

# Dental Network Provider FAQs

This document provides information for the Ameritas Dental network, covering participation, payment, benefits, claims and general administrative procedures.

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## Ameritas Dental Network

### Q. Does Ameritas lease its dental network?

A. Yes. Ameritas has special arrangements with companies who use their network. This enables Ameritas to advertise your practice to a wider range of groups, giving you exposure to more patients. Insured members will have an ID card that includes the Ameritas logo.

Log in to the Provider Portal and go to the Resource Center for more information.

- [Provider](#)
- [Provider \(NY\)](#)

### Q. Is this a capitation/dental DHMO program?

A. No. You will be reimbursed according to the contract fees in your area and for your specialty type. There are no monthly eligibility rosters or a referral process. This is a program that you will be able to integrate into your practice with ease.

### Q. Can your insured members receive benefits from any provider, or must they see a network provider?

A. A member always has a choice in selecting their own dental provider. However, by choosing a network provider, they can save on out-of-pocket expenses. Many insured members choose a network provider for these reasons.

### Q. How will insured members know I participate on the Ameritas network?

A. They can visit our website and view the [online provider directory](#). This website is updated on a daily basis and includes the names and locations of participating providers in the Ameritas PPO network.

### Q. Who do I contact about becoming a member of the Ameritas Dental Network?

A. You may request an application packet by contacting provider relations at 800-755-8844, ext. 88327 or sending an e-mail to [providerrelations@ameritas.com](mailto:providerrelations@ameritas.com).

### Q. Am I automatically accepted onto the network after completing the appropriate paperwork?

A. No. Ameritas' in-house provider relations team is responsible for credentialing each application received. A provider will be added to the dental network once all credentialing and quality assurance requirements are successfully completed.

Upon acceptance in the Ameritas Dental Network, you will receive a welcome letter along with a copy of your executed Ameritas Dental Agreement.

### Q. What types of benefit programs do you offer network providers?

A. Ameritas offers several discounts on items that may be beneficial to your dental practice. Ameritas' reward programs provide savings on spore testing, dental software, eye protection and much more. View the [Reward Programs](#) available when you join the Ameritas network.

### Q. Who can I contact with questions about the network program?

The provider relations team is happy to help.

800-755-8844, ext. 88327.

Monday – Thursday: 6:30 a.m. – 5:30 p.m. CST

Friday: 6:30 a.m. – 4:30 p.m. CST

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## Payment

### Q. How will I get paid for my services?

- A. You will be paid based on your contract fees and the patient's benefit plan.

Payments for claims by Ameritas PPO network providers will be made to the dental provider, based on contractual agreements.

Non-participating providers must submit an "Assignment of Benefits" with each claim to receive benefit payments directly. We also accept "Signature on File." This applies to claims filed in the United States.

You do not need to use a Reliance Matrix claim form. We accept any claim form that meets standard ADA guidelines. If you would like to use our claim form, download a copy [here](#).

### Q. How do I obtain a current list of contract fees?

- A. If you are considering participating in the Ameritas network, you may contact the provider relations team at 800-755-8844, ext. 88327. Once you are an active network provider, current fee schedules are available online.

Ameritas contract fees are reviewed on an annual basis.

## Benefits

### Q. Can your insured members receive services from any provider, or must I be in the Ameritas Dental Network?

- A. Our insured members always have a choice in selecting their own-provider.

However, choosing a network provider in the Ameritas Dental Network, where available, may result in the member receiving reduced out-of-pocket costs. Some plans offer higher benefit percentages, increased maximums, and/or reduced deductibles or copayments when treatment is performed by a network provider.

Therefore, we recommend that you and your patient contact us if you are unsure about how the choice of a network provider may impact benefits. For a description of the member's plan, verify his or her benefit information:

Visit, [www.reliancematrix.com/individuals/dental-and-vision](http://www.reliancematrix.com/individuals/dental-and-vision) to sign in to the Provider Portal.

### Q. My patient needs a referral to another dental provider. Any suggestions?

- A. Our insured members are not required to receive approval or obtain a referral from us to see a general dentist or specialist. Members are welcome to seek treatment from any provider of their choice.

If possible, we suggest you refer the member to an Ameritas participating provider to help the patient maximize his or her benefits. Some plans offer higher benefit percentages, increased maximums and/or reduced deductibles or copayments when treatment is performed by a participating provider.

Use our [online provider directory](#) to access our online list of participating providers. You may search for general dentists or a specific type of specialist.

### Q. How can I find benefit information for a patient?

- A. There are many ways to find patient benefit information. You can go online to your provider account, call and request the information to be faxed to you, submit a pretreatment estimate, or request that your patient provide their certificate of coverage.

- **Go online:** Sign into your [provider account](#), or **if in NY**, and select the Member Information tab.
- **Request a fax:** Receive benefit summaries by fax: Call **800-497-7044 (NY: 800-829-3177)** and press **1** for benefit information, then press **2** for providers. Enter the plan member's identification number.
- **Submit a pretreatment estimate:** We recommend that a pretreatment estimate be submitted for all anticipated work that is considered expensive by our insured members. For more information, visit the Resource Center section of the Provider Portal.
- **View the certificate:** Ask the insured member to bring you his or her certificate of coverage, which outlines plan benefits and limitations. For schedule plans, the member's certificate includes a list of the plan's maximum allowances.

**Q. Do you require preauthorizations or pretreatment estimates?**

A. Pretreatment estimates are the best way to determine a member's out-of-pocket expense. We recommend submitting pretreatment estimates for all anticipated work that is considered expensive by our insured members.

A pretreatment estimate is not a preauthorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

For more information, visit the Resource Center section of the Provider Portal.

**Q. Are Teledentistry Services covered?**

A. All services under our plans are covered when appropriately delivered through teledentistry services. They are subject to the same plan benefits and limitations as equivalent services that are not provided through teledentistry.

## Claims

**Q. How do I obtain claims status information or a copy of an Explanation of Payment (EOP)?**

A. Sign into your [provider account](#), or **if in NY**, and select the Member Information tab.

**Q. When should I submit X-ray films, charting and other supporting documentation?**

A. Please review our [Supporting Documentation Flyer](#). Feel free to print a copy for your office's use.

Additional information about claim requirements is available on in the Resources Center section of the Provider Portal

**Q. What are the advantages of electronic claims submission?**

A. Electronic claims submission is a way for you to reduce some of the expenses associated with running your practice and a way for us to expedite claim processing.

- We process claims submitted electronically the day they are received.
- Electronic claims submission eliminates postage and envelope expenses.
- Electronic claims submission tracking eliminates lost claims and allows for immediate follow-up regarding transmission status.

- Many practice management systems allow entry of information once for both accounting and claims submission.
- Reduced transaction fees are available for participating providers of our PPO network.

**Q. What do I need to submit electronic claims?**

A. Your office will need to have a system that is linked to a clearinghouse with software or internet access.

- All electronic claims must be submitted through a clearinghouse.
- Be sure to submit electronic claims under the same tax identification number that you would use on a paper claim. **If you change this number with the IRS, please be sure to notify Reliance Matrix of these changes.**
- To ensure that your electronic claim is processed properly, include the following information:
  - Name of the **"treating"** dentist
  - Tax Identification Number (or the dentist's identification number)
  - Office address where services were performed

It is **imperative** that you include the above information even if you submit under a corporate business name.

Submit all claims electronically even if you think a claim needs an attachment. Ameritas will let you know if additional information is needed. Many claims can be processed using the narrative or claim remark field to provide replacement dates or pocket depths. Ameritas will accept up to 250 characters in this field.

RSL: Payor ID 36088 /

First Reliance Standard: Payor ID 13317

We accept NEA attachments, Tesia eAttachments and DentalXChange electronic attachments.

**Q. Who do I contact with questions about electronic claims submission?**

A. If you are having problems setting up your electronic claims capabilities or sending electronic claims, please contact your clearinghouse, vendor or billing service first. They can review your daily reports to identify any transmission errors and let you know if further research is needed. You may also contact us at **800-497-7044 (NY: 800-829-3177)**.

**Q. Can I fax or mail a claim?**

- A. Yes, claims not requiring X-ray films may be faxed to **402-467-7336**.

You can mail claims to:

Group Claims  
PO Box 82510  
Lincoln, NE 68501-2510

Please see our [Supporting Documentation Flyer](#) for details on when to submit X-rays and/or other supporting documentation.

**Q. Do you accept standard ADA claim forms?**

- A. Yes, we accept claim forms that meet standard ADA guidelines. You do not need to use a Reliance Matrix claim form. If you would like to use our claim form, download a copy [here](#).

## General

**Q. Who do I contact about a tax statement, withholding or B-notice?**

- A. Contact provider assistance at 800-366-5933, option 2.

**Q. What is the Utilization Review Program?**

- A. Utilization review involves a set of guidelines designed to determine benefits by incorporating the dental policy limitations and coding as defined in the Current Dental Terminology© American Dental Association. Ameritas has established a utilization review program to ensure that any guidelines are used consistently, are clearly documented and include procedures for applying such criteria based on the documentation submitted. This criteria was developed with dental consultants who are licensed dentists. The program is reviewed on an annual basis to ensure that the guidelines are current with dental technology, evidence-based research and any dental trends.

During the review of submitted procedures, there may be a determination by a qualified and appropriately licensed dentist that the procedure(s) do not meet the contractual limitations as outlined in the specific dental policy and/or coding as defined in the Current Dental Terminology. When a claim has been denied or partially denied based on the contractual limitations of the dental policy and/or coding as defined in the Current Dental Terminology or an alternate benefit was recommended, this is considered an adverse determination.

**Q. What are my obligations to arrange for emergency coverage and routine appointments?**

- A. Providers are responsible for the quality of dental services provided and the type of appropriate care to members. There is no financial incentive program that compensates you for ordering or providing less than medically necessary and appropriate care to your patients.

You must provide or arrange call coverage or other back-up 24 hours per day, seven days per week during vacations and/or other periods when your office might normally be closed; or make other arrangements for coverage at your expense.

You must offer appointments to all members upon request within a reasonable time. For non-emergency appointments other than exams, cleanings, and/or X-rays, a reasonable amount of time is no more than 30 days, unless state laws and regulations require that routine appointments for non-emergency care shall be available within a different time frame.



For more information visit [reliancematrix.com](https://reliancematrix.com)