

The screenshot shows a web-based form for submitting dental claims. A red rectangular box highlights the 'PRIOR AUTHORIZATION/REFERRAL NUMBER' section. This section contains the following fields and options:

- Prior Authorization Number: [Text Input]
- Agency PA: Yes No
- Referral Number: [Text Input]
- DELAY REASON: [Text Input]
- CLAIM NOTE: [Text Input]
- Is this claim accident related? Yes No
- Does this claim have backup documentation? Yes No
- Does this claim require a diagnosis code? Yes No

Below the highlighted section is the 'BASIC LINE ITEM INFORMATION' section, which includes fields for Service Date, Appliance Placement Date, Treatment Start Date, Treatment Completion Date, Place of Service, Area Of Oral Cavity, Tooth Number/Letter, Procedure Code, and Procedure Description.

If your claim requires a Prior Authorization (PA), complete the fields for the PA information:

1. Enter the PA number in the **Prior Authorization Number** field.
2. For **Agency PA**, select **Yes** or **No**.
3. Under the **Claim Note** section, answer the questions as applicable, select **Yes** or **No**.

If the claim has back up documentation, select **Yes**. This suspends the claim for 30 days for processing.

Dental Claims Submission

Does this claim require a diagnosis code? Yes No

DIAGNOSIS

Diagnosis Code Category: ICD-10-CM *

Diagnosis Codes: 1: R059 * 2: F402 3: F487

When answer is **Yes** to “Does this claim require a diagnosis code?”, required fields are indicated with an *.

1. The only option for **Diagnosis Code Category** is **ICD-10-CM**.
2. Enter the applicable codes in the **Diagnosis Codes** fields.

Do not place additional characters (.) when adding information as the system will not recognize the diagnosis code as valid. For example: Enter F402 instead of F4-02.

When diagnosis codes are added, diagnosis pointers will be needed in Basic Claim Information.

Dental Claims Submission

BASIC SERVICE LINE ITEMS

Service Date: *

Appliance Placement Date:

Treatment Start Date:

Treatment Completion Date:

Place of Service:

Area Of Oral Cavity:

Tooth Number/Letter: Surface: 1: 2: 3: 4: 5: Fees: *

Procedure Code: *

Quantity:

Procedure Description:

Diagnosis Pointers: 1: 2: 3: 4:

Characters Remaining: 80

Prior Authorization Number:

Agency PA: Yes No

Referral Number:

Rendering Provider ID (if different from header):

Type:

Taxonomy Code:

Supervising Provider ID (if different from header):

Type:

Add Service Line Item

Complete the **Basic Service Line-Item** information, required fields are indicated with an *:

1. Enter the service date from in the **Service Date** fields.
2. Enter **Procedure Code, Fees and Units/Quantity**.
 - Place of Service is not needed.
3. Enter **Diagnosis Pointers**.
 - Prior Authorization only needs entered at the header of the claim, unless line specific.
4. Select **Add Service Line Item**.
 - The claim automatically returns to the top of the claim.

Dental Claims Submission

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$200.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pointer				Submitted Charges	Units	Prior Auth Number	
	From	To		1	2	3	4	1	2	3	4				
1	03/02/2022	03/02/2022	T2027								200.00	1			Enter Insurance Info Copy Delete

[Enter Insurance Info](#)

At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Insurance Info** to enter the other insurance payments and adjustments.

Dental Claims Submission

The screenshot shows a web form for a "Professional Claim". At the top, there are buttons for "Close", "Basic Claim Form", and "Reset". A red warning message reads: "Warning: Insurance Detail Reason Code(s) is invalid." with a red dashed arrow pointing to the reason code fields. Below the warning, there is a section for "INSURANCE INFORMATION" with a note: "To save the information, Click 'Basic Claim Form' button." and a question: "Does the Beneficiary have insurance other than Medicaid?" with "Yes" selected. Under "OTHER INSURANCE INFORMATION", there is a section for "1. Service Line Other Payer Information". It includes a dropdown for "Primary Payer Responsibility" (1#P#999999#CI-Commercial Insuran), an "Amount Paid" field (\$100.00), and a "Remittance Date" field (mm, dd, yyyy). Below this, there are two rows for "Reason Code": "1.Reason Code: CO45" and "2.Reason Code: PR2". Both reason codes are highlighted in yellow and have red dashed arrows pointing to them. Each row also has an "Amount" field (\$50.00 and \$150.00) and an "Adjustment Quantity" field. There are "Add Another Reason Code" and "Add Another Payer" buttons.

- If you see this error code: “Warning: Insurance Detail Reason Code(s) is Invalid”
- Check to make sure you did not enter the letters of the reason code as shown in the example

Dental Claims Submission

Delta Dental -Sample EOB

Delta Dental
123 Smile St
Cheyenne, Wy
82009

Claim Number: AB-445-24445
Group Name: Delta Dental Plans Assoc
Subscriber: John Wright
Subscriber ID: XXXX5555
Patient: John Wright
Patient DOB: 1/1/1950
Dentist: AJ M. Dentist



TH	SURF	SERVICE Date	Procedure Code	Submitted amount	Approved Amount	Contract Allowed	Delta Dental Payment	Remark Code Amount	Remark Codes
4	M	01/18/2022	D1110	116.00	116.00	116.00	100	16.00	45

For benefit year starting 1/1/2018

\$25.00 of \$25.00 Annual Deductible Met to Date
\$180.80 of \$2,500.00 Annual Maximum Used to Date

Reference Code:

45: Contractual Agreement

Proprietary codes and their descriptions are shown in this sample Explanation of Benefits (EOB), this is used for adjustment reasons.

Dental Claims Submission

The screenshot shows a web form titled "Basic Claim Form" with a "Select Basic Claim Form" button. A note at the top states: "Note: asterisks (*) denote required fields." The form is divided into sections: "INSURANCE INFORMATION" and "OTHER INSURANCE INFORMATION".

1 (Callout 1) points to the question: "Does the Beneficiary have insurance other than Medicaid?" with radio buttons for "Yes" (selected) and "No".

2 (Callout 2) points to the "Primary Payer Responsibility" dropdown menu, which is currently set to "1#P#99999#CI-Commercial Insuran".

3 (Callout 3) points to the "Amount Paid" field, which contains "\$100.00".

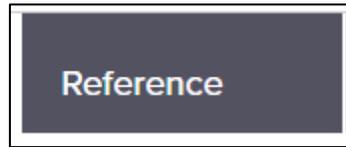
4 (Callout 4) points to the "Add Another Payer" button at the bottom left.

Below the primary payer information, there are two rows for "Reason Code" and "Amount". The first row has "1.Reason Code" set to "45" and "Amount" set to "\$16.00". There are also "Adjustment Quantity" fields and an "Add Another Reason Code" button.

If the Beneficiary has insurance other than Medicaid:

1. Select **Yes**.
2. **Primary Payer Responsibility** auto-populates.
3. Enter total **Amount Paid** from primary payer.
4. Enter all proprietary reason codes from the EOB in the **Reason Code** fields.
 - When finished, select **Basic Claim Form**.

Dental Claims Submission



1



2

Adjustment codes must be proprietary and not from the commercial insurance. Go to x12.org

Filter by code:

Filter codes by status:

1	Deductible Amount <small>Start: 01/01/1995</small>
2	Coinsurance Amount <small>Start: 01/01/1995</small>
3	Co-payment Amount <small>Start: 01/01/1995</small>
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2020</small>
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2018</small>
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>

3

1. Go to **Reference**, in the top right-hand corner.
2. Go to **Claim Adjustment Reason Codes**.
3. Scroll down to the proprietary code list and select a remark code that most accurately compares to the commercial code.
4. Enter this for the **Reason Code** on the other insurance form.

Dental Claims Submission

Close Submit Claim **Submit Claim**

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code: Modifiers: 1: 2: 3: 4:

Service Date: mm dd yyyy
 HCPCS Description:

Last Date of Service: mm dd yyyy
 Characters Remaining: 80

Service Units: *

Total Line Charges: *

Non-covered Line Charges:

Operating Physician ID: (If different from header):

Type:

Other Operating Physician ID: (If different from header):

Type:

Rendering Physician ID: (If different from header):

Type:

Referring Physician ID: (If different from header):

Type:

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**
- A pop-up window opens with claim information and the option to attach documents if needed

Dental Claims Submission

Submitted Claim Details

TCN:	Billing Provider ID:	Beneficiary ID:
Total Number of Lines:	Billing Provider Name:	Beneficiary Name:
Total Claim Charge:	Date of Service:	

Cover Sheet

Please select the document(s) to be mailed/faxed:

<input type="checkbox"/> Hysterectomy Forms	<input type="checkbox"/> Medical Documentation	<input type="checkbox"/> Forms
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Predictive Modeling	<input type="checkbox"/> NDC Drug Dosing and Cost Info
<input type="checkbox"/> Reports	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Voluntary Sterilization Forms
<input type="checkbox"/> EOB Insurance	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Diagnostic Tests
<input type="checkbox"/> Notes		
<input type="checkbox"/> Other <input type="text"/>		

Once the submitted information is validated in BMS, the system displays the Dental **Submitted Claim Details** page.

Dental Claims Attachment

Print Help

Submitted Professional Claim Details

TCN: Billing Provider ID: Beneficiary ID:
Total Number of Lines: Billing Provider Name: Beneficiary Name:
Total Claim Charge: Date of Service:

Cover Sheet

Please select the document(s) to be mailed/faxed:

- Hysterectomy Forms
- History and Physical
- Reports
- EOB Insurance
- Notes
- Other
- Medical Documentation
- Predictive Modeling
- Anesthesia Records
- Ambulance
- Forms
- NDC Drug Dosing and Cost Info
- Voluntary Sterilization Forms
- Diagnostic Tests

Generate Coversheet Reset

Additional Documents

Save Delete

Document Type *	Document Name *	File Name * (Size < 30 MB)	Remarks	TCN
--Select--	--Select--	Choose File	<input type="text"/>	

Close

Select the type of electronic document to attach from the options listed or choose a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the paper clip icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Dental Claims Tertiary Claim

How to bill a Tertiary Claim

Dental Claims Submission

- TPL (Third-Party Liability) is: Other insurance, other health insurance, other medical coverage, or other insurance coverage
- Medicare, Medicare replacement, Medicare supplemental plans, commercial companies like Blue Cross Blue Shield or Cigna, Disability and Workman's comp are all examples of TPL.
- HMS is our TPL vendor and can be reached at 1-888-996-6223
 - Within the IVR say Report TPL or Update insurance to speak with someone.
- TPL can be direct billed, through a clearing house or from Medicare, if applicable
- An EOB or Explanation of Benefits, is a document that is acquired from a primary insurance that explains what was paid and what reason or adjustment codes were applied to the overall payment

Dental Claims Submission

1

The screenshot shows the Wyoming Department of Health Provider Portal. The 'Claims' dropdown menu is open, and 'Submit Dental' is highlighted with a red box. A second orange circle with the number '2' is placed over the 'Submit Dental' option. The main content area shows a search for 'Test BACH Test' with 'No Records Found!' displayed. A calendar for August 2021 is visible on the right side of the screen.

To enter Dental Claims in BMS:

1. Select **Claims**.
2. Select **Submit Dental**.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

Close Submit Claim Save as Template Reset

Dental Claim

Note: Asterisks (*) denote required fields.

Basic Claim Information

Provider | Beneficiary

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI Taxonomy Code: *

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER *

County: OTHER *

State/Province: OTHER *

Country: UNITED STATES *

Zip Code: * - * Validate Address

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

To enter Dental Claims information, required fields are indicated with an *.

1. Provider ID, National Provider Identifier (NPI), or Provider # is auto-populated. Confirm this is the correct NPI.
2. Enter in all caps the applicable Taxonomy Code associated with Provider.
3. For the address, enter Address Line 1 and Zip Code.
4. Select **Validate Address**.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

Close Submit Claim Save as Template Reset

Dental Claim

Note: Asterisks (*) denote required fields.

Basic Claim Info

Provider Beneficiary Claim Service

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: NPI * Taxonomy Code: *

Address Line 1: 508 Livingston Ave *
(Enter Street Address or PO Box Only)

Address Line 2: *

Address Line 3: *

State/Province: WYOMING *

City/Town: Cheyenne *

County: Laramie *

Country: UNITED STATES *

Zip Code: 82007 * - 1996 Validate Address

Address validation successful

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code: *

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

BMS validates the address information and displays the following message:

“Address validation successful” message is displayed

- If a message displays “International Address,” change the Country to **United States** and re-validate.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Ask Medicaid Note Pad External Links My Favorites Print Help

Provider Portal Submit Dental Claim

Close Save as Template

Is this service the result of a referral? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Primary Care Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Middle Initial: Suffix:

Date of Birth: mm dd yyyy * Gender: *

Does the beneficiary have insurance other than Medicaid? Yes No

If the Rendering Provider is not the Billing Provider, enter information as follows:

1. Enter the NPI.
2. Select the type from the **Type** drop-down list—NPI.
3. Enter the Taxonomy Code of Rendering Provider.

If care is a result of a referral, enter referring Provider's information.

Dental Claims Submission

Wyoming Department of Health

My Inbox Claims

Provider Portal Submit Dental Claim

Close Submit Claim Save as Template Reset

Is the Billing Provider also the Rendering Provider? Yes No

RENDERING PROVIDER

Provider ID: * Type: * Taxonomy Code:

Is the Billing Provider also the Supervising Provider? Yes No

Is this service the result of a referral? Yes No

Is this service the result of a Referral? Yes No

BENEFICIARY INFORMATION

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Suffix:

Date of Birth: mm dd yyyy * Gender: *

Does the beneficiary have insurance other than Medicaid? Yes No

Other Insurance

Under Beneficiary Information, required fields are indicated with an *:

1. Enter **Beneficiary ID**. This is the Member's Medicaid ID. These numbers begin with 0600/0800/00000.
2. Enter **First and Last Name, Date of Birth (DOB), and Gender**.
- If other insurance besides Medicaid, select **Yes**.

Dental Claims Submission

The screenshot shows a web form titled "OTHER INSURANCE INFORMATION" with a sub-section "Other Subscriber Information". The form contains several fields, some of which are marked as required with an asterisk (*). Two orange circles with numbers 1 and 2 highlight the "Payer Responsibility Code" and "Payer ID Number" fields, respectively. A red box highlights the "Add Another" button at the bottom right of the form. An orange arrow points from the "Add Another" button to a text box labeled "Add Another".

Does the beneficiary have insurance other than Medicaid? Yes No

1

2

OTHER INSURANCE INFORMATION

Other Subscriber Information

Payer Responsibility Code: *

Payer ID Number: *

Subscriber Last Name:

Insured's Group or Policy Number: *

Claim Filing Indicator:

Remittance Date: mm dd yyyy

Subscriber Member ID:

First Name: [] (State Code): [] Suffix: []

Beneficiary's Relationship:

Total COB Payer Paid Amount:

Add Another

Under **Other Insurance Information** section, required fields are indicated with an *.

1. Select **Primary** from the **Payer Responsibility Code** drop-down list.
2. If the **Payer ID** number is not known, then enter **99999**. There are no system validations for the Payer ID and Group/Policy Number fields.

Complete all required fields indicated with an *.

- To add Secondary Payer Information, select **Add Another**.

Dental Claims Submission

CLAIM DATA

Patient Account No.:	<input type="text"/> *						
Place of Service:	<input type="text"/> *	Appliance Placement Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy		
Service Start Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy *	Service End Date:	<input type="text"/> mm	<input type="text"/> dd	<input type="text"/> yyyy *

Under **Claim Information**, required fields are indicated with an *:

1. Enter the **Patient Account No.** to identify the Member.
2. Select the applicable location from **Place of Service** drop-down list.
3. Enter the **Service Start** and **End Dates**.

Dental Claims Submission

PRIOR AUTHORIZATION/REFERRAL NUMBER

Prior Authorization Number: Agency PA: Yes No Referral Number:

DELAY REASON

CLAIM NOTE

Is this claim accident related? Yes No

Does this claim have backup documentation? Yes No

Does this claim require a diagnosis code? Yes No

BASIC LINE ITEM INFORMATION

Click on Insurance Info to enter each Line's Insurance Information.

BASIC SERVICE LINE ITEMS

Service Date: / / Appliance Placement Date: / /

Treatment Start Date: / / Treatment Completion Date: / /

Place of Service:

Area Of Oral Cavity:

Tooth Number/Letter: Surface: 1: 2: 3: 4: 5: Fee:

Procedure Code: Quantity:

Procedure Description:

If your claim requires a Prior Authorization (PA), complete the fields for the PA information:

1. Enter the PA number in the **Prior Authorization Number** field.
2. For **Agency PA**, select **Yes** or **No**.
3. Under the **Claim Note** section, answer the questions as applicable, select **Yes** or **No**.

If the claim has back up documentation, select **Yes**. This suspends the claim for 30 days for processing.

Dental Claims Submission

Does this claim require a diagnosis code? Yes No

DIAGNOSIS

Diagnosis Code Category: ICD-10-CM *

Diagnosis Codes: 1: R059 * 2: F402 3: F487

When answer is **Yes** to “Does this claim require a diagnosis code?”, required fields are indicated with an *:

1. The only option for **Diagnosis Code Category** is **ICD-10-CM**.
2. Enter the applicable codes in the **Diagnosis Codes** fields.

Do not place additional characters (.) when adding information as the system will not recognize the diagnosis code as valid.

For example: Enter F402 instead of F4-02.

When diagnosis codes are added, diagnosis pointers will be needed in Basic Claim Information.

Dental Claims Submission

BASIC SERVICE LINE ITEMS

Service Date: *

Appliance Placement Date:

Treatment Start Date:

Treatment Completion Date:

Place of Service:

Area Of Oral Cavity:

Tooth Number/Letter: Surface: 1: 2: 3: 4: 5: Fees: *

Procedure Code: *

Quantity:

Procedure Description:

Diagnosis Pointers: 1: 2: 3: 4:

Characters Remaining: 80

Prior Authorization Number:

Agency PA: Yes No

Referral Number:

Rendering Provider ID (if different from header):

Type:

Taxonomy Code:

Supervising Provider ID (if different from header):

Type:

Add Service Line Item

Complete the **Basic Service Line-Item** information, required fields are indicated with an *:

1. Enter the service date from in the **Service Date** fields.
2. Enter **Procedure Code, Fees and Units/Quantity.**
 - Place of Service is not needed.
3. Enter **Diagnosis Pointers.**
 - Prior Authorization only needs entered at the header of the claim, unless line specific.
4. Select **Add Service Line Item.**
 - The claim automatically returns to the top of the claim.

Dental Claims Submission

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$500.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pointer				Submitted Charges	Units	Prior Auth Number	Insurance Info	Copy	Delete
	From	To		1	2	3	4	1	2	3	4						
1	09/15/2021	09/15/2021	93799					1				500.00	1		Insurance Info	Copy	Delete

Top

At the bottom of the **Claims** page, enter each Claim Line's insurance information:

1. Select **Insurance Info** to enter the other insurance payments and adjustments.

Dental Claims Submission

The screenshot shows a web form for a 'Basic Claim Form'. At the top, there are buttons for 'Close', 'Basic Claim Form', and 'Reset'. A red warning message reads: 'Warning: Insurance Detail Reason Code(s) is invalid.' with a red dashed arrow pointing to the reason code fields. Below the warning, the form is titled 'Professional Claim' and includes a note: 'Note: asterisks (*) denote required fields.' The 'INSURANCE INFORMATION' section contains a question: 'Does the Beneficiary have insurance other than Medicaid?' with 'Yes' selected. The 'OTHER INSURANCE INFORMATION' section is titled '1. Service Line Other Payer Information' and contains the following fields:

Field	Value	Notes
Primary Payer Responsibility:	1#P#999999#CI-Commercial Insuran	*
Amount Paid:	\$100.00	*
Remittance Date:	mm dd yyyy	
1.Reason Code:	CO45	Highlighted in yellow with a red dashed arrow pointing to it.
Amount:	\$50.00	
Adjustment Quantity:		
2.Reason Code:	PR2	Highlighted in yellow with a red dashed arrow pointing to it.
Amount:	\$150.00	
Adjustment Quantity:		

Buttons for 'Add Another Reason Code' and 'Add Another Payer' are also visible.

- If you see this error code: “Warning: Insurance Detail Reason Code(s) is Invalid”
- Check to make sure you did not enter the letters of the reason code as shown in the example

Dental Claims Submission

This is an example of what two Explanation of Benefits (EOB) will look like and how you will bill for a Tertiary Claim.

Delta Dental -Sample EOB

Delta Dental
123 Smile St
Cheyenne, Wy
82009

Claim Number:	AB-445-24445
Group Name:	Delta Dental Plans Assoc
Subscriber:	John Wright
Subscriber ID:	XXXX5555
Patient:	John Wright
Patient DOB:	1/1/1950
Dentist:	AJ M. Dentist

TH	SURF	SERVICE Date	Procedure Code	Submitted amount	Approved Amount	Contract Allowed	Delta Dental Payment	Remark Code Amount	Remark Codes
4	M	01/18/2022	D1110	116.00	116.00	116.00	100	16.00	45

For benefit year starting 1/1/2018
 \$25.00 of \$25.00 Annual Deductible Met to Date
 \$180.80 of \$2,500.00 Annual Maximum Used to Date

Reference Code:
45: Contractual Agreement

Other Insurance Co- Example

Dr. Dentist
123 Smile St
Cheyenne, Wy
82009

BILLED CHARGES	ALLOWED AMOUNT	PROVIDER ADJUSTMENT / DISALLOWED	OTHER INSURANCE ADJUSTMENT	PATIENT LIABILITY	PAYABLE AMOUNT
\$474.00	\$82.89	\$391.11	\$0.00	\$0.00	\$82.89
				LESS PAID TO CODES LISTED AS "S" OR "C"	\$0.00
				TOTAL RECOVERED THIS PAYMENT CYCLE	\$0.00
				TOTAL PAYABLE	\$82.89

Reference Code:
23: Other Paid amount

Dental Claims Submission

The screenshot shows the 'Dental Claim' submission screen. At the top, there is a 'Close' button and a 'Basic Claim Form' button. Below this is a header 'Dental Claim' and a note: 'Note: asterisks (*) denote required fields.' The main section is titled 'INSURANCE INFORMATION' and contains a question: 'Does the Beneficiary have insurance other than Medicaid?' with 'Yes' selected. Below this is the 'OTHER INSURANCE INFORMATION' section, which is divided into two parts: '1. Service Line Other Payer Information' and '2. Service Line Other Payer Information'. Each part contains fields for 'Primary Payer Responsibility', 'Amount Paid', 'Remittance Date', and 'Reason Code'. In the first service line, the 'Amount Paid' is \$0.00 (annotated with a red box and a '1' in an orange circle), and there are two reason codes: 45 (annotated with a red box and a '2' in an orange circle) and 2. The 'Add Another Reason Code' button is also annotated with a red box and a '3' in an orange circle. In the second service line, the 'Amount Paid' is \$50.00, and there are two reason codes: 3 and 1. The 'Add Another Reason Code' button is also present in the second service line.

Upon opening this screen, select **Yes** for “Other Insurance information”

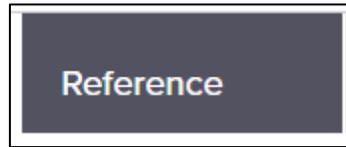
- The Primary Payer Responsibility auto-populates

1. Enter **Amount Paid**.
2. Enter all reason codes in the **Reason Code** fields.
3. To add more than one reason code, select **Add Another Reason Code**.

- When finished, select **Basic Claim Form**.

You will want your Total Paid plus your total Adjustments to equal the total paid for Medicaid. This is how your primary insurance will balance.

Dental Claims Submission



1



2

Adjustment codes must be proprietary and not from the commercial insurance. Go to x12.org

Filter by code:

Filter codes by status:

1	Deductible Amount <small>Start: 01/01/1995</small>
2	Coinsurance Amount <small>Start: 01/01/1995</small>
3	Co-payment Amount <small>Start: 01/01/1995</small>
4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2020</small>
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 03/01/2018</small>
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
7	The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
10	The diagnosis is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
11	The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>
12	The diagnosis is inconsistent with the provider type. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. <small>Start: 01/01/1995 Last Modified: 07/01/2017</small>

3

1. Go to **Reference**, in the top right-hand corner.
2. Go to **Claim Adjustment Reason Codes**.
3. Scroll down to the proprietary code list and select a remark code that most accurately compares to the commercial code.
4. Enter this for the **Reason Code** on the other insurance form.

Dental Claims Submission

Close Submit Claim **Submit Claim**

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code: Modifiers: 1: 2: 3: 4:

Service Date: mm dd yyyy

HCPCS Description:

Last Date of Service: mm dd yyyy

Characters Remaining: 80

Service Units: *

Total Line Charges: *

Non-covered Line Charges:

Operating Physician ID: (If different from header):

Type:

Other Operating Physician ID: (If different from header):

Type:

Rendering Physician ID: (If different from header):

Type:

Referring Physician ID: (If different from header):

Type:

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$0.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges
			1	2	3	4	Service Date	Last DOS			

- At the bottom of the **Claims** page, Service Line items must be entered before Claim Submission
- After all lines of the claim are entered at the bottom of the claim submission form, if no primary insurance is being billed, select **Submit Claim**
- A pop-up window opens with claim information and the option to attach documents if needed

Dental Claims Submission

Submitted Claim Details

TCN:	Billing Provider ID:	Beneficiary ID:
Total Number of Lines:	Billing Provider Name:	Beneficiary Name:
Total Claim Charge:	Date of Service:	

Cover Sheet

Please select the document(s) to be mailed/faxed:

<input type="checkbox"/> Hysterectomy Forms	<input type="checkbox"/> Medical Documentation	<input type="checkbox"/> Forms
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Predictive Modeling	<input type="checkbox"/> NDC Drug Dosing and Cost Info
<input type="checkbox"/> Reports	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Voluntary Sterilization Forms
<input type="checkbox"/> EOB Insurance	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Diagnostic Tests
<input type="checkbox"/> Notes		
<input type="checkbox"/> Other <input type="text"/>		

Once the submitted information is validated in BMS, the system displays the Dental **Submitted Claim Details** page.

Dental Claims Attachment

The screenshot shows a web application interface for managing dental claims. At the top, there are 'Print' and 'Help' icons. Below is a section titled 'Submitted Professional Claim Details' with fields for TCN, Billing Provider ID, Beneficiary ID, Total Number of Lines, Billing Provider Name, Beneficiary Name, Total Claim Charge, and Date of Service. The next section is 'Cover Sheet' with a list of document types to be mailed/faxed, each with a checkbox: Hysterectomy Forms, History and Physical, Reports, EOB Insurance, Notes, Other, Medical Documentation, Predictive Modeling, Anesthesia Records, Ambulance, Forms, NDC Drug Dosing and Cost Info, Voluntary Sterilization Forms, and Diagnostic Tests. There are 'Generate Coversheet' and 'Reset' buttons. Below this is the 'Additional Documents' section, which has a 'Save' button (circled in red) and a 'Delete' button. A table below the 'Save' button has columns for Document Type, Document Name, File Name (Size < 30 MB), Remarks, and TCN. The 'File Name' column has a 'Choose File' button with a paperclip icon (circled in red). A 'Close' button is at the bottom right.

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Select the type of electronic document to attach from the options listed or choose a file from your computer:

Documents size is limited to 25 pages per attachment.

1. Select the paper clip icon, then search for and select a file to upload from your computer.
2. Select **Save** to save the file. A message displays “File Uploaded Successfully”.

Repeat these steps if you have multiple documents to attach to a claim.

Course Review

- Dental Claim Overview
- Dental Claim Submissions
- Dental Claims with Third Party Liability (TPL)
- Dental Claim Tertiary Claim
- Dental Claim Attachments





Wyoming
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Thank you

Claim Submission