AmeriHealth Caritas
District of Columbia

To: **AmeriHealth Caritas DC Dental Providers**

Date: **January 2, 2025**

Subject: **How to Submit Explanation of Benefits (EOB) from Other Insurance Coverage**

Dear Provider,

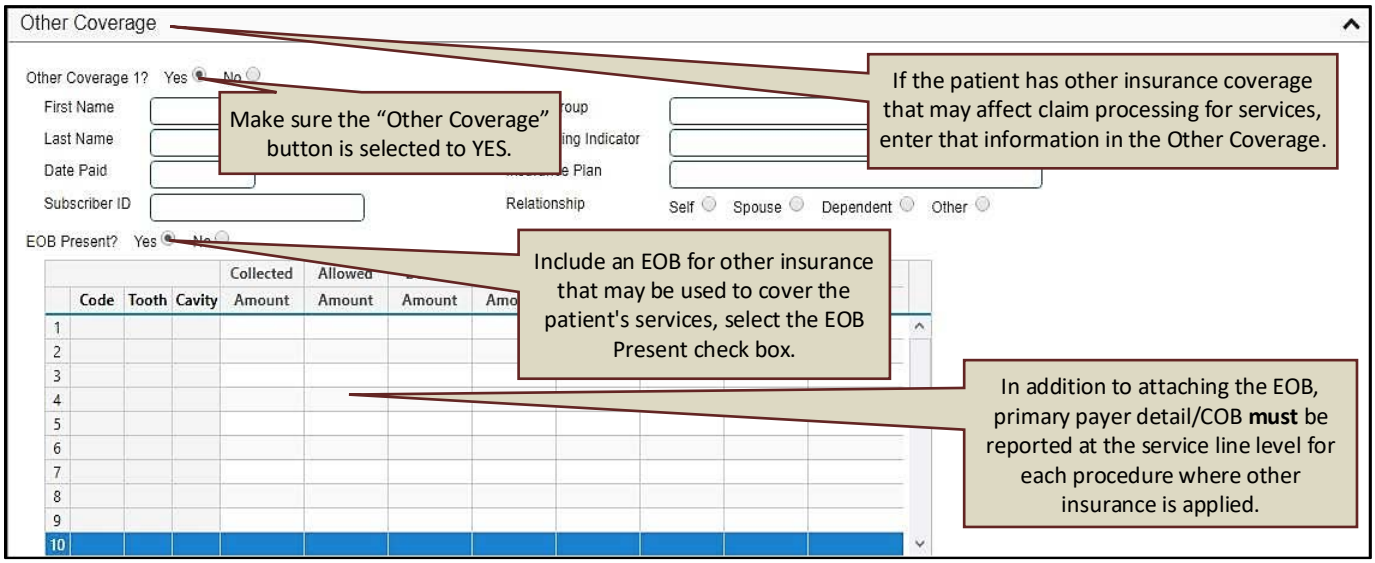
When submitting/resubmitting a claim, if other sources of insurance payment are applicable (primary carrier), the other sources of insurance must be applied first and properly reported. SKYGEN does not assume that primary insurance coverage has already been provided, including an Explanation of Benefits (EOB) that details codes and payment.

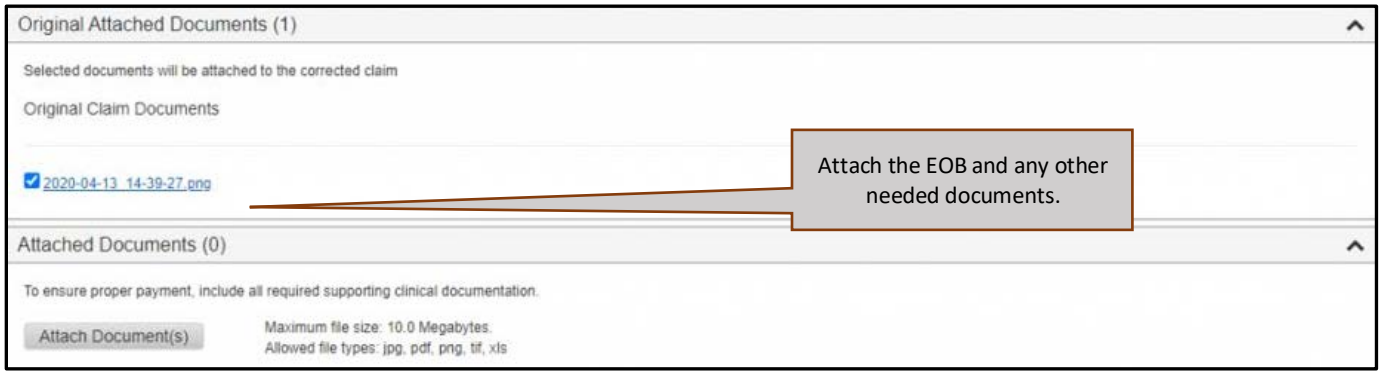
When there is a secondary insurance carrier, a copy of the primary insurance carrier's EOB must be submitted with the claim.

When a primary insurance carrier's payment meets or exceeds a provider's contracted rate or fee schedule, the claim will be considered paid in full, and no further payment will be made on the claim.

Provider Portal

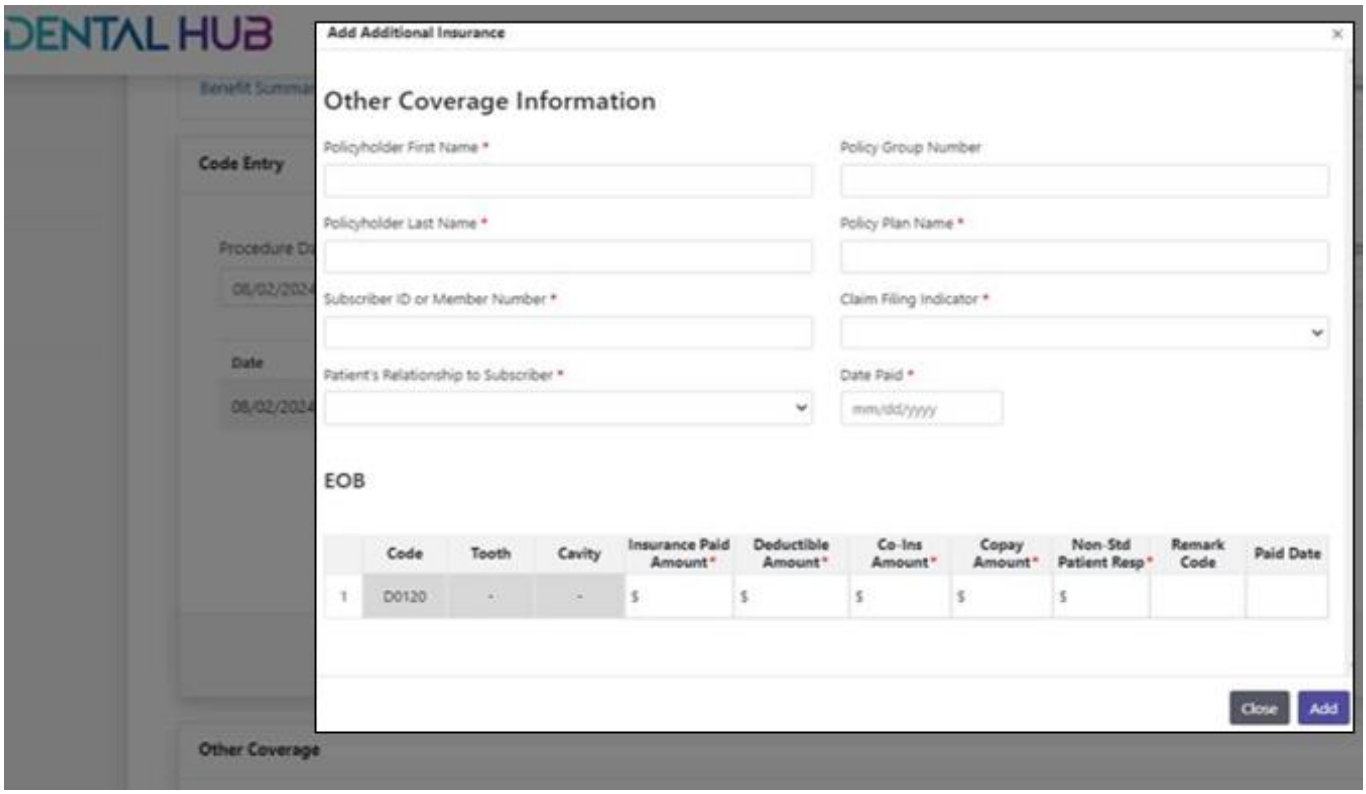
For portal claim submissions, the payment made by the other carrier must be indicated in the appropriate Other Coverage fields.





Dental Hub

For Dental Hub claims submissions, the fields with an asterisk (*) are mandatory for the claim to be accepted.



Electronic Clearinghouse Submissions

Please refer to your clearinghouse for electronic Coordination of Benefits claims submission requirements. Service line level details must be submitted with the claim.

EOB (Coordination of Benefits or Medicare Secondary Payer) and OZ (Support Data for Claim) are acceptable attachment report type codes.

Example below to reference:

	Paid	Allowed	Patient Responsibility			
	Collected Amount	Allowed Amount	Deductible Amount	Coinsurance Amount	Copay Amount	Non-Standard Patient Responsibility
Not Correct	0.00	0.00	0.00	0.00	0.00	0.00
Entry Filled In	$2.00	$10.00	0.00	0.00	8.00	0.00

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F ☐U	8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

The **Allowed amount** must equal the **Paid amount** plus **Patient Responsibility** (which includes deductible, coinsurance, copay and non-standard patient responsibility).

Paper Submissions

Coordination of Benefits – When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's EOB showing the amount paid by the primary payer. When there are multiple Other Payers, attach all relevant EOB's as well as fill in other coverage information as appropriate.

- Claims **MUST** include a copy of the EOB from the other insurance payer(s) showing how they handled the claim/services

If the above guidelines are not followed, claims may be denied or incorrectly adjudicated. For more information, please contact our Provider Services Team:

PROVIDER SERVICES
Telephone: 1-855-609-5170
Email: providerportal@AmeriHealthCaritasDCdental.com

If you have an EOB which indicates that there is no dental benefit or the member has a discount dental program, the EOB must be submitted on paper to the address for claims submission. *These EOBs cannot be submitted on the Dental Hub or through a Clearinghouse and must be manually processed. Otherwise, the submission will not be able to be processed and will need to be resubmitted on paper.*

Paper claims:
AmeriHealth Caritas DC—Claims
P.O. Box 651
Milwaukee, WI 53201

Sincerely,

Nathan Fletcher, DDS
Dental Director