Dental Provider/Staff Quick Reference

Overview

Improving patient retention by educating patients on an alternative to the popular discount plans on the market with an affordable plan offering quality care for dental, vision and hearing care that is both good for the patient and practice.

Policy Highlights

- This is not a dental discount plan (like most plans) this is an insurance plan that has been filed with the state that protects patients and providers.
- Two maximum amount policies available: $1,000 and $1,500
- The plan pays more each year up to a maximum amount.
- The benefits are not coordinated. This means if the policyholder has a medical plan that pays for an annual exam, then the provider can still bill this plan for exam and materials as well.
- There is a **$100 deductible** that is due from the policyholder, if it has not been met for the year.
    - An example is a family of five with a $1,000 per person policy benefit maximum. This means that every family member has a $100 deductible but there is $5,000 dollars of benefit available ($1,000 for each member).
- No maximum plan allowances.

Policy Verification

- When a policyholder presents to the office, the card will have the MOA DVH logo.
- The card will also have the amount of the maximum policy benefit with the “MOA” letters by it.
- The policy can also be verified by selecting Provider>>>Quick Benefits Verification on the ManhattanLife website.
    - Quick Verification can be accomplished without login information. However, providers can register for login information for both the verification and remittance.
- Verifying a remaining balance:
    - It is necessary to verify the remaining balance of the policy maximum benefit. Call ManhattanLife (1-800-999-2971) to verify benefit amount and to see if the deductible has been met.
    - ManhattanLife is working on a live update benefit amount that will be accessible in the future.

Patient (Policyholder) Protocols

A patient will pay the $100 deductible if this has not been met for the policy year. Be sure to verify their available benefits.

Utilize the MOA DVH calculator as a tool to show the expected amount for reimbursement and what the patient is responsible for before they leave the office. There are only a few benefit amounts that have been set. Please have a copy of the Policy Schedule or check your Provider Manual to know amounts for the following:

Preventative

Examination
Prophylaxis
Bite-wing X-Ray
Fluoride Treatment (13 years old and under)
Intraoral X-Ray
Panoramic X-Ray

Basics

Filling
Simple Extraction

Major

Root Canal
Periodontal Screening
Surgical Extraction
Crowns
Partial Dentures

Subject to the exclusions and limitations, any Medically Necessary Preventative, Basic, or Major Dental Benefits not listed above will be subject to the Usual, Customary, Reasonable charge, and the Policy Year Maximum Benefit.

2 Options for Payment:

1. You can collect the full invoice amount from the patient. Then fill out and file the claim form for the patient. This is more hardship on the patient up front; however, the carrier will pay the patient directly.
2. You can fill out and file the claim form for the patient. The carrier will reimburse the provider and the provider can charge the difference between reimbursement and the usual and customary prices.

Filing a Claim with ManhattanLife

Please refer to the Provider Manual for additional details, but the options are:

- File the claim with online upload. You may go through:
  - Manhattanlife.com>>>Provider>>>Provider Remittance
- File the claim by fax: **713-583-0677**
- You may file the claim by sending in the mail. However, please note this option may delay processing and is not the preferred method:

  ManhattanLife
  Claims Department
  P.O. Box 925309
  Houston, TX 77292-2728

CLAIM FOR DENTAL, VISION, AND HEARING EXPENSE BENEFITS

Submit x-rays with:

- treatments involving gold restoration, crowns, root canals, or bridgework

X-RAYS MAY BE REQUESTED FOR OTHER SERVICES

Any person who knowingly and with intent to injure, defraud, or deceive any insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

MAIL TO:
MANHATTANLIFE
CLAIMS DEPARTMENT
P.O. BOX 925309
HOUSTON, TX 77292-2728
FAX: 713-583-0677

PART 1

1. Patient Name	2. Relationship to Employee				3. Sex		4. Patient Birthday			5. If full time student	
	Self	Spouse	Child	Other	M	F	MO	Day	Year	School	City

6. Employee			7. Employee Social Security No.			8. Group number if known
First	Middle	Last				

9. Employee Mailing Address	City, State	Zip

10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim. Patient's Signature (Parent if minor).

PART 2

11. Dentist Name
First Middle Last

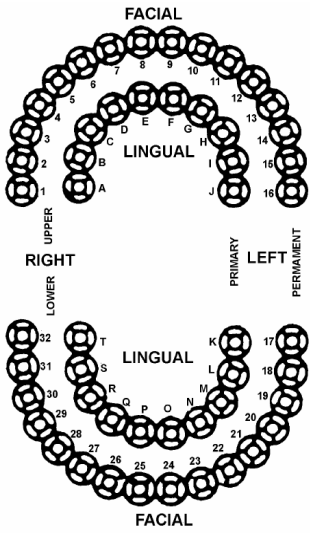
12. Mailing Address	City, State	Zip

TO BE COMPLETED BY DENTIST

13. Dentist Soc. Sec. or ITIN	14. Dentist License No.	15. Dentist Phone No.	16. First Visit Date Current Series	17. Place of Treatment				18. Radiographs or Models Enclosed?	No	Yes	How Many?
				Office	Hosp.	ECF	Other				

19. Dentist - Check One

❑ Pretreatment Estimate
❑ Statement of Actual Services



32. Examination and treatment Plan - List in order from tooth number 1 through tooth number 32
Use chart system shown

For Home Office Only

Tooth No. or Ltr.	Surface	Description of Services (including X-rays, Prophyaxis Materials Used, etc.)	Date Service Performed Mo.	Day	Yr.	Procedure Code	Fee		❑ Schedule ❑ Other	

Dental Unit Use

Employee Eligible Date _____
Employee Effective Date _____
Termination Date _____
Verified By _____
Date _____

These benefits will, subject to Policy provisions, be payable if the described procedures are performed while the patient is insured with ManhattanLife Assurance Company of America

Total Fee Actually Charged		
Deductible		
Patient pays		
Insurance will pay		

Part 3 TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the above named patient on the dates indicated

Dentist Signature _____ Date _____

ManhattanLife

Dental

Claim Filing

A dental insurance claim form is submitted to request payment for services rendered or to file for per-authorization of services to be performed. We accept the ADA's (American Dental Association) standardized dental insurance claim form.

In the information section of the form, you or the dentist must fill in the following information.

- Insured's full name and address
- Insured's ID Number
- The name and date of birth of the insured receiving the dental services.

Attachment of Supporting Documentation

You should substantiate your dental insurance claim expenses by attaching itemized bills and receipts, which contain the following information.

- Insured's full name and address
- Insured's ID number
- Provider's name and address
- Dates that dental care or treatment was provided
- Dentist's Tax ID Number
- Dates that services or treatment were received
- Tooth surface(s) and tooth number(s), arch, quadrant
- ADA procedure codes
- Description of each treatment
- Charge for each service

If your Dental Care Provider Files the Claim for You

Many dental offices will file the claim on your behalf. Some may ask that you pay your share of the cost at the time of the visit. Show your ManhattanLife Assurance Company of America ID card to your dental care provider.

All claims be submitted to ManhattanLife Assurance Company of America by mail or fax.

ManhattanLife Assurance Company of America

Claims Department

P.O. Box 925309

Houston, Texas 77292-4408

Fax: 713-583-0677

www.manhattanlife.com

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