Classic Network Provider Guide

Welcome

This easy-to-use provider reference guide will help you and your staff quickly integrate our network program into your practice. We're glad you joined our network and look forward to a lasting partnership.

Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of New York

Ameritas
fulfilling life.

AM 668 8-25

Table of contents

Use these QR codes to view or download forms and flyers mentioned on Page 8. Open your cell phone camera and hold it over each QR code to link to each piece.

AM906 AM430 AM878 AM715

Frequently asked questions

Advertising your name

Q: How will my practice be advertised?
A: *Members can visit our website at ameritas.com to locate a participating provider closest to them. Our online directories list your facility information, office hours and languages spoken, and a map of your office locations.*

Q: How often is the directory updated?
A: *The online directory is updated daily so members have access to current network information.*

Billing

Q: How will I get paid for dental services?
A: *You'll be reimbursed based on the Maximum Allowable Charges [MAC] and the member's dental benefit plan. Depending on the member's benefits and the services you provide, your reimbursement may be from one of the following:*

- *Ameritas only*
- *Ameritas and the member combined*
- *Member only*

Q: Can I bill up front?
A: *As stated in the network agreement, you're entitled to bill and collect any copayments, coinsurance amounts or deductibles for covered services from the insured member at the time services are performed. To avoid overcharges or miscommunication with patients, we encourage you to obtain the applicable amounts. For further information, review the "PAYMENT" section of your provider agreement.*

Q: Can I bill the patient for the difference between the agreed upon discount and my usual charges?
A: *No. You are not allowed to "balance bill" the difference between the agreed upon fee and your usual charges.*

Q: What can I bill for non-covered procedures?
A: *In states where discounts on non-covered services are allowed:*

1. *If the non-covered procedure is listed in your MAC fees, you agree to accept the MAC fee.*
2. *If the non-covered procedure isn't listed in your MAC fees, you agree to a 20% discount off your normal charges.*

In states where discounts on non-covered services are not allowed:

1. *You may charge the patient your usual and customary fee.*

Q: Do I bill the MAC fee or my Usual and Customary fee when the patient has reached their maximum?
A: *As stated in the PPO agreement, you may bill to the MAC fee if the patient has reached their maximum.*

Q: What can I bill for alternate benefit situations?
A: *Our dental plans include provisions for alternate benefits. If two or more procedures are considered adequate and appropriate to correct a dental condition, payment is based on the charge for the least expensive procedure. If you perform a different method of treatment, you can collect the difference in the MAC allowance amounts from what was actually performed to what was considered from the member. For example, if you perform a composite on a molar tooth, we'll consider and process the procedure as an amalgam. Your office can collect the difference between the MAC fee for the amalgam and the MAC fee for the composite.*

Q: When do I need to submit a prestatement of benefits?
A: *We recommend you submit a prestatement of benefits when you have a claim that equals $200 or more. This provides you and the member with potential benefits and out-of-pocket expense information prior to treatment.*

Q: Can I assign the benefits to go to the patient on the claim form?
A: *No. As a participating provider, assignment of benefits automatically goes to the dental office where services are performed. Even if the claim form is marked for the assignment to go the patient, assignment will be made to the provider.*

Q: What type of availability do I need to have for emergency care?
A: *Our network providers should provide for emergency care services 24 hours a day, 7 days a week, through arrangements such as an answering machine or answering service. You should also provide emergency coverage during vacations and holidays.*

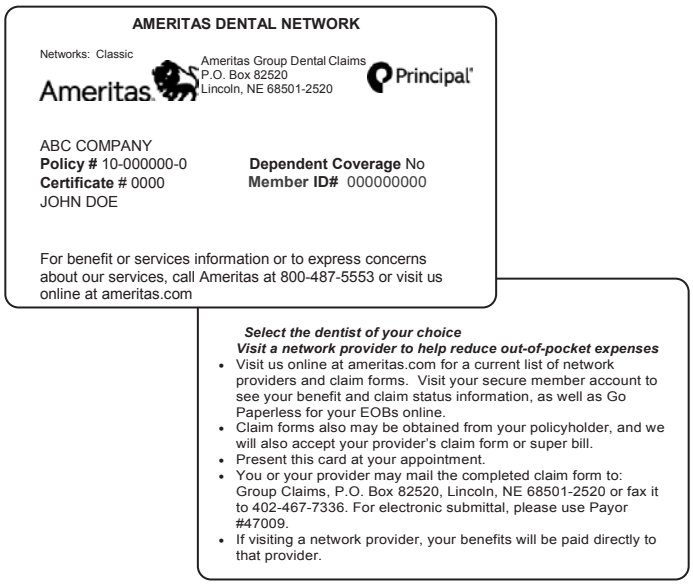
Q: Is there a certain time frame under which I'm required to schedule a patient?
A: *Your network agreement states that members are to be seen within 30 days for non-emergency care. Some states may have more specific service time frames, in which case the state requirement prevails.*

Q: Is there a deadline for claim submittal?
A: *The majority of group benefit contracts allow 90 days to submit claims from the date of services, as indicated on the Ameritas claim form.*

ID cards

Q: Do you issue ID cards to your insured members?

A: *The majority of our members receive an ID card, however they're not required to have one to see a dentist. When our members visit your office, you may request they bring in their ID card for your review.*



AMERITAS DENTAL NETWORK

Networks: Classic

Ameritas

Ameritas Group Dental Claims
P.O. Box 82520
Lincoln, NE 68501-2520

Principal

ABC COMPANY
Policy # 10-000000-0
Certificate # 0000
JOHN DOE

Dependent Coverage No
Member ID# 000000000

For benefit or services information or to express concerns about our services, call Ameritas at 800-487-5553 or visit us online at ameritas.com

Select the dentist of your choice
Visit a network provider to help reduce out-of-pocket expenses

- Visit us online at ameritas.com for a current list of network providers and claim forms. Visit your secure member account to see your benefit and claim status information, as well as Go Paperless for your EOBs online.
- Claim forms also may be obtained from your policyholder, and we will also accept your provider's claim form or super bill.
- Present this card at your appointment.
- You or your provider may mail the completed claim form to: Group Claims, P.O. Box 82520, Lincoln, NE 68501-2520 or fax it to 402-467-7336. For electronic submittal, please use Payor #47009.
- If visiting a network provider, your benefits will be paid directly to that provider.

Network leasing

Q: Do you lease your network?

A: *Yes, we have special arrangements with companies who use our network, including:*

- *Aetna*
- *Cigna Health and Life Insurance Company*
- *First Reliance Standard Life Insurance of New York*
- *Guardian*
- *Metropolitan Life Insurance Company*
- *Physicians Mutual*
- *Reliance Matrix Life*
- *Standard Insurance Company*
- *Standard Insurance Company of New York*
- *The Principal*
- *United Concordia*

By leasing our network we can advertise your practice to a wider range of insured members, thus helping you reduce empty chair time.

Referrals to a specialist

Q: What should I do if a member needs a specialist?

A: *We suggest you refer the member to a specialist on our network, if possible, to help the patient maximize their dental benefits.*

To obtain a list of Classic Network specialists in your area, visit our website at ameritas.com

Q: How do I nominate a specialist for participation on your Classic Network?

A: *Visit our website at ameritas.com to complete an online nomination form. Or, call our Provider Relations department at* **800-755-8844, ext. 88327** *and ask us to send the specialist an invitation packet.*

Claims submission procedures

Patient eligibility

We recommend the following steps to determine a member's eligibility:

1. Access benefits online:
   - Visit **ameritas.com**
   - Select "For Dental Providers", then "Verify Patient Benefits"
   - Type in the member's name, date of birth and ZIP Code
   - Select "Submit" to receive the patient's current dental plan information
2. Use our FaxBack system:
   - Call Ameritas at **800-487-5553**
   - From the main prompt menu, select 1 for benefit information, then 2 for provider
   - Using your phone's keypad, input the member ID and date of birth, then select option 6
   - Sit back and relax. Your fax is on the way
3. Contact our Claims Customer Service Department at **800-487-5553**
   [Monday - Thursday, 7:00 a.m. – 12:00 a.m. CST and Friday, 7:00 a.m. – 6:30 p.m. CST]

Please remember, this is not a guarantee of eligibility, as the patient must be covered on the date services are performed.

Electronic claims

With electronic claim submission, you can save money and get paid faster.

Advantages of electronic claim processing:

- Most eClaims processed the same day received
- Consolidated checks sent within 7 business days (compared to 14 business days for paper claims)
- Eliminate postage and envelope expenses
- Lower rejection rate and less follow-up required
- Virtually free or reduced fees for network providers – we reimburse up to 30 cents per eClaim submission
- Optimize cash flow management
- Streamline administrative tasks and enhance office productivity

We currently accept dental claims and/or attachments from the following clearinghouses:

DentalXChange
800-576-6412
dentalxchange.com

Change Healthcare
800-477-7042
changehealthcare.com

VYNE
866-712-9584
nea-fast.com

Please note: Ameritas and Ameritas Life Insurance Corp. of New York network providers are reimbursed up to 30 cents for each claim submitted through any of the above clearinghouses (reimbursement does not apply to electronic attachments submitted through NEA). Quarterly checks will be issued in February, May, August, and November for amounts of $25 or greater. Reimbursement will be on a cumulative basis.

Key information to remember when submitting a claim electronically:

1. Your office will need to have a "practice management" system that's linked to a clearinghouse or internet access. See page 10 for more information on clearinghouse discounts offered to our network providers.
2. All electronic claims must be submitted through a clearinghouse.
3. Submit claim[s] under the same tax identification number as you would on a paper claim. If you change this number with the IRS, please be sure to notify us.
4. We accept all claims and attachments electronically. Please be sure to include the following information:
   - Name of the "treating" dentist
   - Tax Identification Number
   - Office address
   - NPI Number

It's vital that you include the above information even if you submit under a "corporate business name."

5. Submit ALL claims even if you think they need an attachment. We'll let you know if additional information is needed. **Many claims can be processed by using the narrative or claim remark field with replacement dates or pocket depths. We'll accept up to 200 characters in this field.** Refer to page 15 for a comprehensive list of attachments necessary when submitting claims.

For more information about electronic claim submission, contact us at **800-487-5553, ext. 82238.**

Completing a claim

Refer to the following steps when completing a claim and/or a prestatement of benefits:

- Part 1 (name, address, Member ID Number, birth date, etc.) must be completed.
- Discuss with the patient the treatment plan and fees based on procedures to be performed. Enter your usual charges when completing the claim form, however the maximum covered allowance will be the lesser of your usual charges or the maximum fee allowance.
- If your treatment program will be less than $200 or emergency services are performed, complete parts 1 and 2 of the claim form. Payment of benefits for covered services are automatically issued to the participating provider. Mail the completed claim form to:

Group Claim Office
PO Box 82520
Lincoln, NE 68501

New York Claims
Ameritas Life Insurance Corp. of New York
PO Box 82595
Lincoln, NE 68501-2595

Or, fax your claims to **402-467-7336**

- If your treatment program will be $200 or more, we suggest submitting the claim for a prestatement of benefits. A pretreatment estimate helps the patient understand potential benefits and out-of-pocket expenses prior to treatment.
- 98% of our claims are paid within 10 business days. We consolidate the payment for several claims into one and send payment directly to the provider (approximately twice each month). You'll receive an Explanation of Payment (EOP) and the insured will receive an Explanation of Benefits (EOB).

Claim submission tips

To provide the best service possible, we use image technology by scanning our claims into our system. The better quality the claim form and superbill, the faster we can process a claim.

The following list of helpful hints will speed up the processing of your claim:

Do	Don't
Submit clear, legible claim forms.	Submit dark copies of claim forms. During scanning these turn black.
Underline or circle important information.	Highlight—this can cause a black area when scanned.
Use a fresh ink cartridge in your printer.	Submit poor quality or faded printed claims.
Use black ink or black felt tip pens.	Use colored ink, fine point pens or pencils.
Use original claim forms or superbills.	Use photocopied claim forms or superbill carbons. Some items don't carbon legibly.
Type, print or stamp the treating dentist's name, address and TIN, SSN or NPI clearly.	Use foil-covered stickers for the dentist's information. These always turn black on the image.
Notify us of any changes in tax identification number or address.	
Use the most current CDT terminology for procedures performed.	
Include patient's birth date and employee's identification number.	
Include the relationship of the patient to be insured.	
Include tooth number, quadrant, and surface information.	
Include missing teeth information, if applicable, to covered procedures.	
Include prior placement information for crowns and bridges.	
Consider use of electronic payment to eliminate many common errors and the resulting delays.	

Provider billing procedures

Bill to Dentist Normal Fee

You can bill your normal charge when:

- the procedure date of service is outside of the effective or termination dates of your contract.
- service is provided outside of effective or termination dates of the patient's coverage.
- the patient isn't an eligible dependent because of child age, non-student status or class of coverage, i.e. no dependent coverage elected.

Bill to Maximum Allowable Charge (MAC)

You can bill to your MAC fee when:

- A covered procedure is denied for waiting period, late entrant provision or elimination period reasons, or the patient's maximum has been reached.
- A covered procedure is denied for frequency or criteria (example: 3rd exam in benefit period or crown replaced <5 years).
- A covered procedure is modified due to age limitation on age sensitive procedures (example: adult cleaning submitted on child, 1110>1120).
- A reported procedure is allowed as an alternate procedure. Office is allowed to bill the member the difference up to the MAC for the actual procedure performed (examples: initial exam allowed as a periodic exam if not 1st visit to the provider, high noble allowed as noble metal, crown with veneer on molar allowed as crown without veneer, composite on molar allowed as amalgam).
- The member is covered under an MCE Plan. In this case, the maximum covered expense is the maximum amount considered per procedure. The network provider will collect from the member the difference between the plan's maximum covered expense amount and their MAC fees.

Procedure Code	U & C Fee	MAC Fee	Maximum Covered Expense	Deductible Amount	Ameritas Pays	You Collect from Patient	Total Received by Provider
1110	$60	$50	$42	waived	$42	$8	$50
2150	$80	$71	$51	$50	$1	$70	$71
2750	$700	$522	$330	satisfied	$330	$192	$522

This example is for illustrative purposes only and does not represent a specific plan or area fees.

Multiple radiographs/diagnostic imaging

When periapicals, bitewings or any combination of the following procedure codes: 0220, 0230, 0270, 0272 or 0274 are submitted on a claim and the films total 14 or more, the separate procedures will be combined and considered as an entire denture series, code 0210. Benefits for the entire denture series will be subject to the limitations under the insured's dental plan. For a list of the clearinghouses from which we accept claims, please see page 5 – Claims submission procedures.

Customer service

Verify Patient Eligibility

1. Access benefits online:
   - Visit ameritas.com
   - Select "For Dental Providers", then "Verify Patient Benefits"
   - Type in the member's name, date of birth and ZIP Code
   - Select "Submit" to receive the patient's current dental plan information
2. Request a FaxBack:
   - Call Ameritas at **800-487-5553**
   - From the main prompt menu, select 1 for benefit information, then 2 for provider
   - Using your phone's keypad, input the member ID and date of birth, then select option 6
   - Your fax is on the way

Claims/Customer Service
[claims and benefits questions]
800-487-5554
800-659-5556 [in New York]
Monday – Thursday 7:00 a.m. to 12:00 a.m. CST
Friday 7:00 a.m. to 6:30 p.m. CST

Provider Relations
[contract and fee questions]
800-755-8844
Monday – Thursday 6:30 a.m. to 5:30 p.m. CST
Friday 6:30 a.m. to 4:30 p.m. CST
providerrelations@ameritas.com

Internet Access
ameritas.com

Dental Claims and Perio Charting Fax
402-467-2030

Dental Benefit Summaries by Fax
800-487-5553 [24-hour automated option]

Electronic Claims Questions
800-487-5553, ext. 82238

Claims Mailing Address
Group Claim Office
PO Box 82520
Lincoln, NE 68501

New York Claims Mailing Address
Ameritas Life Insurance Corp. of New York
PO Box 82595
Lincoln, NE 68501

Utilization review and quality improvement programs

Our Quality Improvement and Utilization Management programs identify, evaluate and improve quality standards for us and our network providers. Your feedback helps us continue to improve our program and, in turn, improve your practice.

Credentialing

Our Provider Relations department is responsible for the credentialing review of our prescreening process, which begins once we receive your application. Contents include demographic information, provider identification information, infectious disease questions and past or present lawsuit information. If any applicable questions are marked "yes," you must provide a detailed explanation with the application. We'll contact you if any information is incomplete or missing.

Along with your application, we request current copies of the dentist license, malpractice certificate, DEA and specialty license, diploma, certificate or permit. Primary source verification is performed on each dentist's license. Once all credentialing and quality assurance requirements have been met, you'll become a participating provider on our network. Your office name, address and specialty (if applicable) will be listed in our online and paper directories.

Recredentialing

Our network providers are recredentialed throughout their participation on our dental network. Upon expiration of your dental license and/or DEA information on file, we'll perform primary source verification to ensure your license and DEA are still in good standing and you're continuously meeting the requirements to participate on the network.

You're required to submit a current copy of your malpractice/professional liability insurance certificate, as applicable. You're also required to complete a Quality Assurance Recredentialing form every three years, which is similar to the one completed during the initial application process.

Quality assurance

You completed an Office Evaluation Worksheet in order to be accepted on our network. The worksheet consists of several items, ranging from office accessibility to standards that meet or exceed the OSHA requirements.

The Office Evaluation Worksheet covers: Sterilization and Infection Control, Medical Emergency Preparedness, Environment and Radiology Safety, Biohazardous Waste Removal, and Accessibility.

We may conduct onsite evaluations to ensure quality assurance standards and requirements are being met. If they're not, the office under evaluation has 30 days to comply with our standards by submitting written proof of compliance.

Utilization management

We have established a utilization review program to promote and monitor the appropriateness and efficiency oaaf dental care services. The program was developed in conjunction with licensed dentists in all areas of specialty expertise and is based on the definitions published in the Current Dental Terminology © American Dental Association. Our panel of dental consultants, with input from other practicing providers, reviews the criteria and guidelines regularly to ensure they are current and are applied consistently in the review of dental claims.

Office information updates

We realize your practice will have changes from time to time, whether those changes involve your tax identification number, new address information, additional office location(s), ability to accept new patients, or adding and terminating dental associates. To ensure that we're advertising for you appropriately and processing claims accurately, we ask that you notify our Provider Relations team:

- Call 800-755-8844 with new information pertaining to your practice
- Email providerrelations@ameritas.com with information updates
- Fax the applicable, completed forms to 402-467-7339 to make updates

Forms to print, complete and fax with practice updates:

AM906 Ameritas PPO Provider Revision Form
AM430 Changes to Your Ameritas Dental Network Application Form

Codes needing documentation, Provider rewards program

AM878 Supporting Documentation
AM715 Provider Rewards Program

Use the links above, or use the QR codes on Page 2, to view or download these forms and flyers as needed.

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