

2025 BlueDentalSM PROVIDER MANUAL



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BlueDental Provider Manual

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Introduction

About AZ Blue's BlueDental Provider Manual

This BlueDentalSM Provider Manual ("Manual") sets forth policies and procedures to be followed by BlueDental providers in rendering services to Blue Cross[®] Blue Shield[®] of Arizona (AZ Blue) members with a BlueDental stand-alone benefit plan (separate plan just for dental benefits) or a BlueDental Prime Medicare benefit ID card (included as part of a Medicare Advantage plan). It is an extension of the Provider Participation Agreement and incorporated by reference into your Agreement with AZ Blue. In the event of a conflict between this Manual and your Agreement, the Agreement will govern.

Some sections of the Manual describe and summarize member benefit plans. If the information in the Manual differs from the applicable benefit plan summary, the terms of the member's benefit plan will apply. Details of a specific BlueDental member's benefit plan are available online at azblue.com/bluedentalprovider > Eligibility and Benefits, or by calling Provider Services at 1-888-271-7806.

Please reference the AZ Blue Provider Operating Guide ("Guide") for information on general policies and procedures, as well as specific information regarding servicing members with other types of benefit plans (e.g., AZ Blue medical plans that include embedded dental benefits for members up to age 19, BlueCard[®] (out-of-area) plans, Federal Employee Program[®] (FEP[®]) plans, and Medicare Advantage plans. Provisions of the Guide that are generally applicable to all network providers (e.g., dispute resolution) and provisions applicable to dental benefits and providers are also incorporated by reference into your Agreement. In the event of a conflict between the Guide and your Agreement, the Agreement will govern.

For BlueDental assistance or information that is not included in this manual or the Guide, contact BlueDental Provider Services at 1-888-271-7806, Monday through Friday, 6:00 a.m. to 6:00 p.m., Arizona time.

AZ Blue Dental Products and Networks – Quick Guide

TYPE OF PLAN	BENEFIT PLAN INFO	MEMBER ID PREFIX	NETWORK AND CONTRACTING	PLAN ADMINISTRATOR
AZ Blue Stand-Alone Commercial Dental Plans (separate dental ID card)	BlueDental PPO	99D, MUM	BlueDental PPO 1-888-271-7806	BlueDental Team 1-888-271-7806 azblue.com/bluedentalprovider Submit claims to AZ Blue: EDI 53589 Claim and predetermination submissions that require attachments are <i>only</i> accepted electronically via DentalXchange or Vyne Dental . If you can't use these services, mail a paper claim <i>with your documentation</i> to AZ Blue BlueDental Claims at: P.O. Box 211424 Eagan, MN 55121 Fax (claims only): 1-833-517-1939
	BlueDental Prime	99D	BlueDental Prime exclusive network 1-888-271-7806	
	BlueDental DHMO	99D	BlueDental DHMO 1-888-271-7806	
AZ Blue Medical Plans with dental benefits	Medical benefit plans that cover oral surgery Affordable Care Act (ACA) medical plans with embedded dental benefits for members up to age 19; Medical ID card displays this benefit indicator: Pediatric Dental Benefits YES	Various prefixes for AZ Blue medical plans	AZ Blue medical networks (providers must be contracted for the network used by the member's plan) 1-888-271-7806	AZ Blue 1-844-995-2583 azblue.com/provider Submit claims to AZ Blue: EDI 53589 <i>Paper claim to AZ Blue Claims at:</i> P.O. Box 2924 Phoenix, AZ 85062-2924
		IAZ	ACA Health Choice Network (for the ACA StandardHealth with Health Choice plan) 1-800-322-8670	ACA Health Choice Team 1-800-322-8670 azblue.com/aca-standardhealth-health-choice Submit claims to Health Choice: EDI RP105 <i>Paper claims to ACA StandardHealth with Health Choice at:</i> P.O. Box 52033 Phoenix, AZ 85072-2033
Federal Employee Program® (FEP®) Medical Plans with limited dental benefits	Two FEP medical plans include limited dental benefits: <ul style="list-style-type: none"> • FEP Blue Standard • FEP Blue Basic 	R	FEP Dental Network 1-888-271-7806	AZ Blue FEP Team 1-800-345-7562 azblue.com/provider Submit claims to AZ Blue: EDI 53589 <i>Paper claims to AZ Blue Claims at:</i> P.O. Box 2924 Phoenix, AZ 85062-2924
FEP Stand-Alone Dental Plans	BCBS FEDVIP coverage with separate dental ID card: <ul style="list-style-type: none"> • High Option • Standard Option 	F	BCBS FEP Dental® Network (AKA GRID+ Dental Network ; includes all AZ Blue BlueDental PPO providers) 1-888-271-7806	BCBS FEP Dental 1-855-504-2583 bcbsFEPdental.com Submit claims to FEP: EDI BCAF <i>Paper claims to Dental Claims at:</i> P.O. Box 75 Minneapolis, MN 55440-0075
BlueCard® (Out-of-Area) Plans (for members from other Blue Plans)	Dental benefits covered by medical plans and stand-alone dental products	Varies	Varies (BCBS GRID or other national network) 1-888-271-7806	See back of member ID card for specific information
AZ Blue Medicare Advantage (MA) Plans with dental benefits (separate ID card for dental)	Blue Best Life Plus Blue Best Life Classic	99D	Subset of the BlueDental Prime exclusive network 1-888-271-7806	BlueDental Team 1-888-271-7806 Submit claims to AZ Blue: EDI 53589 <i>Paper claims to AZ Blue MA Dental Claims at:</i> P.O. Box 211424 Eagan, MN 55121 Fax (claims only): 1-833-517-1939

BlueDental Networks – Overview

The following is a brief overview of the BlueDental networks and the product lines they service.

BlueDental PPO Network

Participation in this network requires an AZ Blue provider participation agreement with a dental services reimbursement exhibit. Reimbursement is based on the AZ Blue dental PPO fee schedule. BlueDental PPO providers are considered in-network for several types of benefit plans:

- AZ Blue stand-alone BlueDental PPO plans with member ID prefixes 99D and MUM (includes preventive and enhanced PPO plans)
- Benefit plans using the BCBS National Dental GRID networks: All AZ Blue BlueDental PPO network providers are part of the BCBS GRID/GRID+ networks (administered by DeCare). These networks are used for the following types of members (GRID or GRID+ will be indicated on the back of the ID card):
 - Members with BlueCard® (out-of-area) dental plans
 - Members with BCBS FEP Dental stand-alone plans (member ID prefix is F) offered through the Federal Employees Dental and Vision Insurance Program (FEDVIP)

BlueDental Prime Network

AZ Blue BlueDental Prime PPO is an exclusive (narrow) network for stand-alone BlueDental Prime plans and dental benefits covered under AZ Blue Medicare Advantage plans (see page 7). Participation in the Prime Network is optional for BlueDental PPO providers.

Please note that there are two provider directories for the Prime Network—one for the [BlueDental PRIME stand-alone plans](#) and one for the [BlueDental Prime Medicare plans](#). Not all Prime network providers are included in the directory for the BlueDental Prime Medicare plans.

BlueDental DHMO Network

The AZ Blue DMHO Network is for members with BlueDental DHMO stand-alone plans. Provider participation in this network requires a separate provider participation agreement.

For a more comprehensive overview of AZ Blue dental networks, please see the AZ Blue Provider Operating Guide, Section 26.

BlueDental PPO Stand-Alone Benefit Plans

AZ Blue stand-alone PPO dental benefit plans are designed to promote good oral health through easy access to diagnostic and preventive services. We offer two types of PPO dental benefit plans:

BlueDental PPO (these plans use the BlueDental PPO Network)

BlueDental Prime PPO (these plans use the exclusive BlueDental Prime Network)

Reimbursement for in-network and out-of-network claims is based on the AZ Blue dental fee schedule. Network dentists receive the AZ Blue allowed amount for covered services, which includes the member cost-share. The allowed amount is the total amount of reimbursement allocated to a covered service. It includes any applicable member cost-share payment and adjustments for less expensive alternative treatment (LEAT) considerations.

BlueDental Prime Dental Plans

Services covered under the BlueDental Prime PPO plan are reimbursed according to a negotiated provider rate.

- Members must pay copay amounts for covered services. You can check these amounts in the Prime Evidence of Coverage/ Benefit Summary or review them when calling the BlueDental Customer Service team (1-888-271-7806) to confirm eligibility and benefits.
- Procedures not covered under the plan are the member's responsibility.
- Care received from out-of-network providers results in much higher out-of-pocket costs for the member.

Predeterminations

AZ Blue does not require predeterminations for any dental services. However, for AZ Blue BlueDental members, pre-treatment estimates or "predeterminations" are available as a courtesy to dentists and members. Please see more information on predeterminations on page 15.

Eligibility and benefits

Providers can access BlueDental eligibility and benefit information, including benefit summaries, in the secure provider portal at azblue.com/bluedentalprovider or call 1-888-271-7806.

Diagnostic and preventive care

All stand-alone PPO dental plans cover in-network diagnostic and preventive care with no or minimal member cost share. These services are generally not subject to deductibles, and do not count against the calendar year maximum for many plans. (However, most of the plans require members to pay coinsurance for out-of-network preventive care and diagnostic services.)

Orthodontic rider

Optional orthodontic benefits are available to employer groups as child-only or child-and-adult options for stand-alone dental plans. Lifetime maximums of \$1,000, \$1,500, or \$2,000 per member are standard offerings.

Amounts applied to the benefit maximum are calculated based on the lesser of the AZ Blue dental fee schedule or billed charges for covered services, plus or minus any contractual allowance. No benefits will be paid over the maximum amount specified in the benefit plan. Only the amounts paid by AZ Blue count toward the benefit maximum, not the cost-share amounts paid by the member.

Orthodontic payments made by AZ Blue are based on the plan benefit and are paid at the time of banding at 100% of the covered expense.

BlueDental PPO Stand-Alone Benefit Plans

Orthodontic claim submission guidelines

The procedure for reporting and billing orthodontic services covered under stand-alone dental plans requires a single billing to AZ Blue for the entire case at the beginning of treatment, using one of the CDT procedure codes in the range D8010 through D8090. This total case (global) billing and reimbursement includes:

- All diagnostic records
- All pretreatment consultations
- Initial appliance placement
- Periodic visits for appliance adjustments
- Any repair, replacement, or removal of appliances
- Any necessary retention appliances, including necessary adjustments

Note: When circumstances require a change of provider prior to treatment completion, the new provider must bill per visit.

Waiting periods may apply


Certain groups may have waiting periods for some types of benefits. Please contact AZ Blue Dental Customer Service at 1-888-271-7806 for this information.


Member ID cards

Members with AZ Blue stand-alone dental plans will have a separate dental ID card. Use the information on the member’s card for claim submission information.


The member ID prefix for most BlueDental and BlueDental Prime stand-alone dental plans is 99D. One employer group uses the prefix MUM.

Sample BlueDental PPO individual member ID card:

 BlueCross BlueShield Arizona <small>An Independent Licensee of the Blue Cross Blue Shield Association</small>		BlueDental PPO	
Member Name: MEMBER NAME	Group No:	00001	
Member ID: 99D987654321	Card Print Date:	01/01/25	
Deductible Ind/Family: Orthodontia:	\$50/\$150 YES		
		AZDOI	

 BlueCross BlueShield Arizona <small>An Independent Licensee of the Blue Cross Blue Shield Association</small>		To locate a dental provider please visit us at: www.azblue.com/member	
Possession of this card does not guarantee eligibility for benefits.			
All claims should be filed with Blue Cross Blue Shield of Arizona.			
Waiting periods are from the effective date of the policy, not the card print date.			
		BCBSAZ Customer Service: (888) 271-7806 azblue.com/bluedentalprovider	
		Send Claims To: BlueCross BlueShield of Arizona P.O. Box 211424 Eagan, MN 55121 Fax: 833.517.1939	

Sample BlueDental Prime PPO member ID card:

 BlueCross BlueShield Arizona <small>An Independent Licensee of the Blue Cross Blue Shield Association</small>		BlueDental Prime	
Member Name: MEMBER NAME	Group No:	000001	
Member ID: 99D987654321	Card Print Date:	01/01/2025	

BlueDental DHMO Stand-Alone Benefit Plans

BlueDental DHMO benefit plans

AZ Blue stand-alone BlueDental DHMO benefit plans are available to individuals and families.


Primary care dentists

A general dentist is contracted as a primary care dentist and paid a monthly capitation amount for each member who designates that dentist for primary care. The monthly capitation plus any required plan fees paid directly to the dentist constitute the full reimbursement for services rendered to covered members. Members pay a fixed rate for services directly to the provider.

Specialty care providers, including Orthodontists

Contracted specialists agree to provide services at a discount from their billed charges. Members pay the discounted amount directly to the specialist.

BlueDental DHMO member ID card sample

 <p>BlueCross BlueShield Arizona <small>An Independent Licensee of the Blue Cross Blue Shield Association</small></p>	BlueDental DHMO	
	Member Name: MEMBER NAME Member ID: 99D987654321	Group No: 000001 Card Print Date: 01/01/2025

 <p>BlueCross BlueShield Arizona <small>An Independent Licensee of the Blue Cross Blue Shield Association</small></p>	<p>To locate a dental provider please visit us at www.azblue.com/member</p> <p>BCBSAZ Customer Service: (888) 271-7806 azblue.com/bluedentalprovider</p>
	<p>Possession of this card does not guarantee eligibility for benefits.</p> <p>All claims should be filed with Blue Cross Blue Shield of Arizona.</p> <p>Waiting periods are from the effective date of the policy, not the card print date.</p>
<p>Send Claims To: BlueCross BlueShield of Arizona P.O. Box 211424 Eagan, MN 55121 Fax: 833.517.1939</p>	

BlueDental Prime Medicare Benefit Plans

Many Medicare Advantage plans include dental benefits

Several of our Medicare Advantage plans include preventive and restorative dental benefits that are administered by AZ Blue. To qualify as an in-network provider for these benefits, you must be contracted with us for the BlueDental Prime dental network. You must also have a separate reimbursement exhibit for Medicare Advantage. For more information about this participation arrangement, contact the BlueDental team at 1-888-271-7806.

All dental office visits require a \$10 co-pay. Other than the office visit copay, preventive services are covered with no additional cost share. Type II and III services vary in coverage and cost share. Here is an overview (for details, visit the BlueDental provider portal at azblue.com/BlueDentalProvider):


BENEFIT PLAN NAME and ID #	PREFIX (DENTAL)	SERVICE AREA	BENEFIT MAXIMUMS
Blue Best Life Plus (HMO) H0302-001 (prefix M2K for medical plan)	99D	Maricopa and Pinal counties	\$3,000 per calendar year
Blue Best Life Classic (HMO) H0302-006 (prefix M2K for medical plan)	99D	Maricopa and Pinal counties	\$2,000 per calendar year
Blue Best Life Classic (HMO) H0302-008 (prefix M2K for medical plan)	99D	Pima County	\$2,000 per calendar year


Claim submission

Please submit 837D transactions for dental services rendered to Medicare Advantage members.

MA dental ID cards

Medicare Advantage members have a separate ID card for dental benefits. Like the BlueDental stand-alone plans, these cards display the 99D prefix in the member ID.

 BlueCross BlueShield Arizona <small>An Independent Licensee of the Blue Cross Blue Shield Association</small>		BlueDental Prime Medicare	
Member	Network	PRIME	
MEMBER NAME			
Member ID			
99D98765432			
Service Types		Dental	
Office Visit Copay		\$10	
Preventive		100%	
Comprehensive		50%	
Orthodontia		No	
Benefit Maximum		\$2000	

 BlueCross BlueShield Arizona <small>An Independent Licensee of the Blue Cross Blue Shield Association</small>		azblue.com/medicare	
For Dental Providers ONLY			
Send claims to:		Member Services: (480) 937-0409	
BCBSAZ BlueDental Claims		Toll Free: (800) 446-8331	
P.O. Box 211424		TTY: 711	
Eagan, MN 55121		Find a Dental Provider: azblue.com/FindMedicareDoc	
Fax (dental claims only): 1-833-517-1939		For Dental Providers Only	
		Dental Provider Services: (888) 271-7806	
Please present this card at time of every dental service.			
Card Print Date: 10/31/2024			

BlueDental Online Resources

AZ Blue's secure BlueDental provider portal at azblue.com/bluedentalprovider supports providers with information, tools, and resources, including:

- Eligibility and benefits
- Claim status
- Online remits
- Benefit confirmation
- Fee schedules
- DHMO panel roster
- Provider resources
- AZ Blue Provider Operating Guide

Creating an account

To create an account on the azblue.com/bluedentalprovider portal you will need of the following information:

- Your organization's tax ID
- The last name of an active provider within your facility
- Your facility's ZIP code

Once you enter this information, you will be guided through the steps necessary to create an account.

You only need to set up one BlueDental account and login/password for your facility, regardless of the number of dentists practicing in that location.

Create New Account page

BlueCross BlueShield Arizona
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Interested in Becoming a Participating Dentist? [Click Here!](#)

Create New BlueDental Account

Complete all required fields and click Submit. You will receive a confirmation email from BlueDental within 24 hours, including your initial login information.

Questions? Contact Provider Services at 1 (888) 271-7806.

All fields marked with an asterisk (*) are required.

Facility Tax Id # *

Provider Last Name *

Facility Zip Code *

Submit Cancel

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BlueDental Online Resources

Homepage (return to this page at any time by clicking the logo in the upper left corner)

Eligibility & Benefits page (search a member’s eligibility and benefits)

BlueDental Online Resources

Claims page (claim status search tool)

BlueCross BlueShield Arizona
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Welcome !

[Technical Support](#) [Account Profile](#)

[ELIGIBILITY & BENEFITS](#) [CLAIMS](#) [REMITTS](#) [BENEFIT CONFIRMATION](#) [FEE SCHEDULES](#) [ROSTERS](#) [RESOURCES](#)

Search Claims

For the Member ID, do *not* include the 3-character prefix, e.g., 99D.
Claim history is available for the past two years.
Have questions or need more information? Contact Provider Services at 1 (888) 271-7806.

Search using Member ID, *or use*: SSN *or use*: Last Name *and* Date of Birth

Member ID (Do *not* enter the 3-character prefix, e.g., 99D) *Or use:* Last Name *and* Date of Birth (MM/DD/YYYY)

Results

Claim #	Name	Date of Birth (MM/DD/YYYY)	Type	Status	Dentist	Service Date (MM/DD/YYYY)	Paid Date (MM/DD/YYYY)	Check #	Remit #
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Remits page (online remits)

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[ELIGIBILITY & BENEFITS](#) [CLAIMS](#) [REMITTS](#) [BENEFIT CONFIRMATION](#) [FEE SCHEDULES](#) [ROSTERS](#) [RESOURCES](#)

Search Remits

Note: BlueDental remits are available for dates of service starting with 5/1/18. To access remits for dates of service prior to 5/1/18, go to the BCBSAZ secure provider portal at azblue.com/providers (Practice Management > Claims > Online Remits).

DOS Start (MM/DD/YYYY) *To:* DOS End (MM/DD/YYYY) *Or:* Claim # *Or:* Check #

Results

Remit #	Check #	Payee	Amount	Check Date
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BlueDental Online Resources

Benefit Confirmation page (view benefit summaries to help with treatment planning)

Benefit Confirmation

Scroll down! We have new customizable benefit confirmation summaries that will offer you much more information and will allow you to better treatment plan your patients.

Member ID Or Last Name and Date of Birth (MM/DD/YYYY)

Search Results

Member ID	Member Name	Group Name	Plan Name
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Fee Schedules page (check fees)

Fee Schedules

Select a Plan Type
Please select

Search Results

ADA Code	Procedure Description	Maximum Charge(s)
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DHMO Panel Roster page (view current patients)

DHMO Panel Roster

Blue Cross Blue Shield of Arizona
Active Eligibility Roster
01/12/2021

Facility Details

Facility Name	Facility ID	Tax ID	Address 1	Address 2
---------------	-------------	--------	-----------	-----------

Member Details

Last Name	First Name	Plan Name	Group ID	SSN	Date of Birth (MM/DD/YYYY)	Status	Facility Assignment Effective Date (MM/DD/YYYY)
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No data available in table

BlueDental Online Resources

Provider Resources page (includes information, forms, and guides)

BlueCross BlueShield Arizona
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Welcome !

[Technical Support](#) [Account Profile](#)

[ELIGIBILITY & BENEFITS](#) [CLAIMS](#) [REMITTS](#) [BENEFIT CONFIRMATION](#) [FEE SCHEDULES](#) [ROSTERS](#) [RESOURCES](#)

Provider Resources

- [DENTAL PRODUCTS AND NETWORKS - QUICK REFERENCE GUIDE](#)
- [BLUEDENTAL COVERAGE GUIDELINES](#)
- [BLUEDENTAL COVERAGE GUIDELINES - GENERAL ANESTHESIA](#)
- [BLUEDENTAL PROVIDER eLEARNING](#)
- [BLUEDENTAL PROVIDER MANUAL](#)
- [BLUEDENTAL PROVIDER OPERATIONS GUIDE](#)
- [COB INFO FORM FOR BCBSAZ MEMBERS](#)
- [CONTRACT TERMINATION FORM](#)
- [CONTRACTING-CREDENTIALING PROCESS - OVERVIEW](#)
- [DHMO PARTICIPATION AGREEMENT](#)
- [ELECTRONIC CLAIM ADJUSTMENTS - USER GUIDE](#)
- [HIPAA TRANSACTION STANDARD - BCBSAZ COMPANION GUIDE](#)
- [LIMITED WAIVER OF RESTRICTION FORM](#)
- [MEMBER APPEAL - AUTHORIZED REPRESENTATIVE DESIGNATION FORM](#)
- [MEMBER APPEAL - STANDARD PACKET 1](#)
- [MEMBER APPEAL - STANDARD PACKET 2](#)
- [PPO PROVIDER AGREEMENT](#)
- [PROVIDER CHANGE FORM](#)
- [PROVIDER GRIEVANCE FORM](#)

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BlueDental Coverage Guidelines

Our BlueDental coverage guidelines assist AZ Blue in making dental coverage determinations and support providers in treating members with BlueDental stand-alone plans. AZ Blue continually evaluates and updates its coverage guidelines to align with industry standards.

The guidelines are not a guarantee of coverage. Rather, they provide a review of the available scientific evidence, if applicable, to determine dental necessity.

Dentally necessary service

A dentally necessary service is one that meets all of the following criteria:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease, or injury.
- Is not primarily for the convenience of a member or provider.
- Is not primarily for improving the cosmetic appearance of a member.
- Meets AZ Blue's dental necessity guidelines and criteria in effect when the service is rendered. If no such guidelines or criteria are available, AZ Blue will base its decision on the judgment and expertise of an AZ Blue healthcare professional or dental consultant retained by AZ Blue.

AZ Blue's decision about dentally necessary services may differ from the provider's opinion. A provider may prescribe, order, recommend, or approve a service that AZ Blue decides is not dentally necessary and, thus, not a covered benefit. The member and provider should decide whether to proceed with a service that is not covered.

Eligibility for coverage

To be eligible for coverage, all services must be dentally necessary. The final benefit determination is also based on benefits included the member's benefit plan. Always check eligibility and benefits for specific information.

Where to find the BlueDental Coverage Guidelines

The most current version of the BlueDental Coverage Guidelines is available at azblue.com/bluedentalprovider > [Provider Resources](#). The guidelines also detail documentation requirements for a variety of procedures, including:

Procedures	Documentation Requirements
Inlays Onlays Crowns Prosthodontics Surgical extractions Implants	Radiographs and charting
Periodontal Procedures	Documentation Requirements
Gingival flap procedures Crown lengthening Guided tissue regeneration Periodontal scaling and root planing Osseous surgery	Radiographs and periodontal charting
Gingivectomy Grafts	Periodontal charting

BlueDental Claim Submission

Claim submission for BlueDental plans

Claims for BlueDental plans should be submitted directly to AZ Blue (EDI 53589). We can receive dental records electronically only if your practice uses one of the following options for electronic claim attachments (such as x-rays and chart notes):

[DentalXchange](#)

[Vyne Dental](#)

Be sure to enter the attachment reference number in the “Remarks” section (field 35) of your claim. This allows us to access the electronic attachments upon receipt of the claim.

If you don't use DentalXchange or Vyne Dental, for electronic attachments and are billing for services that require documentation (e.g., radiographs, images, provider notes), submit the claim using the ADA paper form, along with all required documentation, to:

AZ Blue BlueDental Claims
P.O. Box 211424
Eagan, MN 55121

Electronic claim submission

AZ Blue supports the following options for electronic claim submission (EDI payer ID 53589):

- **Claim submission through the Availity Essentials portal**
We now offer claim submission (professional, institutional, and dental) through the [Availity Essentials™ provider portal](#) at no charge to you. If you're not registered yet, visit Availity's [Register and Get Started page](#).
- **Third-party clearinghouse**
You may also conduct electronic business through a third-party clearinghouse. AZ Blue is networked to multiple national clearinghouses operating in Arizona. For a current list of these clearinghouses, visit our [Electronic Options page](#) under Getting Started with Electronic Transactions.

Claim submission for other types of benefit plans

Please refer to the Quick Reference Guide on page 2 for claim submission information for AZ Blue medical plans, FEP, FEDVIP, and BlueCard plans.

Availity is a separate, independent company contracted with AZ Blue for provider portal services. Availity and Availity Essentials are registered trademarks of Availity, LLC.

BlueDental Billing Guidelines

You can avoid most claim processing delays by including these key data elements:

- Accurate and complete information identifying the patient and policyholder (if different from patient), including full names, identification numbers, and dates of birth
- Date and place of service
- Identification of the service(s) provided by appropriate diagnosis code(s), procedure code(s), and applicable modifiers
- Evidence that any required prior authorization was obtained
- Identification of the treating and billing provider, including NPI numbers as indicated in the following table:

LOOP	ELEMENT	ADA Field	DESCRIPTION	AZ BLUE REQUIREMENTS
2310B	NM109	54	Treating provider NPI	Required. Enter the individual (not organizational) NPI number corresponding with the treating dentist's name. All dental claims must have the treating dentist's NPI.
2310C	N301-N403	56	Treating provider address, city, state, ZIP code	Required when different from billing address. Enter the physical location where the treatment was rendered. Must be a street address, not a P.O. box.
2010AA	NM103 NM301-403	48	Billing provider info	Required. Enter the name and complete address of the billing dentist or dental entity that furnished the services to the patient. Use the full nine-digit ZIP code.
2010AA	NM109	49	Billing provider NPI	Required. Enter the appropriate NPI number for the billing dentist or dental entity. All dental claims must have the billing provider/entity NPI.
2010AA	REF*EI	51	Billing provider SSN or Federal tax ID	Required. Enter the federal tax ID number of the billing dentist or dental entity.

Tax ID edits

Note: Our claim processing system includes edits to filter out and reject claims that have one or more of the following tax ID number (TIN) errors:

- Billing TIN not valid for date of service
- NPI/TIN combination not in our database for treating provider (treating provider NPI must be an individual NPI, not an organizational NPI)
- NPI/TIN combination not in our database for billing provider

How to update your information

If you need to update your provider directory listing or ensure our claim systems have your current NPI/TIN information, use the Dental Provider Information Change Form. You can access the form at azblue.com/BlueDentalProvider or on our forms page at azblue.com/provider/resources/forms in > Provider Information Change > Dental Providers-Information Change Form.”

BlueDental Predeterminations

When to request a BlueDental predetermination

If treatment costs are expected to exceed \$300, AZ Blue recommends that you obtain a pretreatment estimate of benefits.

How to request a BlueDental predetermination

To request a predetermination for a member with a BlueDental stand-alone plan (prefix 99D or MUM), submit an 837D transaction (EDI 53589) according to the provider's treatment plan, along with estimated charges, periodontal charting, and diagnostic radiographs. In the CLM19 field, enter PB for predetermination.

Please note: When submitting a predetermination, Loop 2300 and 2400 DTP SVC Date are not used.

AZ Blue will provide an estimate of the amount to be paid to the provider and the member's cost share. The predetermination estimate is nonbinding as the availability of benefits may change subsequent to the date of estimate due to changes in eligibility status, available maximum benefits, or application of frequency limitations.

AZ Blue may determine that an alternate course of treatment will provide a professionally satisfactory result. Submitting your treatment plan in advance will allow you and your patient to determine what the available benefit is and any applicable plan limitations.

If you are unable to submit predeterminations electronically, you may mail the paper claim request (with documentation) to:

AZ Blue Predeterminations
P.O. Box 211424
Eagan, MN 55121
Fax: 1-833-517-1939

Coordination of Benefits (COB)

Coordination of benefits

The coordination of benefits (COB) provision applies when a person has dental healthcare coverage under more than one plan. The order in which each plan pays a claim for benefits is governed by specific “order of benefit determination” rules.

- The plan that pays first is considered the “Primary Plan.” The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses.
- The plan that pays after the Primary Plan is considered the “Secondary Plan.” The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

Order of benefit determination rules

When a member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
2. A plan that does not have a coordination of benefits provision as described in this section is always the Primary Plan unless both plans state that the plan with a coordination of benefits provision is primary.
3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
4. Each plan determines its order of benefits using the first of the following rules that apply:
 - a. **Non-dependent or dependent:** The plan that covers the member as an employee, policyholder, subscriber, or retiree is the Primary Plan. The plan that covers the member as a dependent is the Secondary Plan.
 - b. **Dependent child covered under more than one plan:** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:
 - i. **Birthdate rule:** The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan.
 - ii. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.
 - iii. **Gender rule:** If one of the plans does not follow the birthday rule, then the plan of the dependent child’s father is the Primary Plan.
 - d. For a dependent child whose parents are *divorced, separated, or not living together*, whether or not they have ever been married:
 - i. If a court decree states that one of the parents is responsible for the child’s health care expenses or coverage and the plan of that parent has actual knowledge of this decree, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the child’s health care expenses or coverage, the provisions of subparagraph (i) determines the order of benefits;

Coordination of Benefits (COB)

- iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the provisions of subparagraph (i) determines the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child is as follows:
 1. The plan covering the custodial parent;
 2. The plan covering the spouse of the custodial parent;
 3. The plan covering the noncustodial parent; and then
 4. The plan covering the spouse of the noncustodial parent.
 - v. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.
- e. **Active employee, retired, or laid-off employee:** The plan that covers the member as an active employee is the Primary Plan. The plan covering that same member as a retired or laid-off employee is the Secondary Plan. The same would hold true if the member is a dependent of an employee covered by the active, retired, or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "non-dependent or dependent" rule can determine the order of benefits.
- f. **COBRA or state continuation coverage:** If a member whose coverage is provided pursuant to COBRA, or under a right of continuation provided by state or other federal law, is covered under another plan, the plan covering the member as an employee, subscriber, or retiree or covering the member as a dependent of an employee, subscriber, or retiree is the Primary Plan. The COBRA, state, or other federal continuation coverage is the Secondary Plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "non-dependent or dependent" rule can determine the order of benefits.
- g. **Longer or shorter length of coverage:** The plan that covered the member as an employee, policyholder, subscriber, or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the plan that covered the member the shorter period of time is the Secondary Plan. The status of the member must be the same for all plans for this provision to apply. The same primacy would be true if the member is a dependent of an employee covered by the longer or shorter length of coverage.

If the preceding rules do not determine the order of benefits, the allowable expense is shared equally between the plans. In addition, this coverage will not pay more than it would have paid had it been the Primary Plan.

Secondary coverage

When coverage is secondary, it may reduce benefits so that the total paid or provided by all plans for a service are not more than the total allowable expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other coverage. That amount is compared to any allowable expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid allowable expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all plans may not exceed the total allowable expense for that claim. In addition, the Secondary Plan credits to its deductible any amounts it would have otherwise credited to the deductible.

Coordination of Benefits (COB)

If a member is enrolled in two or more closed-panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed-panel plan, COB shall not apply between that plan and other closed-panel plans.

Right to receive and release needed information

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this coverage and other plans. AZ Blue may obtain and use information necessary to apply these rules and determine benefits payable under this coverage and other plans covering the member claiming benefits. AZ Blue need not tell, or get the consent of, the member or any other person to coordinate benefits. Each member claiming benefits under this coverage must give AZ Blue any documentation or other information needed to apply those rules and determine benefits payable. Failure to complete any forms required by AZ Blue may result in claims being denied.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this coverage. If it does, AZ Blue may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under this coverage. AZ Blue will not pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

Notwithstanding any other provision contained in this Provider Manual, if the amount of the payments made by AZ Blue is more than the amount that should have been paid under this COB provision, AZ Blue may recover the excess amount. The excess amount may be recovered from one or more of the persons or organizations paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Benefit plan limitations

When benefits are coordinated, any benefit plan limitations that apply to the member’s care may result in denial of a secondary payment.

Other payment sources

Although AZ Blue participation agreements prohibit providers from collecting more than the AZ Blue allowed amount for a covered service, AZ Blue providers may have a right, under A.R.S. § 33-931 (Arizona’s provider lien law) to collect up to billed charges from other sources of payment, such as liability insurance when the provider properly perfects a lien.

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DeCare is a separate, independent company that administers the BCBS GRID/GRID+ networks used by BlueCard dental plans and BCBS FEP Dental stand-alone plans.

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