AmeriHealth Caritas
District of Columbia

To: **AmeriHealth Caritas DC Dental Providers**

Date: **September 15, 2026**

Subject: **Third Party Liability – Submitting Claims with Primary Dental Insurance Information**

Dear Dental Provider,

When submitting or resubmitting dental claims, providers must apply all other sources of insurance payment prior to billing AmeriHealth Caritas District of Columbia (DC) Medicaid through SKYGEN. Medicaid is the payer of last resort. If an enrollee has active primary dental insurance, including Third Party Liability (TPL), for the date of service, the primary insurance must be billed first and properly reported on the claim. SKYGEN does not assume that primary insurance coverage or payment information has been supplied unless it is clearly included with the submission of the claim.

Please use the following information when submitting claims for enrollees who have active primary dental insurance or Third Party Liability (TPL) coverage for the date of service (DOS) on the claim:

- TPL insurance must be billed PRIOR to billing AmeriHealth Caritas DC Medicaid (Medicaid is to be the payer of last resort).
- Providers must include information about active primary TPL dental insurance coverage for enrollees who participate in the AmeriHealth Caritas DC Medicaid dental benefit plan when submitting a claim for the DOS.
- Failure to do this could result in a denial stating, “Please resubmit claim as EOB is either missing, illegible or invalid.”

When submitting a dental claim for enrollees with active primary TPL dental insurance coverage

- When submitting claims electronically, please reference this **SKYGEN USA Quick Guide on Submitting Claims with Other Coverage Information.**
- The Explanation of Benefits (EOB) from the primary TPL dental insurance must be included.
- All COB payments and enrollee responsibility must be documented in the appropriate fields for paper claim submissions and/or the loop or segment fields for submitted EDI/Clearinghouse claim submissions.
- The COB payment amounts from the primary dental insurance must be documented for each service line.

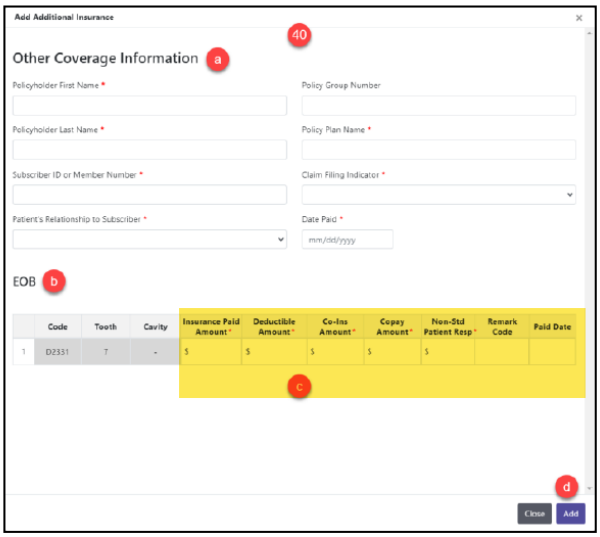
Failure to submit required TPL and COB documentation may result in claim denial or delay in processing.

SKYGEN USA Quick Guide on Submitting Claims with Other Coverage Information

SKYGEN Dental Hub

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

40. Select **Add Other Coverage** if there is an EOB or other coverage associated to this claim
    a. Complete Other Coverage Information
    b. **You must attach the EOB to the claim using Add Document is Step 39**
    c. Enter the other insurance information from the EOB
    d. Select Add to attach this information to the Claim



Electronic Clearinghouse Submissions

Please refer to your clearinghouse for electronic coordination of benefits claim submission. Service line level details must be submitted with the claim.

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

See the example below for 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

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 Explanation of Benefits (EOB) showing the amount paid by the primary payer.

When there are multiple other payers, attach all relevant EOBs and 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

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		

If the above guidelines are not followed, claims may be denied or incorrectly adjudicated.

For additional questions about this process, please contact AmeriHealth Caritas DC Dental Director Nathan Fletcher, DDS, at nlfletcher@amerihealthcaritasdc.com.

Sincerely,
AmeriHealth Caritas DC