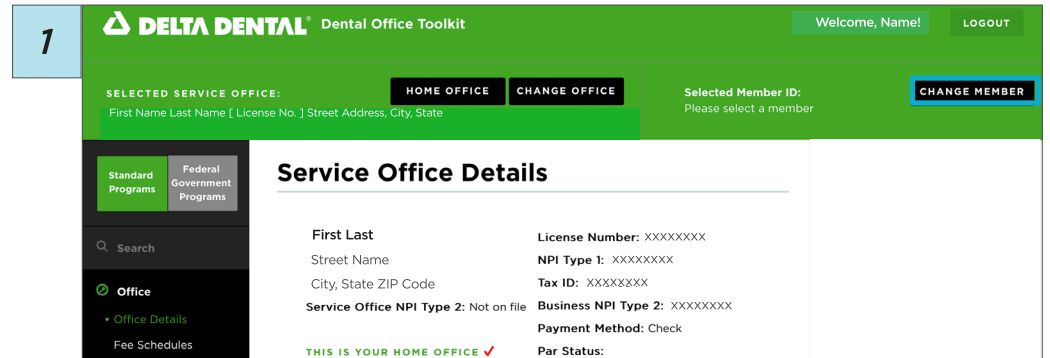


Dental Office Toolkit (DOT) Quick Guide

How to submit a claim

1. On the DOT home screen, click **Change Member**.

Image 1

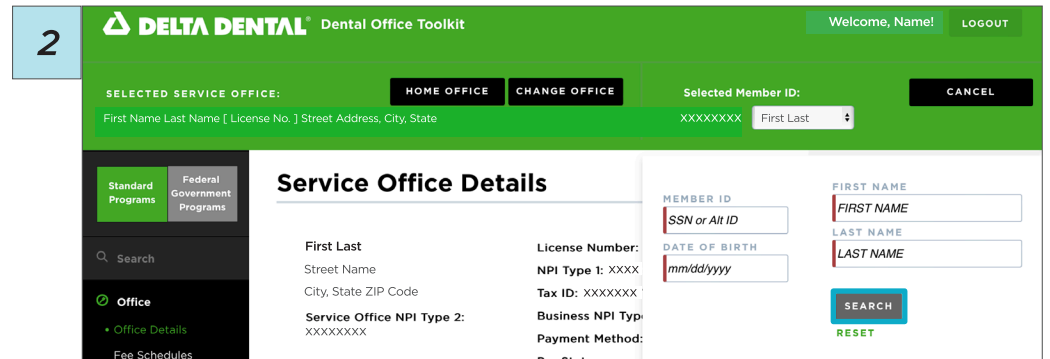


2. Enter the following subscriber information:

- Delta Dental Member ID or SSN
- Date of Birth
- First Name
- Last Name

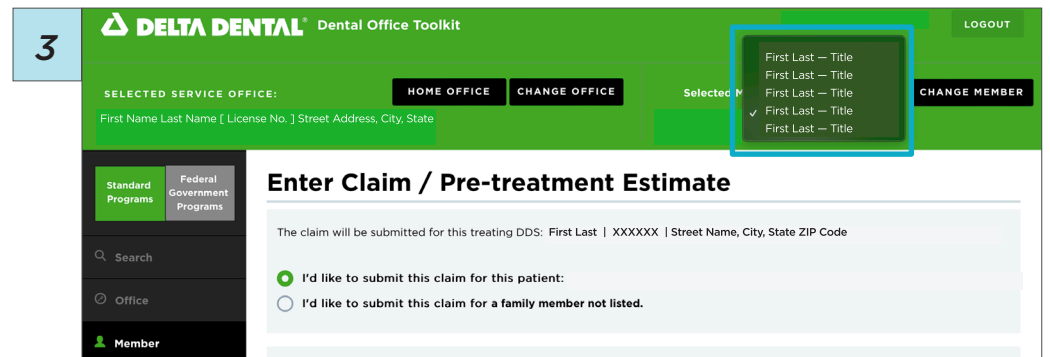
All fields are required. Click **Search**.

Image 2



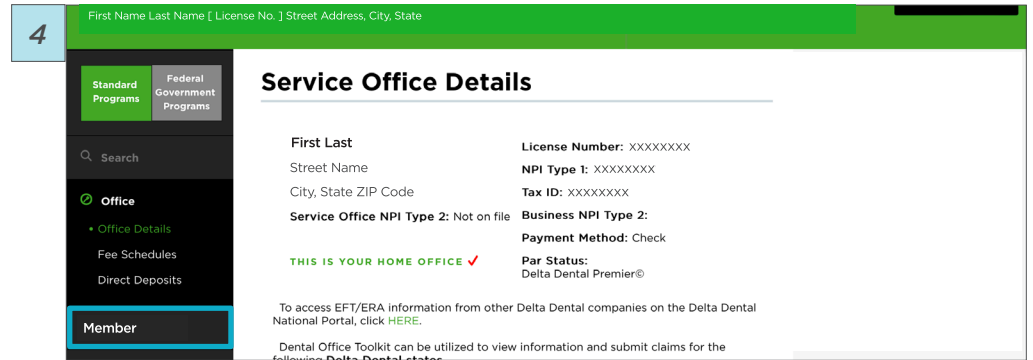
3. Using the Selected Member ID drop down menu, select the patient for this claim.

Image 3



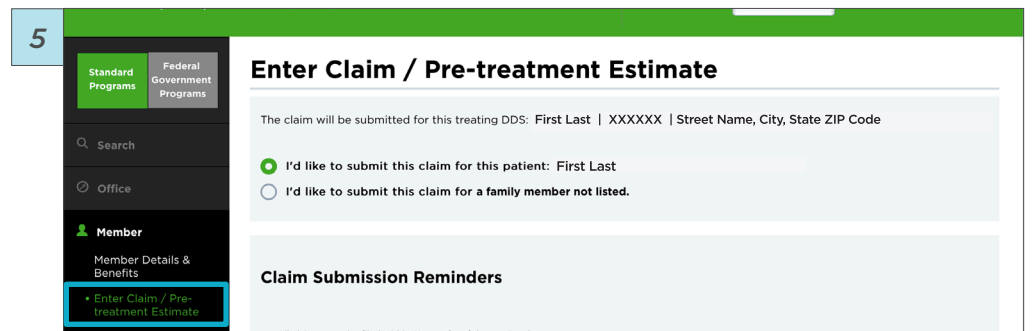
4. Click the Member tab on the left navigation bar.

Image 4



5. Once the Member tab is open, click **Enter Claim / Pre-treatment Estimate**.

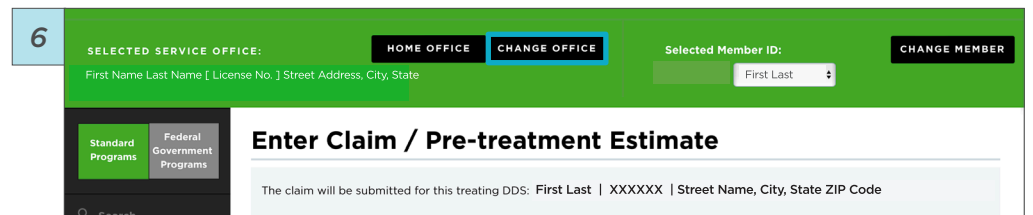
Image 5



6. Verify that the Selected Service Office at the top of the screen matches the provider and location associated with the treatment.

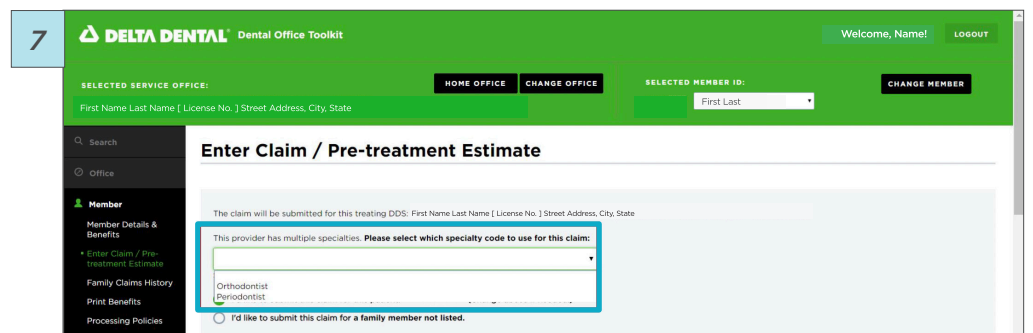
If this information is not correct for the claim you will be submitting, click **Change Office**.

Image 6



7. If the provider has multiple specialties, you'll be prompted to select the specialty code to use for the claim.

Image 7



8. Choose to submit a claim for the patient or for a family member of the patient.

Image 8

9. Scroll down to enter Treatment Details. Fill out fields for:

- Tooth Number
- Area of Arch
- Surface(s)
- Service Date
- Procedure Code
- Submit Amount

Repeat this step if there are multiple treatment lines.

Image 9

10. If the service(s) require additional documentation, click **Choose** or drop files under Claim Attachments.

Image 10

8

SELECTED SERVICE OFFICE: HOME OFFICE CHANGE OFFICE Selected Member ID: XXXXXXXX First Last CHANGE MEMBER

Standard Programs Federal Government Programs

Search

Office

Member Member Details & Benefits

Enter Claim / Pre-treatment Estimate

The claim will be submitted for this treating DDS: First Last | XXXXXX | Street Name, City, State ZIP Code

I'd like to submit this claim for this patient: First Last

I'd like to submit this claim for a family member not listed.

Claim Submission Reminders

9

SELECTED SERVICE OFFICE: HOME OFFICE CHANGE OFFICE Selected Member ID: XXXXXXXX First Last CHANGE MEMBER

First Name Last Name [License No.] Street Address, City, State

Treatment Details

Please fill out one line for each treatment.

Tooth Number	Area of Arch	Surface(s)	Pre-treatment Estimate?	Service Date	Procedure Code	Submit Amount
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="mm/dd/yy"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="mm/dd/yy"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="mm/dd/yy"/>	<input type="text"/>	<input type="text" value="\$"/>

PROCEDURE CODES AND DESCRIPTIONS

10

SELECTED SERVICE OFFICE: HOME OFFICE CHANGE OFFICE Selected Member ID: XXXXXXXX First Last CHANGE MEMBER

First Name Last Name [License No.] Street Address, City, State

Claim Attachments

Upload Documents

CHOOSE OR DROP FILES

Tooth Number	Area of Arch	Surface(s)	Pre-treatment Estimate?	Service Date	Procedure Code	Submit Amount
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>	<input type="text" value="\$"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>	<input type="text" value="\$"/>

Total Amount: \$0.00

- Check the box if Coordination of Benefits does not apply to this claim.

Click **Submit Claim**.

Image 11

11

COB Details ✓

Ortho Details ✓

I do NOT have any COB Details to add to this Claim.

By selecting Submit Claim, I am certifying that I have performed the procedures as indicated by date and/or wish to obtain a pre-treatment estimate for the procedures which are not dated and the procedures were/are necessary in my professional judgment.

SUBMIT CLAIM RESET

- Review claim.

Some CDT codes require additional review and will not process immediately. The claim status will appear as *Routed* and/or *In Process*.

Image 12

12

SELECTED SERVICE OFFICE: [First Name Last Name | License No.] Street Address, City, State

HOME OFFICE CHANGE OFFICE

SELECTED MEMBER ID: XXXXXXXX First Last CHANGE MEMBER

Claim Submitted Successfully

In For Pay Claim < CREATE ANOTHER CLAIM

Patient Information

Patient Account Number: XXXXXXXX
 Patient Name: First Last
 Date of Birth: XX/XX/XXXX
 Relationship Code: XXXXXXXX
 Subscriber Name: First Last

Claim Information

Receipt Date: XX/XX/XXXX
 Process Date: XXXXXXXX
 Claim Number: XXXXXXXX
 Claim Type: .
 Claim Status:
 Other Carrier Payment:

Dentist Information

Dentist Name: First Last
 License Number: XXXXXXXX
 Dentist Title: XXXXXXXX
 Specialty:
 Other Carrier:

PRINT CLAIM DETAIL
CANCEL CLAIM This claim cannot be cancelled.

Tooth Number	Area of Arch	Surface	Date of Service	Proc Code	Submitted Amount	Approved Amount	Allowed Amount	Out of Pocket	Office Visit	CoPay	Patient Pay	Plan Pay	Prior Network	Product	Claim Line Status	Payment Number	Pay To	Initial Date
Group Number 9999 Sub-Group Number 0000																		