

Delta Dental Introduces New Pre-Treatment Estimate of Benefits Vouchers

Delta Dental's Pre-Treatment Estimate of Benefits vouchers have a clean, new look! They have been redesigned to look similar to the new Explanation of Benefits Statements and offer much more information than before.

What Delta Dental's New PTE Offers

1. **Benefit period** shows the benefit period for the patient.
2. **Claim number** (formerly referred to as voucher number), increased from 9 to 15 digits.
3. **Par status** shows the participating status of the dentist.
4. **Plan type** shows the plan that the patient is enrolled in.
5. **Maximum information** displays the patient's annual and individual maximums.
6. A new section for **prep date and seat date for crowns**.
7. **Submitted and paid procedure numbers** to better illustrate when an alternative benefit has been applied.
8. **Description of procedure numbers**.
9. **Description of processing policies pertaining to the pre-treatment estimate**.

For questions about specific PTEs, contact the number for Claim Inquiries on your Pre-Treatment Estimate statement, or e-mail Customer Service at service@deltadentalnj.com.



Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

Pre-Treatment Estimate of Benefits – Dentist Copy This is an estimate, not a guarantee of payment

Claim Inquiries: 800-452-9310 Visit us on the Internet: www.deltadentalnj.com

JOHN SMITH, DMD
123 ANY STREET
SAMPLETOWN, NJ 00000-0000

Delta Dental's Estimated Payment	\$000.00
Your Other Insurance Paid	\$000.00
Applied to Deductible	\$000.00
Dentist Amount Non Billable	\$000.00
Estimated Patient Out of Pocket Payment Obligation	\$000.00

PATIENT: ROBERT JONES
PATIENT DATE OF BIRTH: 00/00/0000
RELATIONSHIP: SUBSCRIBER
GROUP ID: 0000-0000
GROUP NAME: ABC CORPORATION

1 **BENEFIT PERIOD:** 00/00/0000 – 00/00/0000
2 **CLAIM NUMBER:** 0000000000000000
DENTIST ID NUMBER: 12345NJ
3 **DENTIST NAME:** DR. JOHN SMITH
PAR STATUS: PREMIER

4 **PLAN TYPE:** PREMIER

5 Annual **PLAN MAXIMUM:** \$0000.00 Individual **Used to Date:** \$000.00

PRE-TREATMENT ISSUE DATE: 00/00/0000 **PRE-TREATMENT RETURN BY DATE:** 00/00/0000

6 **PREP DATE:** ___/___/___ **SEAT DATE:** ___/___/___

TOOTH NO. OR LETTER	SURFACE	DATE SERVICE COMPLETED	SUBMITTED PROCEDURE NO.	PAID PROCEDURE NO.*	SUBMITTED AMOUNT	APPROVED AMOUNT	AMT USED FOR BENEFIT CALC	DED	% COPAY	ESTIMATED DELTA DENTAL PAYMENT	PROCESSING POLICIES
XX	XXXXX	/ /	2391	2140	\$000.00	\$000.00	\$000.00	\$0.00	000%	\$000.00	000, 000, 000
TOTALS					\$000.00	\$000.00	\$000.00	\$0.00		\$000.00	

8 **PROCEDURE NO. / DESCRIPTION**
2391 Resin based composite – one surface, posterior
2140 Amalgam – one surface, posterior

9 **PROCESSING POLICIES**
Line One
Line Two
Line Three

PLEASE SEE REVERSE SIDE OF THIS FORM FOR INFORMATION RELATED TO OUR NOTICE OF PRIVACY PRACTICES, DEFINITIONS, AND OTHER IMPORTANT INFORMATION.

IMPORTANT NOTICES

I. THIS PRE-TREATMENT ESTIMATE IS BASED ON THE SUBMITTED FEES, FILED FEES OR DELTA'S CONTRACTED LEVEL OF FEES AS OF THIS ESTIMATE'S DATE OF ISSUE. THIS TREATMENT ESTIMATE DOES NOT TAKE INTO ACCOUNT OTHER COVERAGE WHICH THE PATIENT MAY HAVE FOR THE SERVICE. IN MANY INSTANCES THE ACTUAL AMOUNT DELTA DENTAL APPROVES AND/OR PAYS MAY CHANGE FOR REASONS SUCH AS:

- 1) **Other claims** being paid before the claim for the work described hereon is received and paid.
- 2) **Coordination of benefits** with other plans and/or non-duplication plans is used to coordinate the amount Delta Dental approves and/or pays.
- 3) **Patient's coverage** and/or benefits had been corrected, changed or terminated as of the time service was completed.
- 4) **A different dentist** rendered the treatment or a **different fee** was charged.
- 5) **Procedures are disallowed**, resulting in no Delta Dental Payment or Patient Liability **in accordance with the Dentist Participation Agreement**.
- 6) Estimates for all services are determined in accordance with the terms of the group's dental plan and/or with the terms of Delta Dental's dentist participation agreements.

II. The amounts indicated are valid only if the dentist actually charges the subscriber/patient and collects from him/her the fees on this pre-treatment form. Although this treatment plan may have been accepted, payment is contingent upon eligibility and benefit levels effective on the actual date of completion of the services.

III. Terminology and Definitions

Approved Amount: The total amount which the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or copay.

Amount Used for Benefit Calculation: The fee amount that the dental benefit plan provides for use in calculating the dental benefit plan estimated payment for the specified service. The dental benefit plan estimated payment may be less than this fee amount due to patient deductible, copay, plan limitations or exclusions.

Urgent Care: "Pre-Treatment Estimate Involving Urgent Care" means a Pre-Treatment Estimate where use of the standard claim determination period (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function in the opinion of a prudent lay person who possesses average knowledge of health and medicine; or (ii) in the opinion of a physician, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Pre-Treatment Estimate.

IV. Informal Review (Optional to Subscriber)

The covered person (or authorized representative) and/or treating dentist may, within 60 days of the date of mailing of this Pre-Treatment Estimate request that we informally reconsider this claim decision by following the procedure described below; we will respond within 60 days and notify the subscriber (or

authorized representative) and treating dentist of our decision and the reason(s) therefor.

Urgent Care Pre-Treatment Estimates may be faxed to (973) 285-4095. Once your dentist supplies all information, Delta Dental will process within 48 hours.

Submit the following information and documentation:

- a) Dentist name, office name, address and license number
- b) Subscriber name, identification number and date of birth
- c) Patient name, identification number and date of birth
- d) Pre-Treatment Estimate number
- e) The specific decision which you request be reviewed and a description of the reasons why Delta Dental should change its initial decision on the Pre-Treatment Estimate
- f) Any supplemental information or diagnostic materials relevant to the claim in question
- g) In lieu of (a), (b), (c), and (d), attach a copy of the Pre-Treatment Estimate determination you are requesting be reviewed.

A form is available for you to use at http://www.deltadentalnj.com/HIPAA/law_compliance.shtml.

You must sign your request; if you are authorized to act for the covered person, you must state that and complete Delta's authorization form. You may include information and/or documentation pertinent to the Pre-Treatment Estimate even if you had not previously submitted it to us. Informal review requests must be addressed to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054.

V. Notice of Privacy Practices

You may access Delta Dental's Notice of Privacy Practices on our website at www.deltadentalnj.com. You may also obtain a hard copy of this notice by contacting our compliance administrator at (866) 861-4716.

VI. Coordination of Benefits

If you are covered by more than one dental and/or health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

You should always submit first to your primary carrier and, after receiving its determination, submit your claim to your secondary or tertiary carriers (if applicable).