



DELAWARE HEALTH  
AND SOCIAL SERVICES

DIVISION OF MEDICAID &  
MEDICAL ASSISTANCE

Delaware Medical Assistance Program



## How to: Submit a Dental Claim with Third-Party Liability (TPL) on the Portal

**Please Note:** This document contains fictitious information and does not contain protected health information (PHI) or personally identifiable information (PII) data.

**INTRODUCTION:** This user guide provides the steps required to submit a dental claim with TPL on the Portal: [Log-in Steps](#), [Submit Claim Dental – Enter Claim Header Information](#), [Submit Claim Dental – Diagnosis and Primary Insurance \[HEADER\]](#) and [Submit Claim Dental – Service Details, Add Insurance and Add Attachment\(s\)](#).

### Need Assistance?

**Call Us:** Provider Relations at **1-800-999-3371**; Option **0**, then Option **4**.

**Message Us:** Secure Correspondence: Log in to the [Provider Portal](#).

**Email\* Us:** [delawarepret@gainwelltechnologies.com](mailto:delawarepret@gainwelltechnologies.com) – \*Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.

### Log-in Steps

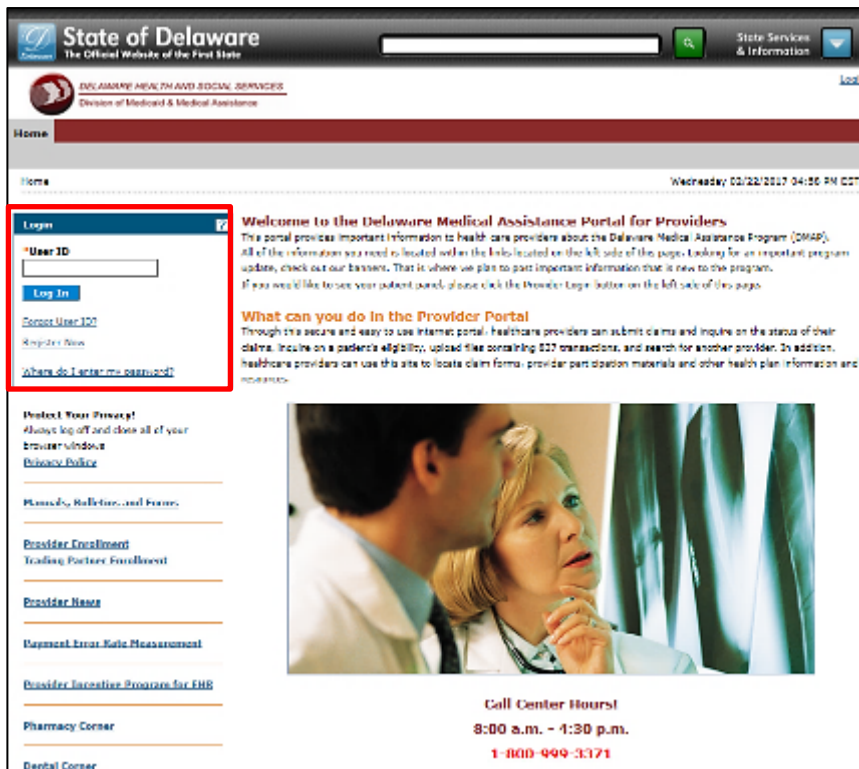
1. Go to the Delaware Medical Assistance Portal: <https://medicaid.dhss.delaware.gov/>.

## Log-in Steps

2. Click [Click here](#) to enter the Provider Portal.



3. Log in to the Provider Portal by entering the User ID, Challenge Question, and Password.



**Reminder:** Some providers may have more than one User ID. To submit a dental claim with third-party liability, please log in the Portal using the **Billing Provider User ID**.

## Submit Claim Dental – Enter Claim Header Information

1. On the Home page, hover over the Claims tab and click on the Submit Claim Dental link.

The screenshot shows the State of Delaware Health and Social Services portal. The 'Claims' tab is selected, and the 'Submit Claim Dental' link is highlighted. The page displays user details for 'KINGSTON DENTAL' and a 'Billing Provider ID' field.

**State of Delaware**  
The Official Website of the First State

**DELAWARE HEALTH AND SOCIAL SERVICES**  
Division of Medicaid & Medical Assistance

**My Home** | **Eligibility** | **Claims** | **Care Management** | **Patient Health History** | **Files Exchange** | **Resources**

Search Claims: **Submit Claim Dental** | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History

My Home Thursday 04/06/2017 01:37 PM EST

**Provider Name** KINGSTON DENTAL | **Role IDs** Provider - In Network - NP | **Location** - KINGSTON DENTAL | **Taxonomy** 122300000X-Dentist

**User Details**  
Welcome Kingston dental  
My Profile | Manage Accounts

**Provider**  
Name KINGSTON DENTAL  
Provider ID (NPI) | Location ID  
Characteristics | Enrollment

**Provider Services**  
Member Focused Viewing | Search Payment History | Associated Providers | Search Documents

Delaware.gov | Privacy | Contact | Phone Directory

The Billing Provider ID displays.

**Submit Dental Claim: Step 1** ?

\* Indicates a required field.

**Provider Information**

General Provider Header Instructions

|  |                    |                             |
|--|--------------------|-----------------------------|
| <b>Billing Provider ID</b>                               | <b>ID Type</b> NPI | <b>Name</b> KINGSTON DENTAL |
| <b>Taxonomy</b> 122300000X-Dentist                       |                    |                             |
| <b>Performing Provider ID</b> <input type="text"/>       | <b>ID Type</b> NPI | <b>Name</b> _               |
| <b>Taxonomy</b> _  |                    |                             |
| <b>Service Facility Location ID</b> <input type="text"/> | <b>ID Type</b> NPI | <b>Name</b> _               |
| <b>Taxonomy</b> _  |                    |                             |

## Submit Claim Dental – Enter Claim Header Information

2. Add the Performing Provider ID and the Service Facility Location ID, as applicable.  
Add a provider by entering the NPI and pressing the Tab key. If the Provider has more than one Taxonomy, select the appropriate taxonomy.

|                              |   |         |      |      |    |
|------------------------------|---|---------|------|------|----|
| Performing Provider ID       | 5123456787  | ID Type | NPI  | Name | HP |
| *Taxonomy                    | 20800000X-Pediatrics  |         |      |      |    |
| Service Facility Location ID | 261QF0400X-Clinic/Center - Federally Qualified Health Center (FQHC) |         | Name |      |    |
| Taxonomy                     | 302R00000X-Health Maintenance Organization                          |         | -    |      |    |

OR

Search for the provider by NPI or Name by clicking the magnifying glass icon.

**Provider ID Search** Back to Claim ?

Search By ID | Search By Name | Search By Organization

\* Indicates a required field.

\*Provider ID  Provider ID Type NPI

Taxonomy ~

3. Enter member's 10-digit ID, press the tab key; the member information auto-populates.

**Patient Information**

General Patient Instructions

\*Member ID

Last Name  First Name

Birth Date

Address

Address Line 2

City

State  Zip Code

4. Enter Header Claim Information and click the Include Other Insurance check box.

**Claim Information**

Accident Related  Accident Date

\*Place of Treatment  11-Office

Patient Number

Initial X-Ray/Photo Date

\*Does the provider have a signature on file?  Yes  No

\*Does the provider accept assignment for claim processing?  Yes  No

\*Are benefits assigned to the provider by the patient or their authorized representative?  Yes  No  N/A

\*Does the provider have a signed statement from the patient releasing their medical information?  Yes  No

**Include Other Insurance**

Total Charged Amount \$0.00

## Submit Claim Dental – *Diagnosis and Primary Insurance*

5. Adding a Diagnosis is optional. To skip entering a diagnosis, continue to Other Insurance Details.
- To add a diagnosis, select Diagnosis Type. Type in Diagnosis Code, select appropriate code from drop-down box, then click Add.

**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

| # | Diagnosis Type | Diagnosis Code        | Action |
|---|----------------|-----------------------|--------|
| 1 | ICD-10-CM      | K050-ACUTE GINGIVITIS | Remove |

1 \*Diagnosis Type ICD-10-CM \*Diagnosis Code gingi

Add Reset

**Other Insurance Details**

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

The diagnosis is displayed. **The first diagnosis entered is considered the primary Diagnosis Code.**

**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

| # | Diagnosis Type | Diagnosis Code        | Action |
|---|----------------|-----------------------|--------|
| 1 | ICD-10-CM      | K050-ACUTE GINGIVITIS | Remove |
| 2 | ICD-10-CM      |                       |        |

2 \*Diagnosis Type ICD-10-CM \*Diagnosis Code

Add Reset

**Tip:** Click the Remove link, under Action, to remove a row.

6. If the State has **primary insurance on file for the member**, the Other Insurance Details pre-populate, as shown below.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

| # | Carrier Name  | Carrier Code | Group #   | COB Payer Paid Amount | Remittance Date | Action |
|---|---------------|--------------|-----------|-----------------------|-----------------|--------|
| 1 | HIGHMARK BCBS | A51          | 123456789 | \$50.00               | 01/01/2017      | Remove |

Click to add a new other insurance.

[Back to Step 1](#) [Continue](#) [Cancel](#)

To expand the existing insurance, click the number on the row. Fill in all **RED \* required**

## Submit Claim Dental – *Diagnosis and Primary Insurance*

fields, as well as any applicable fields.

**Tip:** Click the Remove link, under Action, to remove a row.

**Tip:** To add a new other insurance, click the +.

| # | Carrier Name  | Carrier Code | Group #   | COB Payer Paid Amount | Remittance Date | Action                 |
|---|---------------|--------------|-----------|-----------------------|-----------------|------------------------|
| 1 | HIGHMARK BCBS | A51          | 123456789 | \$50.00               | 01/01/2017      | <a href="#">Remove</a> |

|                             |  |                             |   |
|-----------------------------|--|-----------------------------|---|
| Carrier Name                | <input type="text" value="HIGHMARK BCBS"/>             | Carrier Code                | <input type="text" value="A51"/>        |
| *Subscriber Last Name       | <input type="text" value="JONES"/>                     | *First Name                 | <input type="text" value="JOE"/>        |
| Subscriber Address          | <input type="text"/>                                   |                             |   |
| City                        | <input type="text"/>                                   | State                       | <input type="text"/>                    |
| Zip Code                    | <input type="text"/>                                   | Country                     | <input type="text"/>                    |
| *Subscriber ID              | <input type="text" value="ABC123DEF"/>                 | *Group #                    | <input type="text" value="123456789"/>  |
| Group Name                  | <input type="text"/>                                   |                             |   |
| Insurance Type              | <input type="text"/>                                   |                             |   |
| *Payer Responsibility       | <input type="text" value="P-Primary"/>                 | *Relationship to Subscriber | <input type="text" value="18-Self"/>    |
| COB Payer Paid Amount       | <input type="text" value="50.00"/>                     | *Remittance Date            | <input type="text" value="01/01/2017"/> |
| Remaining Patient Liability | <input type="text"/>                                   |                             |   |
| Total Non-Covered Amount    | <input type="text"/>                                   |                             |   |
| *Claim Filing Indicator     | <input type="text" value="BL-Blue Cross/Blue Shield"/> |                             |   |
| Release of Information      | <input type="text"/>                                   |                             |   |
| Assignment of Benefits      | <input type="text"/>                                   |                             |   |

### Outpatient Adjudication Information

|                           |                      |   |                      |
|---------------------------|----------------------|---|----------------------|
| Reimbursement Rate        | <input type="text"/> | Claim HCPCS Payable Amount                | <input type="text"/> |
| Remark Code 1             | <input type="text"/> | Non-payable Professional Component Amount | <input type="text"/> |
| Remark Code 2             | <input type="text"/> |   |                      |
| Remark Code 3             | <input type="text"/> |   |                      |
| Remark Code 4             | <input type="text"/> |   |                      |
| Remark Code 5             | <input type="text"/> |   |                      |
| Claim ESRD Payment Amount | <input type="text"/> |   |                      |

### Other Insurance Reasons

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

| #  | Group Code  | Reason                            | Amount           | Units of Service     | Action |
|--|-------------|-----------------------------------|------------------|----------------------|--------|
| <input type="checkbox"/> Click to collapse.  |             |                                   |                  |                      |        |
|  | *Group Code | <input type="text"/>              | *Reason          | <input type="text"/> |        |
|  | *Amount     | <input type="text" value="0.00"/> | Units of Service | <input type="text"/> |        |
| <input type="button" value="Add Reason"/> <input type="button" value="Cancel Reason"/> |             |                                   |                  |                      |        |

**Tip:** Choose the most appropriate Claim Filing Indicator available in the drop-down for the type of Primary Insurance being used.

## Submit Claim Dental – *Diagnosis and Primary Insurance*

**Tip:** Do not add Other Insurance Reasons at this time. Other Insurance Reasons will be added in the Service Detail section in Step 3 in the Portal.

Click Save Insurance.

Click Continue to go to Submit Dental Claim: Step 3.

## Submit Claim Dental – *Service Details, Add Insurance and Add Attachment(s)*

7. Enter the Service Details on Svc # 1 (Service Line Number 1). Fill in all **RED \* required fields**, as well as any applicable fields.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Svc Date | Oral Cavity Area | Tooth#/Letter | Procedure Code | Units | Charge Amount | Action |
|-------|----------|------------------|---------------|----------------|-------|---------------|--------|
| 1     |          |                  |               |                |       |               |        |

1 \*Svc Date  Oral Cavity Area  Tooth#/Letter

Tooth Surface

\*Procedure Code  Modifiers

\*Units  \*Charge Amount  Diagnosis

Performing Provider ID  ID Type  Taxonomy

Click Add.

8. Click the Service # to open the Other Insurance Details for the Service Detail.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Svc Date   | Oral Cavity Area | Tooth#/Letter              | Procedure Code | Units | Charge Amount | Action  |
|-------|------------|------------------|----------------------------|----------------|-------|---------------|---|
| 1     | 12/01/2016 |                  | 19-1st Molar -LL-Permanent | D2391          | 1     | \$192.00      | <a href="#" style="color: red; text-decoration: none;">Remove</a> |
| 2     |            |                  |                            |                |       |               |   |

2 \*Svc Date  Oral Cavity Area  Tooth#/Letter

Tooth Surface

\*Procedure Code  Modifiers

\*Units  \*Charge Amount  Diagnosis

Performing Provider ID  ID Type  Taxonomy

Fill in the **RED \* required fields**, as well as any applicable fields.

**Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)**

**Other Insurance Details for Svc. # 1**

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

| #   | Carrier Code | Procedure Code | Modifiers | COB Payer Paid Amount | Remittance Date | Paid Units | Remaining Patient Liability | Bundled Line | Action |
|---|--------------|----------------|-----------|-----------------------|-----------------|------------|-----------------------------|--------------|--------|
| <input type="checkbox"/> Click to collapse.   |              |                |           |                       |                 |            |                             |              |        |
| <p>*Other Carrier: A51-HIGHMARK BCBS Bundled into Line #: 0</p> <p>*Procedure Code: D2391-POST 1 SRFC RESINBASED CMPST</p> <p>Modifiers: [ ] [ ] [ ] [ ]</p> <p>COB Payer Paid Amount: 50.00 *Remittance Date: 01/01/2017 *Paid Units: 1.00</p> <p>Remaining Patient Liability: [ ]</p> <p><a href="#">Add Insurance</a> <a href="#">Cancel Insurance</a></p> |              |                |           |                       |                 |            |                             |              |        |

Click Add Insurance.

9. Click the # on the Other Insurance Details for the Service Line to enter Other Insurance Reasons.

**Service Details**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Svc Date   | Oral Cavity Area | Tooth#/Letter              | Procedure Code | Units | Charge Amount | Action                 |
|-------|------------|------------------|----------------------------|----------------|-------|---------------|------------------------|
| 1     | 12/01/2016 |                  | 19-1st Molar -LL-Permanent | D2391          | 1     | \$192.00      | <a href="#">Remove</a> |

1 \*Svc Date: 12/01/2016 Oral Cavity Area: [ ] Tooth#/Letter: 19-1st Molar -LL-Permanent

Tooth Surface: Occlusal [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

\*Procedure Code: D2391-POST 1 SRFC RESINE Modifiers: [ ] [ ] [ ] [ ]

\*Units: 1 \*Charge Amount: 192.00 Diagnosis Pointers: [ ] [ ] [ ] [ ]

Performing Provider ID: [ ] ID Type: NPI Taxonomy: [ ]

**Other Insurance Details for Svc. # 1**

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Carrier Code | Procedure Code                     | Modifiers | COB Payer Paid Amount | Remittance Date | Paid Units | Remaining Patient Liability | Bundled Line | Action                 |
|---|--------------|------------------------------------|-----------|-----------------------|-----------------|------------|-----------------------------|--------------|------------------------|
| 1 | A51          | D2391-POST 1 SRFC RESINBASED CMPST |           | \$50.00               | 01/01/2017      | 1.00       | \$0.00                      | 0            | <a href="#">Remove</a> |

Click to add a new other insurance.

[Save](#) [Reset](#) [Cancel](#)

## Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)

**Service Details**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Svc Date   | Oral Cavity Area | Tooth#/Letter              | Procedure Code | Units | Charge Amount | Action                 |
|-------|------------|------------------|----------------------------|----------------|-------|---------------|------------------------|
| 1     | 12/01/2016 |                  | 19-1st Molar -LL-Permanent | D2391          | 1     | \$192.00      | <a href="#">Remove</a> |

1 \*Svc Date  Oral Cavity Area  Tooth#/Letter

Tooth Surface

\*Procedure Code  Modifiers

\*Units  \*Charge Amount  Diagnosis

Performing Provider ID  ID Type  Taxonomy

**Other Insurance Details for Svc. # 1**

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Carrier Code | Procedure Code                     | Modifiers | COB Payer Paid Amount | Remittance Date | Paid Units | Remaining Patient Liability | Bundled Line | Action                 |
|---|--------------|------------------------------------|-----------|-----------------------|-----------------|------------|-----------------------------|--------------|------------------------|
| 1 | A51          | D2391-POST 1 SRFC RESINBASED CMPST |           | \$50.00               | 01/01/2017      | 1.00       | \$0.00                      | 0            | <a href="#">Remove</a> |

\*Other Carrier  Bundled into Line #

\*Procedure Code

Modifiers

COB Payer Paid Amount  \*Remittance Date  \*Paid Units

Remaining Patient Liability

**Other Insurance Reasons**

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

| #  | Group Code                       | Reason                       | Amount                                    | Units of Service                      | Action |
|--|----------------------------------|------------------------------|---|---------------------------------------|--------|
| <input type="checkbox"/> Click to collapse.  |                                  |                              |   |                                       |        |
|  | *Group Code <input type="text"/> | *Reason <input type="text"/> | *Amount <input type="text" value="0.00"/> | Units of Service <input type="text"/> |        |
| <input type="button" value="Add Reason"/> <input type="button" value="Cancel Reason"/>                         |                                  |                              |   |                                       |        |
| <input type="button" value="Save Insurance"/> <input type="button" value="Cancel Insurance"/>                  |                                  |                              |   |                                       |        |
| <input type="checkbox"/> Click to add a new other insurance.   |                                  |                              |   |                                       |        |
| <input type="button" value="Save"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/> |                                  |                              |   |                                       |        |

Enter the Other Insurance Reasons.

## Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)

**Other Insurance Reasons** -

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

| #  | Group Code | Reason | Amount | Units of Service | Action |
|--|------------|--------|--------|------------------|--------|
| <input type="checkbox"/> Click to collapse.  |            |        |        |                  |        |
| *Group Code <input type="text" value="CO-Contractual Obligations"/>                    |            |        |        |                  |        |
| *Reason <input type="text" value="1-Deductible Amount"/>                               |            |        |        |                  |        |
| *Amount <input type="text" value="50.00"/> Units of Service <input type="text"/>       |            |        |        |                  |        |
| <input type="button" value="Add Reason"/> <input type="button" value="Cancel Reason"/> |            |        |        |                  |        |

Click Add Reason.

**Other Insurance Reasons** -

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

| #   | Group Code                 | Reason              | Amount  | Units of Service | Action                 |
|---|----------------------------|---------------------|---------|------------------|------------------------|
| <u>1</u>  | CO-Contractual Obligations | 1-Deductible Amount | \$50.00 |                  | <a href="#">Remove</a> |
| <input type="checkbox"/> Click to add a new claim reason. |                            |                     |         |                  |                        |

**Tip:** To edit a row, click the numerical number of the row.

**Tip:** Click the Remove link, under Action, if to remove a row.

**Tip:** To add an additional Insurance Reason, click the +.

**Other Insurance Reasons** -

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

| #  | Group Code                 | Reason              | Amount  | Units of Service | Action                 |
|--|----------------------------|---------------------|---------|------------------|------------------------|
| <u>1</u>   | CO-Contractual Obligations | 1-Deductible Amount | \$50.00 |                  | <a href="#">Remove</a> |
| <input type="checkbox"/> Click to collapse.  |                            |                     |         |                  |                        |
| *Group Code <input type="text"/>   |                            |                     |         |                  |                        |
| *Reason <input type="text"/>   |                            |                     |         |                  |                        |
| *Amount <input type="text" value="0.00"/> Units of Service <input type="text"/>        |                            |                     |         |                  |                        |
| <input type="button" value="Add Reason"/> <input type="button" value="Cancel Reason"/> |                            |                     |         |                  |                        |

## Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)

### Other Insurance Details for Svc. # 1

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

| #        | Carrier Code | Procedure Code                     | Modifiers | COB Payer Paid Amount | Remittance Date | Paid Units | Remaining Patient Liability | Bundled Line | Action                 |
|----------|--------------|------------------------------------|-----------|-----------------------|-----------------|------------|-----------------------------|--------------|------------------------|
| <u>1</u> | A51          | D2391-POST 1 SRFC RESINBASED CMPST |           | \$50.00               | 01/01/2017      | 1.00       | \$0.00                      | 0            | <a href="#">Remove</a> |

**\*Other Carrier**  **Bundled into Line #**   
**\*Procedure Code**   
**Modifiers**    
**COB Payer Paid Amount**  **\*Remittance Date**  **\*Paid Units**   
**Remaining Patient Liability**

### Other Insurance Reasons

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

| #        | Group Code                 | Reason              | Amount  | Units of Service | Action                 |
|----------|----------------------------|---------------------|---------|------------------|------------------------|
| <u>1</u> | CO-Contractual Obligations | 1-Deductible Amount | \$50.00 |                  | <a href="#">Remove</a> |
| <u>2</u> | PR-Patient Responsibility  | 3-Co-payment Amount | \$92.00 |                  | <a href="#">Remove</a> |

Click to add a new claim reason.

**Important:** A Group Code of Patient Responsibility (PR) needs to be added. Use the appropriate Reason of 1-Deductible, 2-Coinsurance, or 3-Copay.

When all the Other Insurance Reasons are entered, click Save Insurance to save the insurance details to the Service Detail line.

## Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Svc Date   | Oral Cavity Area | Tooth#/Letter              | Procedure Code | Units | Charge Amount | Action                 |
|-------|------------|------------------|----------------------------|----------------|-------|---------------|------------------------|
| 1     | 12/01/2016 |                  | 19-1st Molar -LL-Permanent | D2391          | 1     | \$192.00      | <a href="#">Remove</a> |

1 \*Svc Date  Oral Cavity Area  Tooth#/Letter

Tooth Surface

\*Procedure Code  Modifiers

\*Units  \*Charge Amount  Diagnosis

Performing Provider ID  ID Type NPI Taxonomy ...

Other Insurance Details for Svc. # 1

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Carrier Code | Procedure Code                     | Modifiers | COB Payer Paid Amount | Remittance Date | Paid Units | Remaining Patient Liability | Bundled Line | Action                 |
|---|--------------|------------------------------------|-----------|-----------------------|-----------------|------------|-----------------------------|--------------|------------------------|
| 1 | A51          | D2391-POST 1 SRFC RESINBASED CMPST |           | \$50.00               | 01/01/2017      | 1.00       | \$0.00                      | 0            | <a href="#">Remove</a> |

Click to add a new other insurance.

Click Save to save the Service Detail with the Other Insurance Information.

10. Repeat steps 8-9 to add additional service detail lines.
- Important:** The Other Insurance Reasons Amounts plus the COB Payer Paid Amount must equal the charge amount of the detail line.
- Important:** The COB Payer Paid Amounts on each service detail line together must equal the COB Payer Amount entered on the Other Insurance Details entered in the Portal Step 2.

11. If documentation needs to be included in the claim submission, upload it in the Attachments section.

Attachments

Click the **Remove** link to remove the entire row.

| #  | Transmission Method | File | Control # | Attachment Type | Action |
|--|---------------------|------|-----------|-----------------|--------|
| <input style="border: 2px solid red; padding: 2px 5px;" type="button" value="Click to add attachment."/> |                     |      |           |                 |        |

Add the documentation by uploading the file under Attachments by clicking +.

## Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)

**Attachments**

Click the **Remove** link to remove the entire row.

| #   | Transmission Method | File | Control # | Attachment Type | Action |
|---|---------------------|------|-----------|-----------------|--------|
| Click to collapse.  |                     |      |           |                 |        |
| <p>*Transmission Method FT-File Transfer</p> <p>*Upload File <input type="text"/> <b>Browse...</b></p> <p>*Attachment Type <input type="text"/></p> <p>Description <input type="text"/></p> |                     |      |           |                 |        |
| <p><b>Add</b> <b>Cancel</b></p>   |                     |      |           |                 |        |

Click the Browse link to choose the file.

**Attachments**

Click the **Remove** link to remove the entire row.

| #  | Transmission Method | File | Control # | Attachment Type | Action |
|--|---------------------|------|-----------|-----------------|--------|
| Click to collapse.   |                     |      |           |                 |        |
| <p>*Transmission Method FT-File Transfer</p> <p>*Upload File C:\Users\dunfords\Desktop\TEST Files\This is a test.pdf <b>Browse...</b></p> <p>*Attachment Type <input type="text"/></p> <p>Description <input type="text"/></p> |                     |      |           |                 |        |
| <p><b>Add</b> <b>Cancel</b></p>  |                     |      |           |                 |        |

Select the Attachment Type from the drop-down box and include the Description of file chosen, then click Add.

**Attachments**

Click the **Remove** link to remove the entire row.

| #   | Transmission Method | File | Control # | Attachment Type | Action |
|---|---------------------|------|-----------|-----------------|--------|
| Click to collapse.  |                     |      |           |                 |        |
| <p>*Transmission Method FT-File Transfer</p> <p>*Upload File C:\Users\dunfords\Desktop\TEST Files\This is a test.pdf <b>Browse...</b></p>   |                     |      |           |                 |        |
| <p>*Attachment Type <b>Add</b> <b>Cancel</b></p> <p>Description</p> <ul style="list-style-type: none"> <li>B4-Referral Form</li> <li>DA-Dental Models</li> <li>DG-Diagnostic Report</li> <li>EB-Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)</li> <li>OZ-Support Data for Claim</li> <li>P6-Periodontal Charts</li> <li>RB-Radiology Films</li> <li>RR-Radiology Reports</li> </ul> |                     |      |           |                 |        |

Click Add.

12. Review the row(s).

**Attachments**

Click the **Remove** link to remove the entire row.

| # | Transmission Method | File                      | Control #      | Attachment Type    | Action                 |
|---|---------------------|---------------------------|----------------|--------------------|------------------------|
| 1 | FT-File Transfer    | This is a test.pdf (122K) | 20170406608126 | RB-Radiology Films | <a href="#">Remove</a> |

Click to add attachment.

**Back to Step 1** **Back to Step 2** **Submit** **Cancel**

Click Submit.

Review the information before clicking Confirm to submit the claim.

## Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)

**Confirm Dental Claim** ?

Select Print Preview before you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.

**Provider Information**

|                              |             |                      |
|------------------------------|-------------|----------------------|
| Billing Provider ID          | ID Type NPI | Name KINGSTON DENTAL |
| Taxonomy 122300000X-Dentist  |             |                      |
| Performing Provider ID       | ID Type     | Name                 |
| Taxonomy                     |             |                      |
| Service Facility Location ID | ID Type     | Name                 |
| Taxonomy                     |             |                      |

**Patient Information**

|                              |             |
|------------------------------|-------------|
| Member ID <b>ODDDIIIIII</b>  | Gender Male |
| Member <b>Joe Smith</b>      |             |
| Birth Date <b>01/01/1990</b> |             |
| Address                      |             |
| Address Line 2               |             |
| City                         |             |
| State                        | Zip Code    |

**Claim Information**

|   |               |
|---|---------------|
| Accident Related  | Accident Date |
| Place of Treatment 11-Office  |               |
| Patient Number  |               |
| Initial X-Ray/Photo Date  |               |
| Does the provider have a signature on file? Yes   |               |
| Does the provider accept assignment for claim processing? Yes                                       |               |
| Are benefits assigned to the provider by the patient or their authorized representative? Yes        |               |
| Does the provider have a signed statement from the patient releasing their medical information? Yes |               |
| Total Charged Amount \$192.00   |               |

[Expand All](#) | [Collapse All](#)

**Other Insurance Details**

| # | Carrier Name  | Carrier Code | Group #   | COB Payer Paid Amount | Remittance Date |
|---|---------------|--------------|-----------|-----------------------|-----------------|
| 1 | HIGHMARK BCBS | AS1          | 123456789 | \$50.00               | 01/01/2017      |

**Service Details**

Select the row number to edit the row. Click the Remove link to remove the entire row.

| Svc # | Svc Date   | Oral Cavity Area | Tooth#/Letter               | Tooth Surface | Procedure Code | Mod | Units | Charge Amount |
|-------|------------|------------------|-----------------------------|---------------|----------------|-----|-------|---------------|
| 1     | 12/01/2016 |                  | 19-1st Molar -LL- Permanent | O-Occlusal    | D2391          |     | 1     | \$192.00      |

**Attachments**

| # | Transmission Method | File                      | Control #      | Attachment Type    |
|---|---------------------|---------------------------|----------------|--------------------|
| 1 | FT-File Transfer    | This is a test.pdf (122K) | 20170406608126 | RB-Radiology Films |

No Diagnosis Codes exist for this claim

Back to Step 1
Back to Step 2
Back to Step 3
Print Preview
Confirm
Cancel

Click Confirm.

## Submit Claim Dental – Service Details, Add Insurance and Add Attachment(s)

13. Click Print Preview to view the dental claim details and receipt. Click Print and follow the prompts to print a copy of the submission.

The screenshot displays a web interface titled "Submit Dental Claim: Confirmation". Below the title is a section labeled "Dental Claim Receipt". The text within this section reads: "Your Dental Claim was successfully submitted. The claim status is FinalizedPayment." followed by "The Claim ID is 231700100111". Below this text are five instructions: "Click: **Print Preview** to view the claim details as they have been saved on the payer's system.", "Click: **Copy** to copy member or claim data.", "Click: **Edit** to resubmit the claim.", "Click: **New** to submit a new claim.", and "Click: **View** to view the details of the submitted claim." At the bottom of the interface, there are five buttons: "Print Preview" (highlighted in red), "Copy", "Edit", "New", and "View".

**Reminder:** Follow secure procedures for handling protected health information (PHI).

### Need Assistance?

**Call Us:** Provider Relations at **1-800-999-3371**; Option **0**, then Option **4**.

**Message Us:** Secure Correspondence: Log in to the [Provider Portal](#).

**Email\* Us:** [delawarepret@gainwelltechnologies.com](mailto:delawarepret@gainwelltechnologies.com) – \*Reminder: Do not send any correspondence that has protected health information (PHI) to this mailbox.