MISSOURI OPTOMETRIC ASSOCIATION
Dental • Vision • Hearing

MISSOURI OPTOMETRIC ASSOCIATION

DENTAL / VISION / HEARING PLAN

Missouri Optometric Association

PROVIDER MANUAL

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DENTAL / VISION / HEARING PLAN

GENERAL INFORMATION

The MOA DVH plan is a simple indemnity plan that covers dental, vision, and hearing. The plan is available in a $1,000 and $1,500 policy year maximum per person. It can be sold as a group, single person plan or a family plan (up to 2 adults and 3 children). There is a $100 deductible per plan year per person.

Preferred providers for the plan must be MOA members, either primary or secondary members that already belong to another state. MOA members are asked to sign a provider agreement to become a preferred provider. This provider list will be given to all consumers that purchase the plan.

The vision insurance provides an eye examination immediately after the effective date of the policy. Materials (glasses and contact lenses) are also covered starting after the effective date of the policy. During the first year of the plan, 60% of the submitted charges up to the maximum allowed (caps are listed in the chart to follow) are paid. During the second year, the plan pays 70% of the charges, and after 24 months, the plan pays 80% of your charges.

MOA plan providers are asked to write off the remainder on the exam and glasses (up to cap amount). Contact lenses and contact lens fitting fees may be balance billed to the patient.

Policy Schedule Summary
Maximum Payments

Examination	Up to $100
Refraction	Up to $35
Frame	Up to $200 - can bill overage *(see example)*
Single Vision Lenses	Up to $75/pair
FT Bifocal	Up to $125/pair
Trifocal	Up to $150/pair
Progressives	Up to $300/pair
AR	Up to $105
Polycarbonate	Up to $100
Transitions® and other tints	Not a covered service
CL Fitting Fee	Up to $60 - can balance bill patient
Contact lenses (one-time order)	Up to $300 - can balance bill patient

The plan covers one exam/contact lens fitting per year. One pair of glasses AND one contact lens order per year is covered. You can only invoice one order on the contact lenses. It would be in the patient's best interest to order a year's supply of contacts and use the contact lens company's rebate if the company you choose offers one. This is the strength of the MOA plan: it is not glasses or contact lenses but can be glasses AND contact lenses if there is enough policy benefit available.

The MOA is following the non-covered services statute in Missouri. For items that are not covered by the plan, e.g. Transitions®, you may bill the patient your normal fee. If a provider wishes to give any discount on those items, they may do so.

FRAMES

Providers may bill the patient the overages after the maximum cap and discount. The discount is also applied to the overages since frames are a covered service. For example, let's say the patient is in the first year of their plan and has met their deductible. They have their eye on a $500 designer frame.

The plan will reimburse you the maximum $200. You can charge the patient $100. ($500 x 60% = $300).

If the patient was in the third year of the plan, the reimbursement on this same $500 frame would still be $200 and you would bill the patient $200.

($500 x 80% = $400). **From this example, you can see that it is better for the patient to buy a more expensive frame the first plan year, because it is less out of pocket due to the discount.**

CONTACT LENS EXAM/MATERIALS

Contact lenses are balance billed after the discount is applied and maximum payments are applied.

Contact Lens Exam/Fitting

Example:

Your fee is $80. The plan will pay up to $60. During the first year of the plan, you will be reimbursed $48 from the plan and bill the patient $32. During the third year, you will be reimbursed $60 and bill the patient $20.

Contact Lenses:

The same is true of contact lens materials. The plan will pay up to $300. If the materials cost is $300 for a year's supply, the plan will pay $180 the first year and you balance bill the patient $120. During the third year, the plan will reimburse $240 for these same contacts and the patient pays $60. If the year's supply of lenses is $500, the plan pays $300 and the patient pays $200 in all plan years.

It is easy to determine the amount you will be reimbursed, what you write off, and what is collected from the patient. To make it even easier, we have designed a tool/widget you can use to make this calculation for you. You will be provided a copy of the widget.

CODING & UNDERSTANDING EXPLANATION OF BENEFITS

When using the HCFA 1500 form, if you code a right and left eye separate, please be aware ManhattanLife will reimburse under one code.

Example

V2200 RT $70.00		
V2200 LT $70.00	Max Benefit $125	Total $140 x .6 = $84

ManhattanLife will send EOB stating:

Proc	List Price	Amount Allowed	% Paid	Non-Cvd	Amount Paid
V2020	$140	$125	.60	$50	$75

It will not be broken down per eye, rather paid in one lump sum. This will be the same for all items.

Progressive Lenses

Many offices file progressive lenses different. Some offices file the V2781 (progressive lens) code alone and some offices file it V2781 (progressive lens) + V2300 (trifocal) code. Why is the reason for this? One of the "major" discount plans, no matter how you send it in, always reimburses by splitting them out.

Example, Filed Claim

V2781 RT
V2781 LT

The "major" discount reimburses you labeled on the EOB:

V2781 RT + V2300 RT
V2781 LT + V2300 LT

ManhattanLife wants you to only use the V2781 code as a stand-alone code. By putting the V2781 code in combination with V2300 may delay your payment or you may get reimbursed the incorrect amount.

APPROVED VISION CODES

For any procedure code not listed, please bill at the U&C office charge

Procedure *Examinations*	**Procedure** *Refractions*	**Procedure** *Fitting Fees*	**Material** *Frames*
Max $100.00	Max $35.00	Max $60.00	Max $200.00
Approved Codes			
92002	92015	92310	V2020
92004		92314	V2025
92012		S0592	
92014			

Procedure *SV Lens*	**Procedure** *Bifocal*	**Procedure** *Trifocal*	**Material** *Progressive*
Max $75.00	Max $125.00	Max $150.00	Max $300.00
Approved Codes			
V2100	V2200	V2300	V2702
V2101	V2201	V2301	V2781
V2102	V2202	V2302	S0581
V2103	V2203	V2303	
V2104	V2204	V2304	
V2105	V2205	V2305	
V2106	V2206	V2306	
V2107	V2207	V2307	
V2108	V2208	V2308	
V2109	V2209	V2309	**Material** *Other BF/TF Lens*
V2110	V2210	V2310	
V2111	V2211	V2311	Max $125 or $150
V2112	V2212	V2312	**Approved Codes**
V2113	V2213	V2313	V2219
V2114	V2214	V2314	V2220
V2199	V2299	V2399	V2319
S0504	S0506	S0508	V2320
			V2410

No modifier always Bilateral

Material *A/R*	**Material** *Poly Lens*
Max $105.00	Max $100.00
Approved Codes	
V2750	V2784
V2799	S0580

RT & LT Modifier

Material *Contact Lens*			
Max $300.00			
Approved Codes			
V2330	V2511	V2521.1	S0500
V2500	V2512	V2522	S0512
V2501	V2513	V2523	
V2502	V2520	V2530	
V2503	V2520.1	V2531	
V2510	V2521	V2599	

The below procedure codes are common BUT NOT COVERED		
V2782	V2745	V2762
V2783	V2761	S9986

If the procedure code is not listed on this document, the procedure is not a covered procedure and is the patient's responsibility

VERIFICATION OF COVERAGE

- 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.

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 patient responsibility.

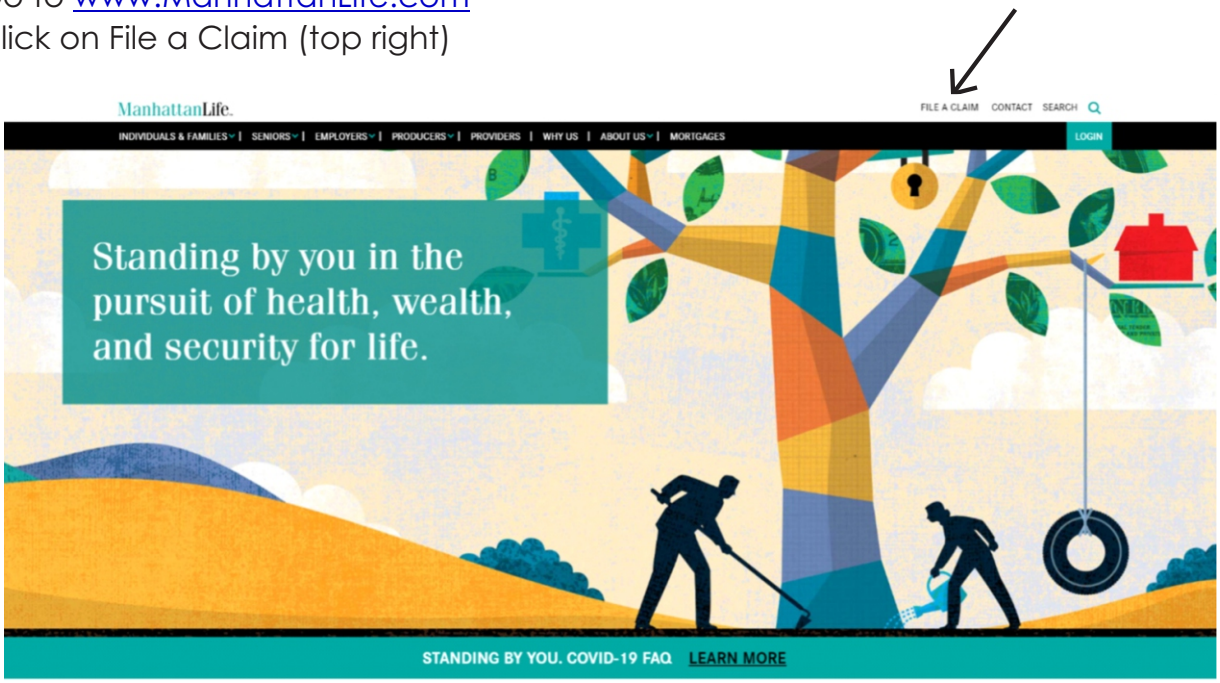
FILING A CLAIM

Filing a claim is done by (in order of preference) Easy Upload online, fax, or mail. Fill out the basic HCFA 1500 form or dental form use the upload features available, fax to ManhattanLife at (713)-583-0677, or mail to: Claims Department, PO Box 925309, Houston, TX 77292-2728

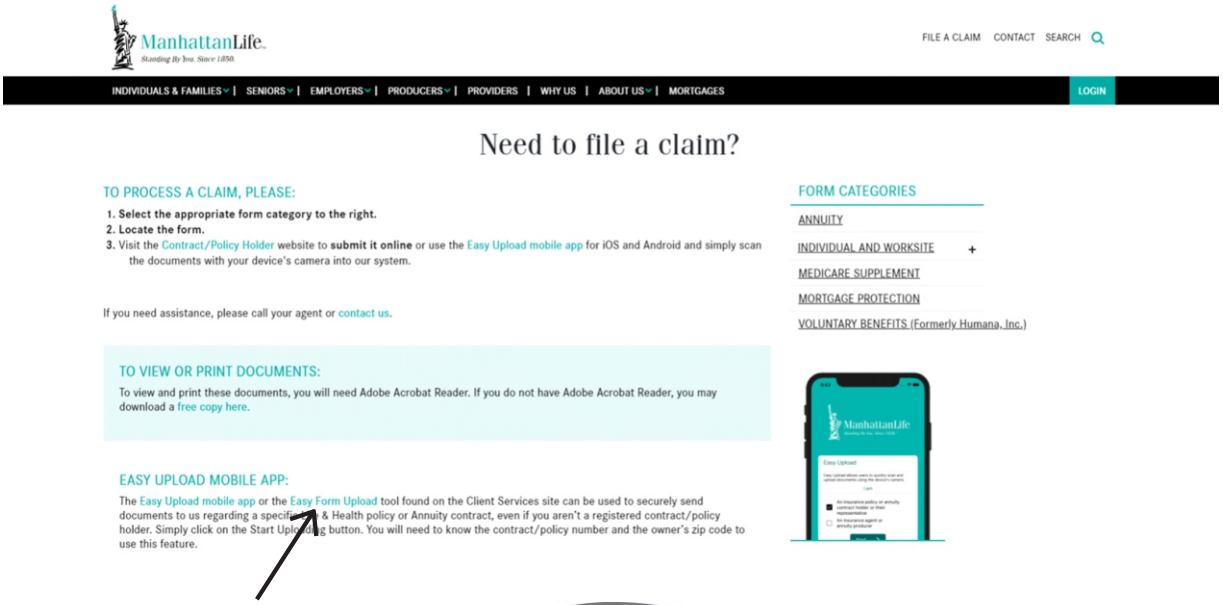
ONLINE CLAIM SUBMISSION

To file a claim online:

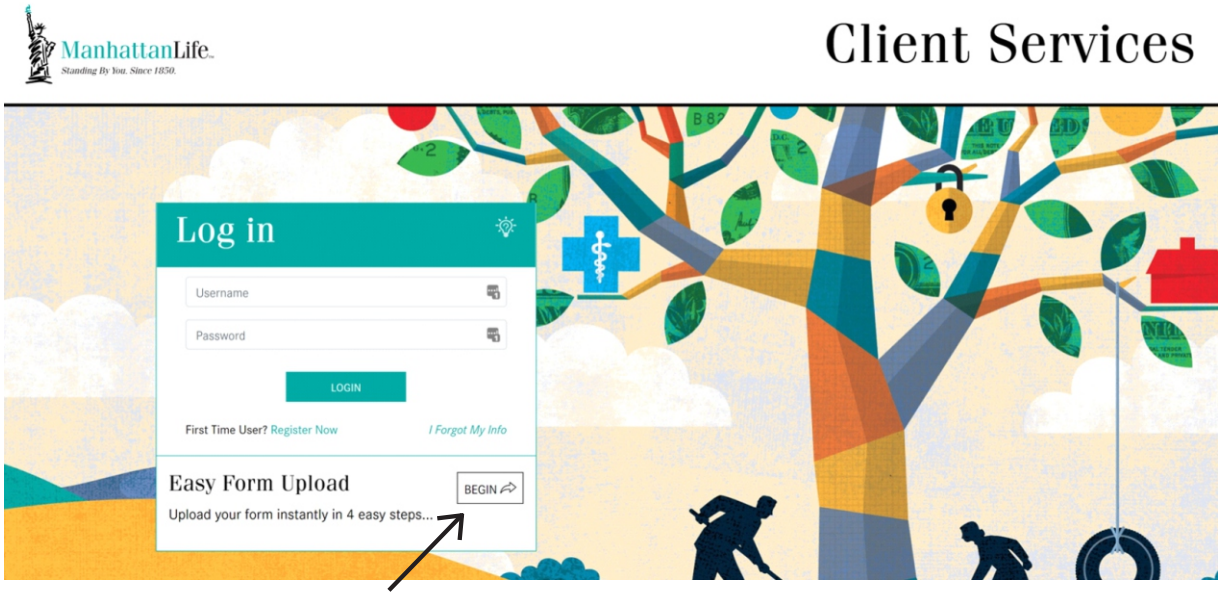
- Scan the completed HCFA claim form and save it to your computer
- Go to www.ManhattanLife.com
- Click on File a Claim (top right)



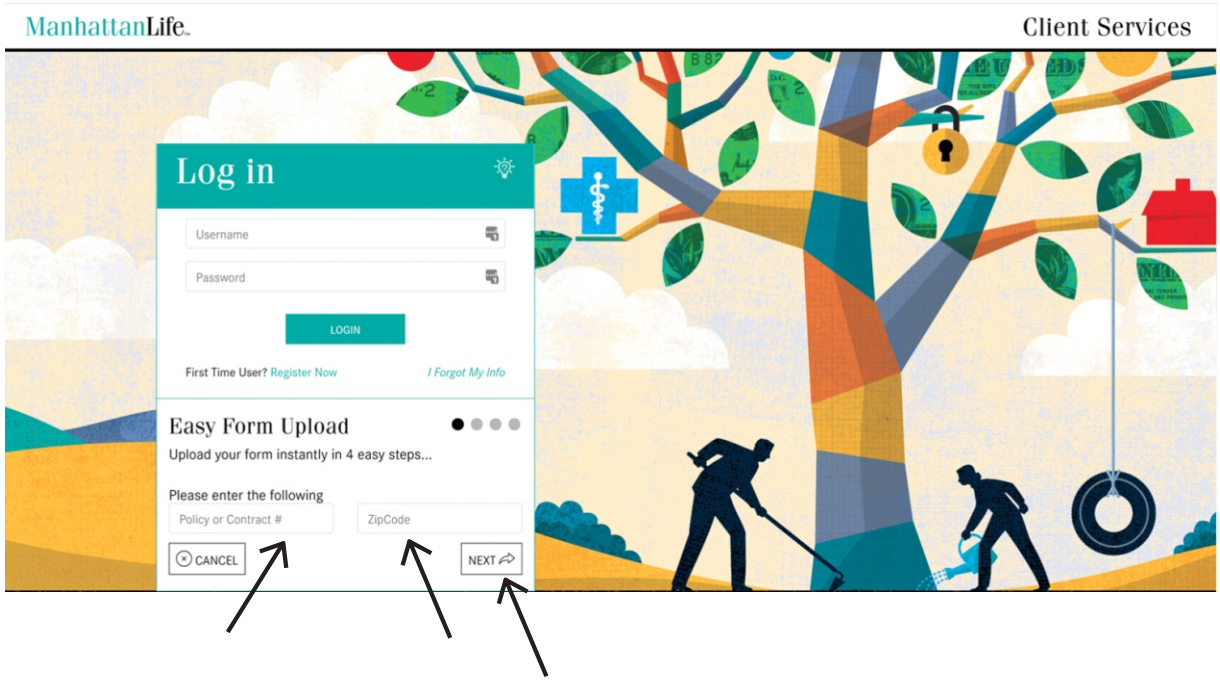
- Click on Easy Form Upload



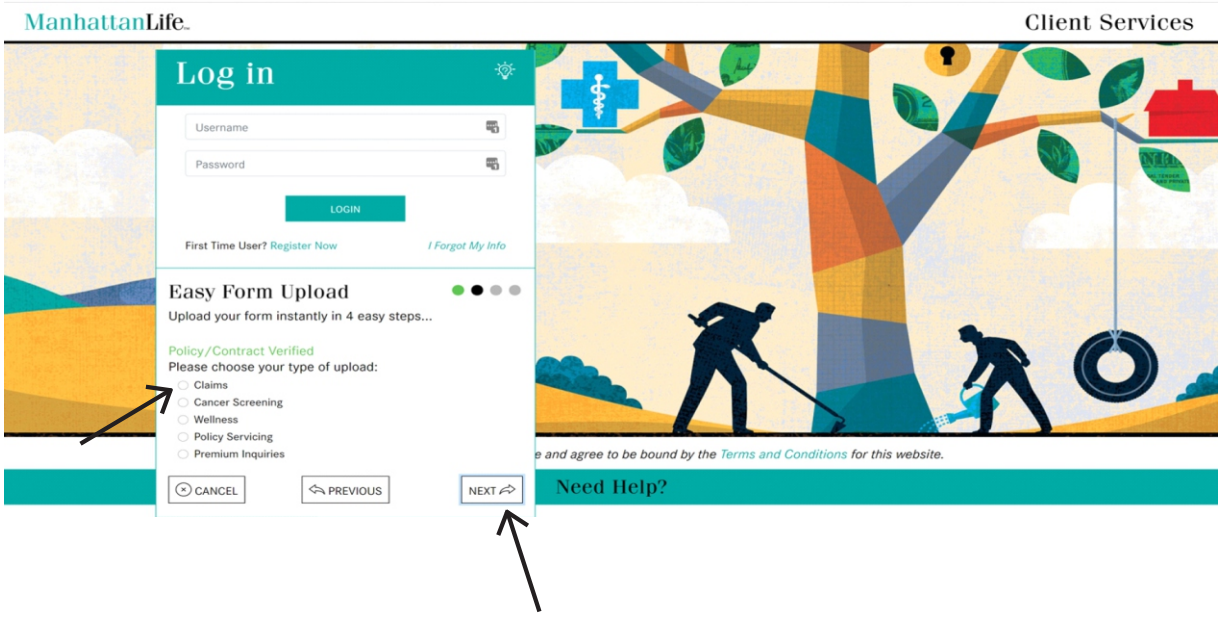
- Click on Easy Form Upload "Begin" button



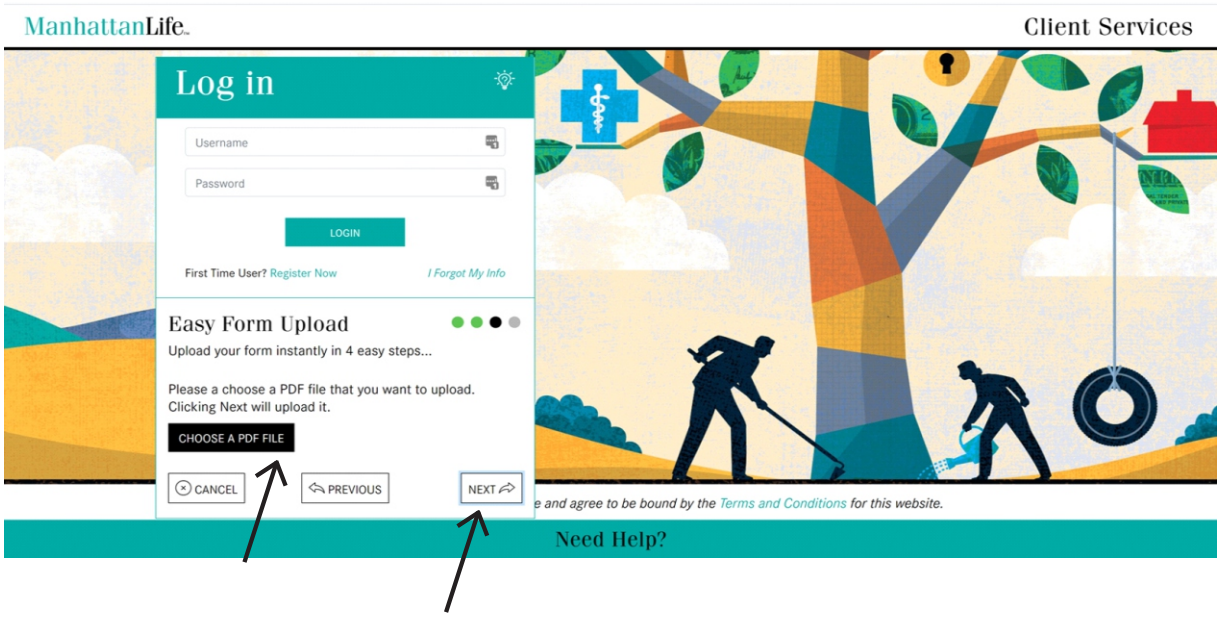
- You will need the policyholder number, the number has eight digits (ie: 72-XXXXXX) but **ONLY** enter the last six digits into the box
- The zip code of the policyholder is entered into the appropriate box
- Click on "Next"



- Click circle by "Claims"
- Click on "Next"



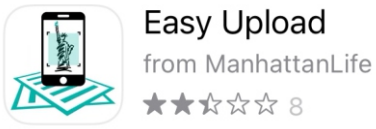
- Click the button that says "Choose a PDF File", this should be the HCFA file on the policyholder.
- Click on "Next" button and this will upload the file
- You will receive a message "Upload Successful" when process is complete



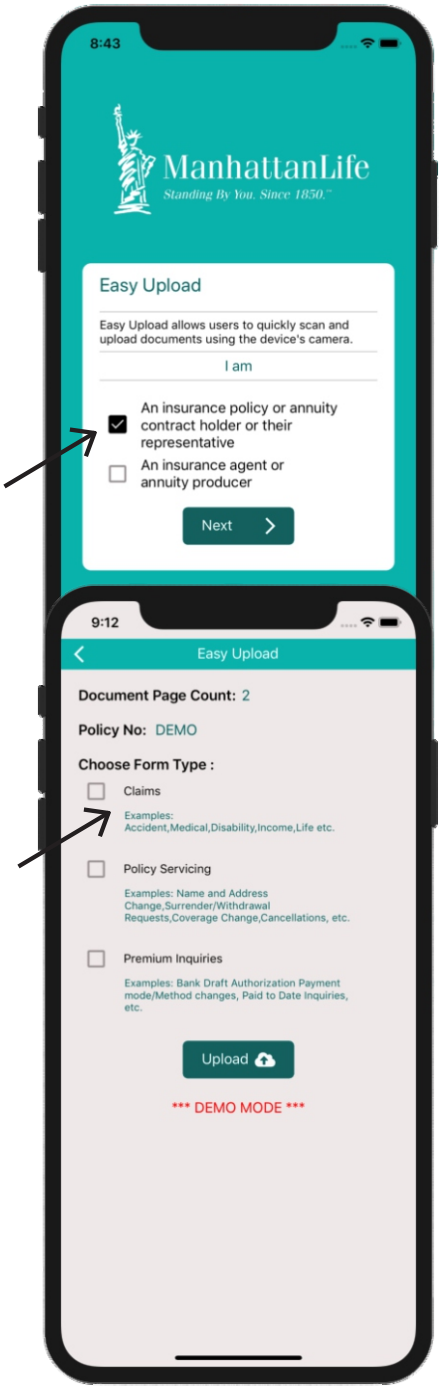
MOBILE CLAIM SUBMISSION

To file a claim with Easy Upload Mobile App:

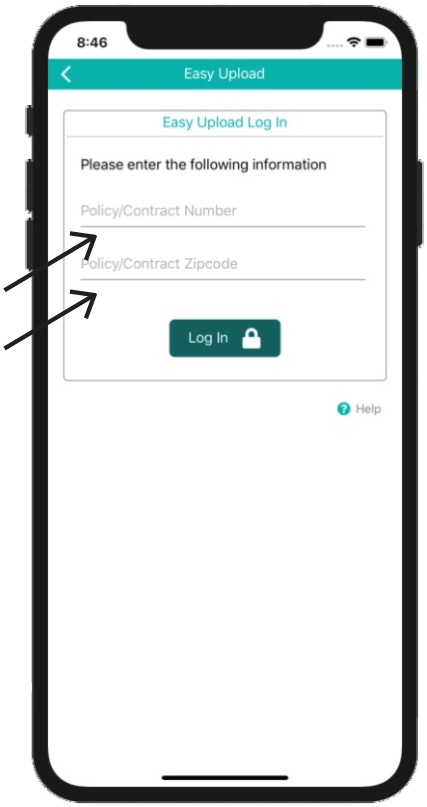
1. Download Easy Upload App



2. Mark box "An insurance policy or annuity contract holder or their representative"



3. Enter "Policy/Contract Number and "Zip Code"



4. Click the "Scan button & push "blue button" to take picture then hit "Continue"

5. Push "Claims" box then hit "upload"

6. The screen will say "Success"

DENTAL PROVIDERS

In case you have staff members or patients who have the plan and have questions, the following is a brief overview of how to find a dental provider and submit a claim.

1. Choose your own dentist (additional savings are available if the dentist is a Preferred Plus Provider).

2. Two ways to find a dentist:
   - Go to www.moadvh.com and select Find a Provider.
   - Call ManhattanLife Customer Service Department (800-999-2971) and they will be happy to assist you.

3. **TAKE YOUR INSURANCE CARD TO YOUR OFFICE VISIT.**
   - Your insurance identification card should have MOA DVH and your maximum benefit ($1000 or $1500) listed on the card.

4. Voluntary use of the MOA DVH network may help you save money on your vision care. If you go outside the network, you will need to ask the office to file on your behalf or file directly with ManhattanLife and be reimbursed from them.

   If you need to file your claim, the following options are available:
   - Easy Upload App (Mobile) – Use Invoice
   - Easy Form Upload (Online) – Use Invoice
   - HCFA Form to be completed by Optometrist – Fax or Mail to ManhattanLife

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

ManhattanLife
Claims Department
P.O. Box 925309
Houston, TX 777292-2728
Fax: 713-538-0677

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 0.00

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Clear Form

How to File a Claim for Your Dental, Vision and Hearing Policy

Vision

Claim Filing

We accept the HCFA 1500 (Health Care Financial Administration) standardized health insurance claim form or the Vision Claim Form at www.manhattanlife.com

Your policy will consider charges for basic eye exams, refractions, eyeglasses and contact lenses.

In the information section of the form, you or your physician 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 vision services.

If your vision care provider files the claim for you

Many ophthalmologist and optometrists will file the claim on your behalf. Many 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 vision care provider.

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

FAX: 713-583-0677

CLAIM FOR DENTAL, VISION, AND HEARING EXPENSE BENEFITS

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

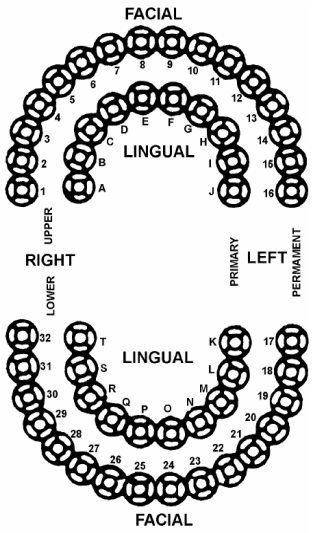
12. Mailing Address	City, State	Zip

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?			
				Office	Hosp.	ECF	Other		No	Yes	How Many?

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 _____

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

ManhattanLife