Dental Insurance Updates

In the past few years, we have noticed that dental insurances have changed dramatically. Our office makes every attempt to keep up with these changes, but your help is vital in this process.

Please remember, it is essential that you read ALL the written material provided by your insurance company. If you have any concerns or questions, ask the Human Resource Representative at your place of employment. Most dental insurances divide the coverage into 3 categories. Typically, your co-pay for these categories varies from 100% - 50%. You need to be aware of your coverage in these categories. Also, it is very important for you to know your maximum payment limit per year and how much you have used. Insurance companies won't warn you (or us) when you reach it; they will just deny payment of further claims once the maximum has been reached. Finally, please realize that insurance companies are now beginning to charge deductibles that vary from $25.00 - $150.00 per year. Check your paperwork to see if you have a deductible. Your insurance company will not provide that information to us until the work is done and the fee is submitted and paid (minus the deductible, which you will owe).

Our doctors always provide the best care available, and they may even offer you several treatment options, but they never base their diagnosis on your insurance coverage. Therefore, your insurance may or may not cover the necessary treatment. Please check your insurance information packet if you're not sure.

Our reception personnel will do everything in their power to help you with your insurance. But, they must follow all guidelines and laws as outlined by HIPAA. When our office calls to verify benefits, we always hear the same message:

"Verification of benefits does not guarantee payment.
Payment will only be made after claim is submitted."

Therefore, any figure our office gives you is based on a "changeable" insurance estimate. It is not always within our power to give a fixed estimate, but your co-pay (**due on date of service**) is calculated as closely as possible with information provided by your insurance company.

Submission of claims to your insurance company is a courtesy we provide to you, our valued patient. It is not required by law. Ultimately, it is your insurance, and you must appeal any denied claim. In addition, you are always responsible for any bills incurred. Insurance is considered supplemental payment. Our office will supply you with all the necessary dates and procedures, but insurance representatives will only discuss benefits with the patient. Insurance companies no longer allow us to "represent" you in denied claims.

Patients with dual insurance MAY have co-payments. Some insurances now have plans with "carve-out" or non-duplication clauses. These clauses state that if the primary pays as much as the secondary would, there will be no secondary payment. Please find out if you have a "carve-out" or non-duplication clause. Your insurance company won't tell us until the work is done.

Patients with an insurance fee schedule MUST provide that list. This list itemizes the amount your insurance will pay for each procedure. We cannot estimate a co-pay without this list, and your insurance company will not provide one for us.

Please be aware that a predetermination is not a guarantee of payment. It is an estimate based on your benefit package. The amount actually payable is determined by your plan maximum available at the time of service.

We try to make your dental visits as pleasant as possible. Please help us by keeping yourself and our office staff fully informed about your insurance. Thank you.