

Claims

Open Claims

Open Claim Status

Claim History

Manual Claim Entry

Manual Claim Entry: Allows user to enter and submit claims manually.

New Patient

Clicking on the New Patient button allows the user to enter or edit patient and subscriber information to be stored for future use.

New Patient/ Edit Patient Information

[Close](#)

Patient is Subscriber: Inactive Primary Secondary

Last Name: First Name:

Date of Birth (MM/DD/CCYY): / / Gender: M F

Street Address:

City: State: Zip Code:

Student Status: FTS OPTS None

Primary Subscriber Information

Last Name: First Name:

Date of Birth (MM/DD/CCYY): / / Gender: M F

Street Address:

City: State: Zip Code:

Relationship to Insured:

Insurance Company: [New Insurance](#)

Insurance Company:
Street Address:
City: State: Zip Code:

Insurance Member ID: Group Number

Employer Name:

Secondary Insurance

Other Dental or Medical Coverage? No Yes (Complete form bellow)

Last Name: First Name:

Date of Birth (MM/DD/CCYY): / / Gender: M F

Relationship to Insured:

Insurance Company: [New Insurance](#)

Insurance Company:
Street Address:
City: State: Zip Code:

Insurance Member ID: Group Number:

Clicking on [New Insurance](#) will expand the insurance section to allow the user to enter Insurance information. Once all information has been added, click the Save or Save and Fill Form. (Clicking on **Save and Fill Form** will auto-populate the information into the claim for the user.)

Existing Patient

Clicking on the Existing Patient button allows the user to search for a previously saved Patient. The Patient's Last Name, First Name, and DOB can be entered.

Active or Inactive patient's may be searched. Once the patient list has been loaded into the window, it can be selected or edited.

If the patient is selected from the list, the patient information will auto-populate into the claim form.

Existing Patient Search [Close](#)

LastName
 FirstName
 DOB
 Status Active

[New](#)

No.	Action	Patient Last Name	Patient First Name	DOB	Status
1	Edit Select	██████████	██	██████████	Active

[View history](#) Users can choose to view previously submitted manual claim entry files:

History list [Close](#)

Search history claim: 1

No	Option	ClaimID	Status Claim	Date Submit	Status Request	Date Request	Count Request
1	Delete Load draft	10894		2013-08-07 01:13:55		2013-08-07 01:13:55	0
2	Delete Load draft	10892		2013-08-07 12:48:42		2013-08-07 12:48:42	0
3	Delete Load draft	10890		2013-08-07 12:41:56		2013-08-07 12:41:56	0
4	Delete Load draft	10889		2013-08-07 12:41:56		2013-08-07 12:41:56	0
5	Delete Load draft	10888		2013-08-07 12:41:56		2013-08-07 12:41:56	0
6	Delete Load draft	9019		2013-06-27 01:20:59		2013-06-27 01:20:59	0
7	Delete Load draft	9017		2013-06-27 01:13:39		2013-06-27 01:13:39	0
8	Delete Load draft	8044269		2012-10-24 02:19:29		2012-10-24 02:19:29	0

Dental Claim Form

<p>HEADER INFORMATION</p> <p>1. Type of Transaction (Check all applicable boxes) <input checked="" type="radio"/> Statement of Actual Services <input type="radio"/> Request for Predetermination/ Preauthorization <input type="radio"/> EPSDT/ Title XIX</p> <p>2. Predetermination/ Preauthorization Number <input type="text"/></p> <p><input checked="" type="radio"/> Primary <input type="radio"/> Secondary</p> <p>PRIMARY PAYER INFORMATION</p> <p>3. Name, Address, City, State, Zip Code New Insurance Company: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/></p> <p>OTHER COVERAGE</p> <p>4. Other Dental or Medical Coverage? <input checked="" type="radio"/> No (Skip 5-11) <input type="radio"/> Yes (Complete 5-11)</p> <p>5. Subscriber Name (Last, First, Middle Initial, Suffix) Last Name: <input type="text"/> First Name: <input type="text"/></p> <p>6. Date of Birth (MM/DD/CCYY) <input type="text"/> / <input type="text"/> / <input type="text"/> 7. Gender <input type="radio"/> M <input type="radio"/> F 8. Subscriber ID # (SSN or ID#) <input type="text"/></p> <p>9. Plan/ Group Number <input type="text"/> 10. Relationship to Primary Subscriber <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent Child <input type="radio"/> Other</p> <p>11. Other Carrier Name, Address, City, State, Zip Code New Name: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/></p>	<p style="text-align: right;"> New Patient Existing Patient Submit Clear form View history </p> <p>PRIMARY SUBSCRIBER INFORMATION</p> <p>12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Last Name: <input type="text"/> First Name: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/></p> <p>13. Date of Birth (MM/DD/CCYY) <input type="text"/> / <input type="text"/> / <input type="text"/> 14. Gender <input type="radio"/> M <input type="radio"/> F 15. Subscriber ID # (SSN or ID#) <input type="text"/></p> <p>16. Plan/Group Number <input type="text"/> 17. Employer Name <input type="text"/></p> <p>PATIENT INFORMATION</p> <p>18. Relationship to Primary Subscriber (Select applicable box) 19. Student Status <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent Child <input type="radio"/> Other <input type="radio"/> FTS <input type="radio"/> PTS <input checked="" type="radio"/> None</p> <p>20. Name, Address, City, State, Zip Code Last Name: <input type="text"/> First Name: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/></p> <p>21. Date of Birth (MM/DD/CCYY) <input type="text"/> / <input type="text"/> / <input type="text"/> 22. Gender <input type="radio"/> M <input type="radio"/> F 23. Patient ID/Account: # (Assigned by Dentist) <input type="text"/></p>																																																																																							
<p>RECORD OF SERVICES PROVIDED</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>24. Procedure Date</th> <th>25. Area of Oral Cavity</th> <th>26. Tooth System</th> <th>27. Tooth Number(s) or letter(s)</th> <th>28. Tooth Surface</th> <th>29. Procedure Code</th> <th>30. Description</th> <th>31. Fee</th> <th style="text-align: right;">Add Row</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td>IP</td> <td></td> <td></td> <td>Load</td> <td></td> <td>0.00</td> <td style="text-align: right;">Add</td> </tr> </tbody> </table>		24. Procedure Date	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	Add Row	1		IP			Load		0.00	Add																																																																					
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<p>MISSING TEETH INFORMATION</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">34. (Place an <input checked="" type="checkbox"/> on each Missing tooth)</th> <th colspan="16">Permanent</th> <th colspan="12">Primary</th> <th rowspan="2">32. Other Fee(s)</th> <th rowspan="2">33. Total Fee</th> </tr> <tr> <th>1</th><th>2</th><th>3</th><th>4</th><th>5</th><th>6</th><th>7</th><th>8</th><th>9</th><th>10</th><th>11</th><th>12</th><th>13</th><th>14</th><th>15</th><th>16</th> <th>A</th><th>B</th><th>C</th><th>D</th><th>E</th><th>F</th><th>G</th><th>H</th><th>I</th><th>J</th><th>K</th> </tr> </thead> <tbody> <tr> <td></td> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> <td>T</td><td>S</td><td>R</td><td>O</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table>		34. (Place an <input checked="" type="checkbox"/> on each Missing tooth)	Permanent																Primary												32. Other Fee(s)	33. Total Fee	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	K		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	O	P	O	N	M	L	K	0.00	0.00
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<p>AUTHORIZATIONS</p> <p>36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.</p> <p><input checked="" type="checkbox"/> SIGNATURE ON FILE <input type="text"/> 08/07/2013</p> <p>37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.</p> <p><input checked="" type="checkbox"/> SIGNATURE ON FILE <input type="text"/> 08/07/2013</p>		<p>ANCILLARY CLAIM/ TREATMENT INFORMATION</p> <p>38. Place of Treatment (Select application box) <input checked="" type="radio"/> Provider's Office <input type="radio"/> Hospital <input type="radio"/> ECF <input type="radio"/> Other</p> <p>39. Number of Endosures (00 to 99) <input type="text"/> Radiograph(s) <input type="text"/> Oral Image(s) <input type="text"/> Model (s)</p> <p>40. Is Treatment for Orthodontics? <input checked="" type="radio"/> No (Skip 41-42) <input type="radio"/> Yes (Complete 41-42)</p> <p>41. Date Appliance Placed (MM/DD/CCYY) <input type="text"/></p> <p>42. Months of Treatment Remaining <input type="text"/> 43. Replacement of Prosthesis? <input checked="" type="radio"/> No <input type="radio"/> Yes (Complete 44)</p> <p>44. Date Prior Placement (MM/DD/CCYY) <input type="text"/></p> <p>45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident</p> <p>46. Date of Accident (MM/DD/CCYY) <input type="text"/> 47. Auto Accident State <input type="text"/></p>																																																																																						
<p>BILLING DENTIST OR DENTAL ENTITY</p> <p>48. Name, Address, City, State, Zip Code New Billing Name: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/> +4 <input type="text"/></p> <p>49. Group NPI <input type="text"/> 50. License Number <input type="text"/> 51. SSN or TIN <input type="text"/></p> <p>52. Phone Number <input type="text"/> 52A. Additional Provider ID <input type="text"/></p>		<p>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</p> <p>53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require more visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.</p> <p>New Signed (Treating Dentist): Last Name: <input type="text"/> First Name: <input type="text"/> Date: <input type="text"/> 08/07/2013</p> <p>54. NPI <input type="text"/> 55. License Number <input type="text"/> 56A. Additional Specialty Code <input type="text"/></p> <p>56. Address, City, State, Zip Code New Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip Code: <input type="text"/> +4 <input type="text"/></p> <p>57. Phone Number <input type="text"/> 58. Additional Provider ID <input type="text"/></p>																																																																																						
<p>35. Remarks <input type="text"/></p>		<p><input type="checkbox"/> NEA <input type="checkbox"/> MN AUC Submit Clear form</p>																																																																																						

Section Descriptions:

- Select Type of Transaction
- Add Predetermination/Preauthorization Number if necessary
 Select Primary or Secondary coverage
- Add Primary Payer Information.
 Select [New](#) to add Primary Payer information to database. Once completed, click Save and Fill Form.

Insurance Company list

[Close](#)

Insurance Company: Inactive



Street Address:

City: State: Zip Code:


[Save](#) [Save and Fill form](#)

Click on the magnifying glass icon [New](#) to Search for previously stored Insurance Payer/Carrier information.

- Indicate Other Dental or Medical Coverage.
- Secondary Coverage information, subscriber Last and First name

6. Date of Birth of Secondary Subscriber.
7. Gender of Secondary Subscriber.
8. Subscriber ID# for Secondary Subscriber.
9. Plan / Group number for Secondary Subscriber.
10. Relationship to Primary Subscriber.
11. Other Carrier Information. Click on [New](#) to add new Insurance Payer/Carrier information. Click on  to Search for previously stored Insurance Payer/Carrier information.
12. Primary Subscriber Information: Last Name, First Name, Address, City, State and Zip.
13. Primary Subscriber Date of Birth
14. Primary Subscriber Gender.
15. Primary Subscriber ID#.
16. Primary Subscriber Plan/Group Number.
17. Primary Subscriber Employer Name.
18. Patient Information: Indicate Relationship to the Primary Subscriber.
19. Patient's Student Status
20. Patient information: Last Name, First Name, Address, City, State and Zip.
21. Patient's Date of Birth.
22. Patient's Gender.
23. Patient ID/Account Number assigned by Dentist.
24. Procedure Date: Key in Procedure Date or click on  to choose date.
25. Area of Oral Cavity: Click on to view list of Areas of Oral Cavity. Choose if needed.
26. Tooth System: Defaults to JP.
27. Tooth Number(s) or Letter(s): Click on to view a list of tooth numbers/letters to choose from.
28. Tooth Surface: Click on for each Surface needed per the procedure code used.
29. Procedure Code: Click on [Load](#) to view a list of procedure codes to choose from. Click on in the Procedure Code list to choose the procedure code.
30. Description: The Description will auto-populate when the procedure code is selected.
31. Fee: Enter the proper Fee associated with the code selected.



Note: Rows may be added or deleted as needed by choosing or .







32. Other Fee(s): Select the  icon to enter Primary Paid amount and Date. Select Save when information has been entered.

Enter Primary Payment Information [Close](#)

Primary Paid Amount:

Primary Paid Date: / /
(MM/DD/CCYY)

33. Total Fee: This will auto-populate and calculate the fee to be sent on the claim.
34. Missing teeth Information: Click on the tooth number(s) to indicate any missing teeth.
35. Remarks: Located at the bottom of the form. Additional remarks or narrative may be added.
36. Authorizations: Click into the box to indicate that the patient agrees to the treatment plan and fees. Enter date or click on  to select date.
37. Click into the box to indicate payment is to pay to the provider. Enter date or click on  to select date.
*Note: No checkmark indicates that the payment will pay to the **patient**.*
389. Place of Treatment: Select place of Treatment
39. Number of Enclosures: Indicate Number of Enclosures.
40. Is Treatment for Orthodontics? Indicate if Treatment is for Orthodontics.
41. Date of Appliance Placed: If treatment is for Orthodontics, then there MUST be a placement date entered.

- 42. Months of Treatment Remaining: If treatment is for Orthodontics, then Months of Treatment Remaining must be entered.
- 43. Replacement of Prosthesis: Indicate if Prosthesis is New or Replacement.
- 44. Date Prior Placement: If the Prosthesis a Replacement, then the Prior Placement Date must be keyed in or click on  to select date.
- 45. Treatment Resulting From: Indicate if an Occupational Illness, Auto Accident or Other Accident.
- 46. Date of Accident: If treatment was due to an Accident then the Date must be keyed in or click on  to select date.
- 47. Auto Accident State: If the Auto Accident box was selected in box 45, the State of the Accident must be entered.
- 48. Billing Dentist or Dental Entity: Enter Name, Address, City and Zip Code of Billing Dentist or Dental Entity.
Click on  to Search for previously stored Billing Dentist information.
- 49. Group NPI: Key in Group NPI.
- 50. License Number: Not Used
- 51. SSN or TIN: Enter SSN# or TID (Tax ID)
- 52. Phone Number: Enter Phone Number for the Office.
- 52A. Additional Provider ID: Enter required Insurance Company issued Group ID number.
- 53. Treating Dentist and Treatment Location Information: Enter Last Name, First Name and Date. Click on  to Search for previously stored Treating Dentist information. Enter date or click on  to select date.
- 54. NPI: Enter Treating Dentist's Individual NPI number.
- 55. License Number: Enter Treating Dentist's License Number.
- 56. Address, City, State, Zip Code: Enter Treating Dentists Physical Address, City, State and Zip Code. Click on  to search for previously stored Physical Location information. *Note: This CANNOT contain a P.O. Box in the address.*
- 57. Phone Number: Enter Phone Number of the Office.
- 58. Additional Provider ID: Enter required Insurance Company issued Provider ID number.

At the bottom of the form are 2 options:

NEA Creates a Pop-Up for NEA information to be entered:

NEA Information [Close](#)

NEA#

MN AUC Allows the user to add information required by Minnesota offices submitting via fax to Minnesota Payers. This will Pop-Up a window for the user to add additional information:

Fax and Appeals Submission Contact Information

[Close](#)

Insurance Company Fax

Minnesota Department of Human (800-366-5411 or 651-431-2700 800-366-5411 or 651-431-2700)

Contact Information

Contact Name

Contact Phone Number Extension

Attachment Information

Type	Send By	Attachment Send Date(mm/dd/yyyy)	Pages	Attachment Number
Explanation of Benefits <input type="button" value="v"/>	Fax <input type="button" value="v"/>	01 / 01 / 2013	2	7038291759

Number of Pages * Including This Cover Sheet and Copy of Claim

Property and Casualty Claim Number

NOTICE

Some insurance companies may require their own form, in that case you can save or print this form and transfer the information to their property cover sheet

Once this Pop-Up is completed the user must click on Save. This will close the window and add the Attachment Number to the Remarks section of the Claim. The user must now complete the MN AUC Form Claims Attachment Cover Sheet located at: <http://www.health.state.mn.us/auc/forms.htm>

Once the Cover sheet is completed, it must be faxed with the EOB to 651-491-7786.