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Insurance Aging Checklists

11 PRINTABLE TOOLS
to unstick & reclaim lost revenue!

Insurance aging is one of the most common (and frustrating) places revenue gets stuck in a dental practice.

The dentistry is done, the claim is sent, and then... nothing. No alert when something stalls, no reminder to follow up, and no warning when a claim quietly drifts from 30 to 60 to 90 days.

That's why systems matter.

We built this guide as a practical field manual for dental teams. Each section is designed to be a simple, printable cheat sheet you can use while working claims — whether you're fixing rejections, documenting claim notes, calling insurance, responding to denials, or preparing appeals. When these systems are used consistently, insurance aging becomes far more predictable and less stressful.

At Wisdom, we partner with dental practices to manage insurance billing, follow-ups, and revenue cycle workflows so your team can stay focused on patient care.

Table of contents

Workflow checklist: Insurance Aging

Claims age because insurance doesn't send reminders when something stalls. Without simple checkpoints and a clear follow-up rhythm, claims quietly drift from 30 to 60 to 90 days.

Use this checklist to protect the revenue you've already earned. Assign an owner, follow it consistently, and use it as your guide to proactively prevent aging.

Insurance Aging Tasks

Daily	Weekly	Monthly
Focus: Movement & prevention	**Focus:** Accountability & momentum	**Focus:** Strategy & cleanup
□ Work high dollar claims first (ex: over $500 or office defined threshold) □ Resolve obvious issues immediately ◦ Missing attachments ◦ Incorrect payer address ◦ Electronic rejection fixes □ Resubmit claims and corrected claims same day □ Document every touch clearly in claim status notes □ Flag patterns like same payer denying repeatedly	□ Run aging report by payer and age every week □ Work 30 to 90+ day buckets aggressively, every 14 days □ Escalate stalled claims ◦ Request supervisor review ◦ Send reconsiderations, appeals and resubmissions when appropriate □ Identify claims needing clinical support and request additional information from the clinical team □ Track top denial reasons that week □ Spot payers requiring portal work vs phone calls	□ Full aging audit by bucket ◦ 30 to 60 days ◦ 60 to 90 days ◦ 90 plus days □ Identify systemic issues ◦ Credentialing problems ◦ Coordination of benefits errors ◦ Payer specific delays □ Meet with doctor or leadership on trends ◦ Top denial codes ◦ Slowest paying carriers ◦ Process breakdowns □ Adjust workflows based on data ◦ New clinical note templates ◦ Attachment protocols ◦ Pre submission checklists
Leadership intent: Daily work keeps aging from growing.	Leadership intent: Weekly cadence prevents quiet buildup.	Leadership intent: Monthly review turns aging into process improvement.

Workflow: Common Rejections

Fix Fast, Prevent Aging

A rejection means the claim never made it to the insurance company. It was stopped by the clearinghouse due to missing, incorrect or mismatched information.

Luckily, rejections are usually quick fixes — but only if you're looking for them. If no one checks daily or weekly, they quietly stall revenue before it ever starts aging.

Remember: Rejections are not aging. Unworked rejections become aging.

Step 1:
Check the Clearinghouse (Daily)

□ Open clearinghouse "Rejected"/"Failed" tab
□ Review every rejected claim
□ Identify exact error message

Non-negotiable:
Someone owns this check.

Step 2:
Fix the Root Cause

Common rejection causes:

- Patient legal name mismatch (i.e. Katie vs Katherine)
- Incorrect DOB
- Subscriber ID error
- Terminated coverage
- Wrong payer ID
- Missing subscriber information
- Coordination of benefits not accurate

Fix the information inside the PMS so it doesn't happen again.

Step 3:
Resubmit Same Day

□ Correct error in PMS
□ Verify payer ID
□ Confirm attachments (if required)
□ Resubmit claim
□ Document if claim was resubmitted by paper, fax, or via portal

Do not batch for later or wait until "insurance aging day." Rejections are same-day problems.

Step 4:
Document It

<u>Claim status note format:</u>
Date – Rejection reason – Correction made – Resubmitted – Initials

Example:
3/5/26 – Rejected for invalid subscriber ID. Updated ID in PMS per insurance card, but claim was still rejecting electronically. Faxed claim to 888-777-5757 Att: Claims department. At 9:35am. – AB

Clear documentation prevents repeat work.

Rejection Prevention Checklist

To Reduce Rejections:

- □ Verify benefits 48 hours before appointment
- □ Confirm legal name, subscriber address, and DOB at check-in
- □ Double-check payer ID before submission
- □ Update subscriber info immediately when patient provides new card or information
- □ Review rejections at least weekly

Small front-end details prevent back-end delays.

Remember:
Rejections are not complicated, they are attention problems. Fix them fast, and you protect your cash flow before it ever turns into aging.

Claim Status Notes

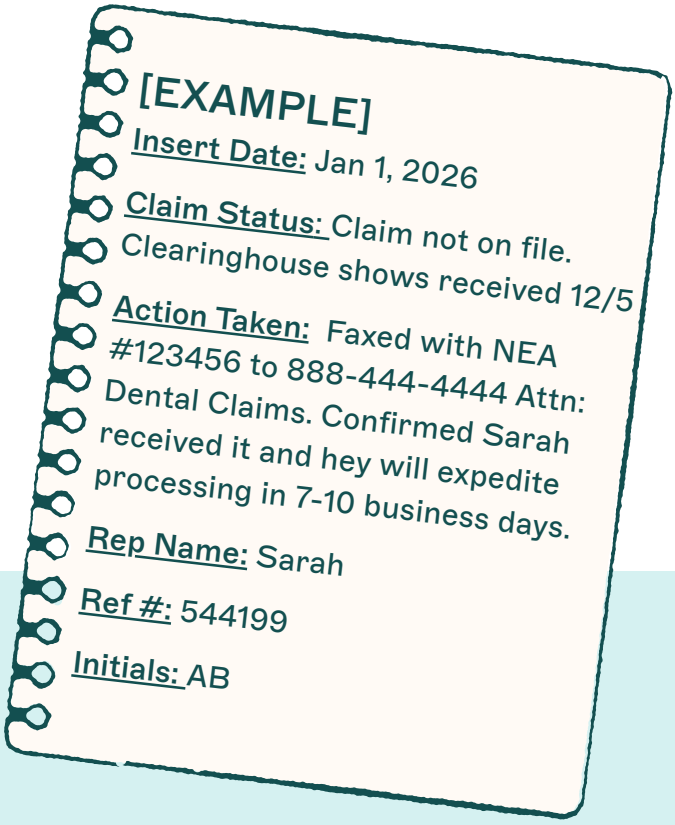
Your note must read like a story. If your notes are vague or incomplete, you start over every time.

Strong claim notes:

- Protect you when insurance says “we never received it.”
- Prevent repeat phone calls.
- Allow anyone on your team to pick up where you left off.
- Create leverage in escalations.

Non-negotiables for good notes:

- If someone else picks up the claim, they should know exactly what happened.
- Always get the rep’s name
- Always get a reference number
- Always document inside the claim status section of your PMS
- Never rely on sticky notes, paper logs, or memory



[TEMPLATE]

Insert Date: _____

Claim Status: _____

Action Taken: _____

Rep Name: _____

Ref #: _____

Initials: _____

REMEMBER: Clear notes save time, reduce stress, & protect the revenue you already earned.

SCRIPT: How to Call Insurance

Follow up with strategy, not guesswork

Step 1: Check before you call
Never wait on hold for something you can see online

Before dialing:

- □ Check payer portal
- □ Check clearinghouse status
- □ Confirm claim was not rejected
- □ Confirm attachments were sent
- □ Review last claim note

Step 2: Call with Everything Ready

Have this in front of you:

- □ Patient name
- □ Patient DOB
- □ Date of service
- □ Subscriber ID / SSN
- □ Claim total
- □ Tax ID
- □ NPI
- □ Doctor license #
- □ Office address
- □ DCN / NEA number

Time saver rule:
Call by payer, not by patient (i.e.-- if calling Cigna, work ALL Cigna claims at once)

Base script:

"Hi, I'm calling about an outstanding claim for a patient of ours."

They will likely request:

- Member ID
- Date of service
- Patient DOB
- Claim amount

IF THEY SAY "WE NEVER RECEIVED IT"
If clearinghouse shows received:

- Provide DCN or NEA
- Provide date/time received
- Ask them to search by that number

If they still cannot locate:

- Ask for supervisor
- Request direct fax number
- Ask "whose attention should this be sent to?"
- Fax immediately (do NOT mail)
- Write DCN or NEA # on claim form
- Document everything in claim notes

Never blindly resubmit the same claim multiple times without escalating.

Checklist: Common Denials

A denial is not the end, it's a clue

Most denials fall into predictable categories. When you know what to look for, you can start responding strategically.

Before posting a write-off or billing the patient

- □ Review the EOB carefully
- □ Compare to your benefits breakdown
- □ Check frequency limitations
- □ Check waiting periods
- □ Confirm prior placement date (if applicable)
- □ Confirm attachments were sent
- □ Review clinical notes

Many denials are fixable with missing information.

Most common denial categories

Buildup Denied as "Inclusive"

This is extremely common. Before adjusting:

□ Confirm documentation supports necessity
□ Include intraoral photos
□Include % tooth structure removed
□ Appeal

If in-network and EOB says you cannot bill patient, appeal before adjusting.

SRP Denials

Often denied for insufficient documentation.

□ Include recent FMX
□ Include perio charting
□ Document bone loss clearly
□ Avoid relying on pano alone

If documentation supports it — appeal.

Missing Prior Placement Date (Crowns)

If crown is replacement:

□ Include original placement date in clinical note
□ Resubmit with documentation
□ Appeal if necessary

Make prior placement part of your crown template.

Implant Claims

Common issues:

- Missing extraction date
- Missing FMX
- Missing tooth documentation

Attach complete clinical story before resubmitting.

Frequency / Limitations

Example: "Prophy not covered – frequency exceeded"

□ Check ledger
□ Confirm how many used this year
□ Verify against breakdown
□ Call if discrepancy

Do not assume insurance is correct.

$0 Payment Rule

Never auto-adjust. Before posting $0:

□ Confirm truly non-covered
□ Confirm no processing error
□ Confirm documentation was included
□ Confirm plan limitations

Ask: Is this unpayable — or under-documented?

Checklist: Monthly Denial Tracking

Track:

- □ Top denial codes
- □ Top denying payers
- □ Procedure patterns
- □ Documentation gaps
- □ Appeal win rate

Denials are data. Use them to improve systems.

Remember:
Nearly 75% of denials are preventable. When documentation improves and follow-up is consistent, denial rates drop — and collections rise.

Denials aren't random. They reveal where your system needs tightening.

Appeals Best Practices: When & How

Many offices only appeal when a patient complains or when the amount feels “big enough.” But consistent appeals send a message: your office pays attention, documents well, and doesn’t quietly write off earned revenue.

The more consistently you appeal, the fewer careless denials you’ll see.

Appeal If:

- ☐ Documentation supports medical necessity
- ☐ Denial contradicts benefits breakdown
- ☐ Buildup denied as inclusive
- ☐ Frequency denial appears incorrect
- ☐ Downgrade seems misapplied
- ☐ $0 payment lacks clear justification
- ☐ Timely filing denial when there is proof of original electronic timely filing

Do not auto-adjust before reviewing

Weekly Appeal Workflow

- ☐ Review denied EOBs
- ☐ Add detailed claim status note
- ☐ Call payer to clarify denial reason
- ☐ Ask what reviewing dentist required
- ☐ Gather supporting documentation
- ☐ Scan appeal into the patient’s document center for proof of filing
- ☐ Submit appeal according to the payer’s correct appeals address or fax number [confirm info before sending]
- ☐ Set follow-up date (14 days)

Consistency beats intensity.

What to ask on the phone:

- What specifically caused the denial?
- What documentation was missing?
- What did the reviewing dentist note?
- Can I have the reviewing dentist’s name and license number?
- Is peer-to-peer available?

Appeals Packet Checklist

What to ask on the phone:

- What specifically caused the denial?
- What documentation was missing?
- What did the reviewing dentist note?
- Can I have the reviewing dentist's name and license number?
- Is peer-to-peer available?

Before Sending:

- ☐ Clear appeal letter
- ☐ Clinical notes (detailed and procedure-specific)
- ☐ Required radiographs (diagnostic quality)
- ☐ Intraoral photos (if applicable)
- ☐ Prior placement date (if crown replacement)
- ☐ Any additional requested documentation
- ☐ NEA/DCN referenced

Incomplete appeals waste time.

Escalation ladder | If denied again:

Repsesentative → Supervisor → Peer-to-peer review → Patient involvement (HR, benefits department)

Track your results. Review monthly:

- ☐ Number of appeals sent
- ☐ Appeal win rate
- ☐ Top procedures appealed
- ☐ Payers with highest overturn rate

Remember: Insurance companies use systems and automation. You must use systems too. Appealing isn't being difficult, it's protecting the revenue your team already earned.

Procedure Code Attachment Checklist

Clean claims start before submission

Crown (D2740, etc.)

- □ Pre-op diagnostic-quality x-ray
- □ Intraoral photo (if applicable)
- □ Clear clinical note (why crown needed)
- □ Prior placement date (if replacement crown)
- □ Fracture, decay, failing restoration documented in detail

Avoid vague notes – be specific and tooth-specific.

Implants (D6010, etc.)

- □ FMX and/or Pano
- □ Extraction date (if applicable)
- □ Missing tooth documentation
- □ Narrative supporting necessity

Incomplete implant submissions often stall.

Core Buildup (D2950)

- □ Pre-op x-ray
- □ Pre-op photo
- □ Mid-prep photo (showing missing structure)
- □ % of tooth structure missing documented
- □ Clear explanation why buildup necessary

Many payers deny buildups as inclusive.
Strong documentation makes appeals easier.

Root Canal Therapy (D3310, etc.)

- □ Pre-op, mid-pp and post-op diagnostic-quality x-ray
- □ Apex visible
- □ Clinical notes supporting diagnosis
- □ Referral document if necessary

Blurry or cropped x-rays trigger denials.

SRP (D4341 / D4342)

- □ Recent FMX (not pano alone)
- □ Full Periodontal charting
- □ Bone loss and bleeding points clearly documented
- □ Clinical justification in notes with staging and grading

If bone loss isn't obvious on x-ray, explain why SRP was necessary.

Occlusal Guards (D9944, etc.)

- □ Upper or lower specified
- □ Bruxism documented
- □ Perio surgery notes (if applicable)

Extractions (D7140, etc.)

- □ Pre-op and post-op x-ray
- □ Clinical notes
- □ Infection, fracture, or pathology documented

Pre-Submission Claim Quality Check

Before Clicking Submit:

- □ Double-check procedure codes
- □ Confirm attachments actually transmitted
- □ Confirm payer ID is correct
- □ Confirm documentation matches clinical notes
- □ Confirm NEA/DCN numbers populate

Never assume attachments “flowed through.” Confirm if your clearing house sent attachments electronically or if the payer doesn’t accept electronic attachments. In those cases, mail might be your only option.

Team Alignment Reminder

Clean claims are a team effort:

Doctors → detailed clinical notes

Assistants → clear photos & x-rays

Admin team → correct attachments & submission

When roles are defined, denials decrease.

Remember:

If the claim doesn’t clearly tell the story, it gives insurance a reason to deny.

Strong attachments = faster payments and fewer appeals.

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