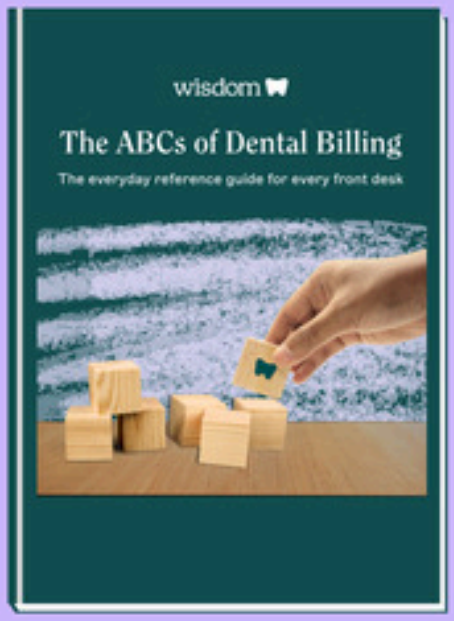
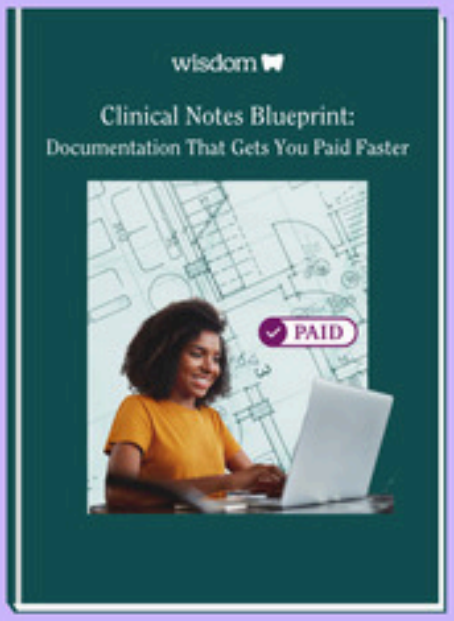
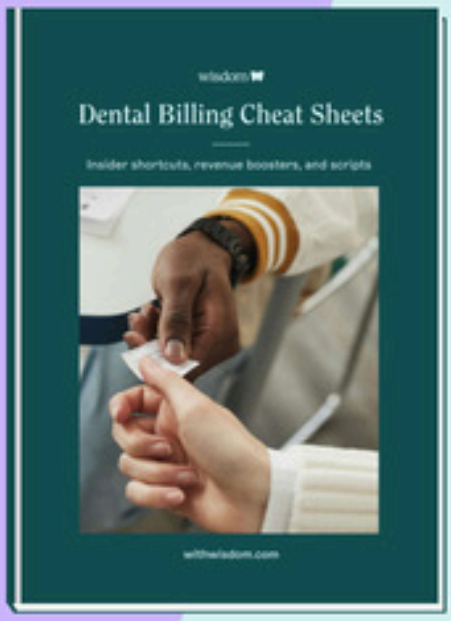
wisdom

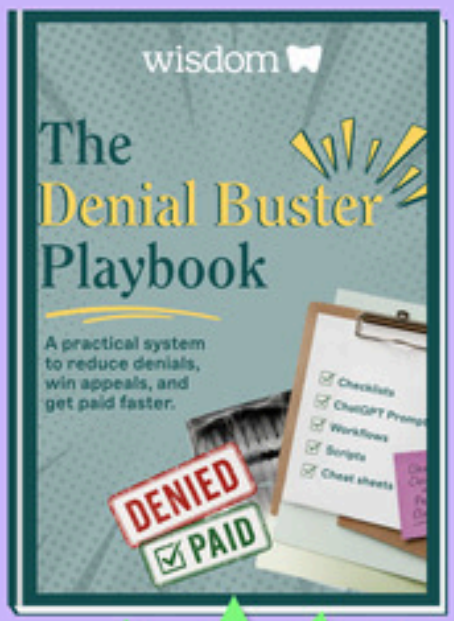
The Dental Billing Power Pack

The comprehensive toolkit for stronger systems, cleaner claims, & higher collections

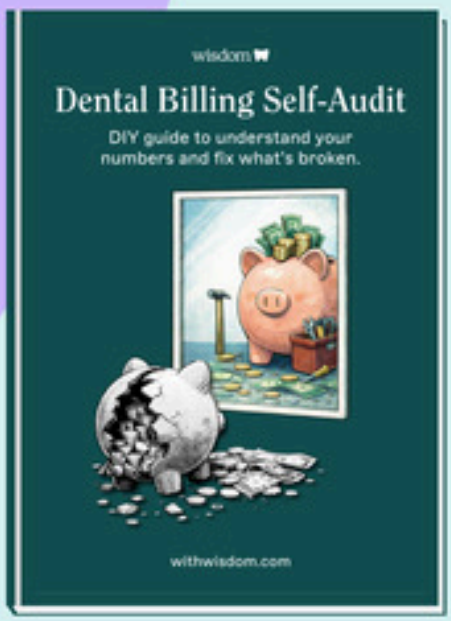












PLUS a comprehensive dental billing glossary!

withwisdom.com

Billing Must-Haves — All in One Place

Running a successful dental practice means juggling patient care, clinical workflows, insurance rules, and the constant pressure to keep revenue moving. It's a lot, and most teams are doing their best with systems that weren't built to keep up.

That's why we created the **Dental Billing Power Pack**: our top ebooks consolidated into one comprehensive resource designed to:

- Simplify the complex
- Strengthen your team's confidence
- Help your practice get paid what it's owed faster and with less stress.

Inside, you'll find our most popular guides, frameworks, cheat sheets, and definitions bundled into one powerful toolkit.

Whether you're refreshing your processes, onboarding new team members, or leveling up your entire revenue cycle, this collection gives you clear steps, proven strategies, and real-world shortcuts you can start using right away.

What's Inside

The ABCs of Dental Billing 04-17

Billing is complex—but it doesn't have to feel chaotic. This guide breaks the process into four simple building blocks that help you stay organized, keep claims moving, and support steady cash flow. It's about smart habits, not memorizing codes.

The Clinical Notes Blueprint 18-32

Great dentistry can go unpaid if the notes don't back it up. This blueprint shows your team how to write clean, complete, defensible documentation that prevents denials and keeps claims moving without adding extra time to your day.

Dental Billing Cheat Sheets 33-51

A quick-hit library of the references billers use most: insurance contact info, templates, scripts, and time-saving tools. Keep it nearby for instant clarity and fewer billing headaches.

The Denial Buster Playbook 52-73

A practical, hands-on guide to reducing dental insurance denials and recovering unpaid revenue. Inside: procedure-specific attachment checklists, clinical documentation tips, proven appeals workflows, and ready-to-use templates, that'll help dental teams submit cleaner claims, fight denials, and get paid faster.

Insurance Aging Checklists 74-86

Learn how to tackle insurance aging with tools your team can put to work right away, including follow-up checklists, call scripts, documentation and attachment guides, appeal strategies, and ready-to-use templates to help prevent delays, resolve outstanding claims, and recover more of the revenue your practice has earned.

Dental Billing Self-Audit 87-109

A DIY guide to understand your numbers and fix what's broken using a variety of efficient systems for documentation, claim submission, follow-up, and appeals.

Dental Billing Glossary 110-123

A straightforward glossary of everyday billing and insurance terms so your whole team can speak the same language. Perfect for onboarding, training, and quick clarification.

wisdom

The ABCs of Dental Billing

The everyday reference guide for every front desk



withwisdom.com

The Building Blocks of a Healthy Revenue Cycle

Dental billing can feel like a lot. Whether you're brand new or have been in the game for years, there's always that nagging feeling: Am I missing something?

This isn't about memorizing codes or becoming a full-time biller. It's about learning the essential habits that keep claims moving, cash flowing, and your front desk from feeling buried.

We've broken it down into four core building blocks to help you focus on what matters: getting paid faster, staying organized, and knowing when to call in backup.

You don't have to do it all. But you do need a system, and that's what this guide is here for.

Table of contents

A: Align with the Details 06

B: Build it Right 09

C: Consistency is Key 12

D: Don't DIY 15

A: Align with the Details

Because what gets overlooked, doesn't get paid.

There are a lot of steps when it comes to dental billing, and every one of those steps is hard enough on its own.

Billing doesn't fall apart all at once — it breaks down in the little things:

- A wrong DOB
- A missing x-ray
- A vague clinical note
- A claim you thought was submitted... but wasn't

These little things delay payments or stop them entirely.

That's why the first building block is getting the details right. This section is your checklist of what can't be skipped.

When these basics are in place, you've already lowered your risk of denials by more than half.

Key Concepts to Know

Eligibility Verification

Verifying insurance before the appointment helps catch issues like terminated plans, waiting periods, or maxed-out benefits before they lead to $0 payments and upset patients.

Best practice | Verify 48 hours in advance and confirm:

- Subscriber ID, group name and number, payer ID
- Deductibles, annual max, remaining benefits
- Frequency limitations and Coordination of Benefits (COB) rules
- Eligibility date, plan limitations and exclusions

Clean Demographics

Patient full legal name, DOB, and subscriber ID are make-or-break for getting paid. Even one typo can get a claim rejected.

Administrative training and standardized intake forms matter more than you think.

Clinical Notes & Narratives

SOAP notes should explain in detail what was done and why. Avoid vague or stock language. Instead, justify dental necessity with precision in order to guarantee approval.

✗ "Needs crown"

✓ "Tooth #19 has fractured mesial cusp with decay under existing restoration."

Key Concepts to Know

Attachments & Documentation

Clearinghouses don't always catch missing pieces, so internal checklists are key – and don't rely just on attachment pop-ups!

Always include what the payer wants to see:

- ✓ Diagnostic X-rays
- ✓ Intraoral photos
- ✓ Perio charting
- ✓ Clinical notes

Coordination of Benefits (COB)

When multiple coverages exist, you must know who pays first. COB errors can lead to instant denials, and even worse, months-long delays if the wrong insurer pays out of order.

Collect this information before the appointment, not after the claim bounces back or the refund letter hits your mailbox.

If this feels overwhelming, it's not you. It's the system.
Wisdom was built to help fix it.
Our team flags detail mismatches
early, before they hit the payer.

B: Build it Right

If your billing systems aren't working, it's not a people problem. It's a process problem.

If your billing success depends on one rockstar employee remembering everything, you're one vacation away from a mess.

Billing works best when it's built on repeatable processes rather than memory or luck.

Learn how to build strong systems that don't fall apart when someone's out or things get busy.

Key Concepts to Know

Daily, Weekly, & Monthly Workflows

Billing shouldn't be reactive. You need routine checkpoints to keep money moving:

Daily

- ✓ Submit claims
- ✓ Post payments
- ✓ Balance deposit slips
- ✓ Check clearinghouse rejections

Weekly

- ✓ Run aging reports
- ✓ Follow up on 30+ day claims
- ✓ Send patient statements

Monthly

- ✓ Review AR numbers with your doctor
- ✓ Review collection percentage, adjustments, & production numbers

PMS Configuration

Poor configuration leads to slow follow-up and messy patient balances. Your practice management software (PMS) should support your process, not confuse it. Set it up with:

- Billing types that reflect the true account status (e.g., active, pre-collections)
- Accurate fee schedules and payment tables by insurance
- Statement settings that trigger promptly; send patient statements the same week balances are posted, not 30 days later

Claim Tracking & Status Notes

Don't just submit and forget.
Every claim should include a status note with:

- Date of last follow-up
- Who you spoke with
- What was said
- Action taken
- Reference number
- Your initials

This simple habit makes multi-person follow-up possible and ensures no claim gets stuck in limbo.

Key Concepts to Know

Batch Processing

Submitting claims in one clean daily batch saves time, reduces errors, and makes it easier to identify what went out when.

Run reports at least weekly on procedures that have not been sent to insurance or secondary claims not created.

Clearinghouses help flag issues before they're submitted, **but don't JUST rely on automatic attachment flags.** Dental billing experts must review each procedure code before submission.

Report Discipline

Your reports are your early warning system.

Use:

- Daily: Unsent/unprocessed claims reports
- Weekly: Insurance & patient account aging reports
- Monthly: Collection, production and adjustment reports

If you're not sure how to read these, Wisdom can show you what matters — and where to look first.

C: Consistency is Key

Clean claims aren't luck, they're a habit.

Great billing isn't about big pushes of productivity. It's about what gets done every day, every week, every month. When collections fall behind, it's rarely one big failure — it's the slow drip of missed follow-ups, unbatched claims, and broken routines.

Consistency is the secret to a billing system that runs smoothly even on your busiest days.

With Wisdom, those habits get reinforced: we help you track what's working, flag what's slipping, and keep everyone on the same page.

Key Concepts to Know

Define Roles Clearly

If no one owns it, it doesn't get done. From updating patient demographics to sending correct attachments, assign roles clearly.

Use role-based task lists or SOPs (standard operating procedures) to assign and clarify.

Daily Discipline

Every day should follow the same rhythm:

- Claims submitted
- Payments posted
- Deposit slips matched
- Issues flagged

Consistency here means fewer surprises at month's end.

Track What You Touched

Your PMS should tell a story: who followed up, when, why, and what happened next.

Claim status notes are your audit trail.

Key Concepts to Know

Weekly Reporting

Make “Report Friday” a thing.

Block time (or a huddle) to run and review:

- Insurance Aging
- Unsent/Unprocessed Claims
- Credit Balances and Adjustments
- Outstanding Patient Balances

Same day, same reports, same person — that’s how patterns get caught early.

Monthly Reviews

Once a month, step back and look at the bigger picture:

- Collection % (aim for 98%+)
- Production Numbers
- Insurance + Patient AR >30 days
- Most common denial reasons

Then act. Ask questions, update workflows, and clean up the messes before they grow.

Consistency doesn’t just protect your revenue, it protects your people. With the right tools and habits, it gets easier.

D: Don’t DIY

You were never meant to do it all

Most dental teams are already stretched thin—balancing phones, scheduling, treatment coordination, and now... full-scale revenue cycle management? It’s no wonder billing falls behind.

Here’s the truth: dental billing is a full-time job.

Actually, it’s several. And most in-house teams just don’t have the capacity to manage all of it at once. That’s where the right support changes everything.

You don’t have to carry it all.

The smartest, most sustainable move is often getting help, whether that’s full outsourcing, hybrid support, or smarter tools that lighten the load. With the right partner, your team can finally breathe and your billing can finally work.

You’re not failing if you need help. You’re scaling.

The Cost of DIY

Doing everything in-house might seem lean, but it's often leaky. Practices that DIY dental billing typically underestimate how much time, labor, and lost revenue it takes to do it well.

It's not just about submitting claims; it's about verifying insurance accurately, tracking follow-ups weekly, appealing denials, and preventing small errors from stacking into major delays.

Most practices don't even realize they're leaving 10–15% of collections on the table — money already earned, but never recovered or adjusted off.

Signs You Need Help

The red flags aren't always dramatic:

- Insurance AR keeps creeping past 30+ days
- Claims are followed up sporadically or when a patient complains
- Denials get ignored or worse, adjusted off
- One person "owns billing" with no backup
- The front office team is juggling too much to keep up

The sooner you catch it, the faster you can fix it.

Types of Support

Billing support doesn't have to be all or nothing. The best option depends on your size, staff, and structure. **The goal isn't to replace your team**—it's to strengthen it with focused expertise and clear systems.

Full RCM	Companies like Wisdom handle insurance verification, claim submission, follow-up, payment posting, and patient billing.
Insurance Only Support	Your team handles patient communication, an outsourced team manages claims, posting and insurance AR.
Billing Workflow Audit	Not ready to outsource? An outsourced company can still assess and optimize your in-house processes.

What changes when you outsource?

With a dedicated team you get:

- ✓ Faster claim turnaround
- ✓ Clean claim submission
- ✓ Fewer rejections and denials
- ✓ Transparent reporting and performance tracking
- ✓ More time for your team to focus on patient experience and care

It's not just a time-saver — it's a revenue upgrade.

wisdom

Clinical Notes Blueprint:

Documentation That Gets You Paid Faster



Tweaks to your clinical notes for faster claim approvals

The Hidden Reason Claims Get Denied (and How to Fix It)

Whether you're a dentist, hygienist, assistant, or biller, you're focused on delivering excellent patient care and keeping the practice running smoothly. But there’s one overlooked detail that can quietly derail all that hard work: your clinical notes.

Incomplete or vague documentation is one of the most common — and costly — reasons claims are delayed or denied. You can provide excellent dentistry and still not get paid simply because the notes didn’t say why the treatment was necessary.

And unless someone is combing through every denial (and let’s be honest, who has time?), this problem often flies under the radar while draining your collections.

That’s why we created this guide: to make documentation easier, clearer, and more consistent for everyone on the team.

Inside you’ll find:

- Plug-and-play SOAP templates for key treatment categories
- Claim-friendly phrasing that supports medical necessity
- Insurance-specific reminders to keep claims airtight

Why SOAP Notes Are the Backbone of Clean Claims

In a busy practice, great documentation is essential — not just for insurance, but for communication, continuity of care, and legal protection. That's where the SOAP format comes in.

SOAP stands for Subjective, Objective, Assessment, and Plan — a widely used method for structuring clinical notes that helps everyone on the team stay on the same page.

When your notes follow this format, they're easier to write, easier to read, and far more likely to support clean claim submission.

SOAP Breakdown

Subjective:

What is the patient's chief complaint? What has the patient told you?

Objective:

What does the clinical team see during the exam? What is observed?

Assessment:

What does the clinician recommend based on S, and O? (Diagnosis)

Plan:

What treatment was completed, and what comes next?

What's at Stake When Notes Aren't Done Right

In the day-to-day pace of dental care, documentation can feel like just another task.

But how you write your notes has a direct impact on your revenue, your risk, and your ability to deliver consistent care.

When notes are incomplete or inconsistent, the consequences show up fast — in the form of denied claims, stalled payments, audit risk, or confused team members trying to interpret what was done and why.

Using the SOAP format protects your practice from:

- Claim denials due to lack of clinical justification
- Delayed or underpaid reimbursements
- Compliance gaps that can raise audit flags
- Miscommunication between providers, especially in multi-location or DSO settings

You deserve to get paid for the care you deliver, on time, every time. But good treatment requires good documentation to back it up.



Tip: Use our category-specific templates in the following pages, or skip to page 9 for an all-in-one version that works for any procedure.

Table of Contents

Each page provides a basic template tailored to a general treatment type essential guidelines that apply to every treatment type on page 9.*

Diagnostic (D0100-D0999) 23

Preventative (D1000-D1999) 24

Restorative: Fillings (D2000-D2500) 25

Restorative: Crown/Bridge: (D2500-D2999) 26

Endodontic: (D3000-D3999) 27

Periodontal (D4000-D4999) 28

Prosthetics, Removable: (D5000-D5899) 29

Implant Services: (D6000-D6199) 30

Key Principles for All Notes 31

*Use of codes in table of contents for reference only, not affiliated with the ADA.

Exams & Diagnostics
(D0100–D0999)

Example SOAP Template:

S:

- **Patient reports pain in upper right molar; worsens when biting.**

O:

- **Swelling noted at tooth #3. Radiograph shows periapical radiolucency.**

A:

- **Diagnosis: Periapical abscess on tooth #3.**

P:

- **Discussed options (RCT vs. extraction). Prescribed amoxicillin. Patient to follow up in 7 days.**



This template applies to all exams. Whether comprehensive, limited, or periodic - always view your exams as a reference point for original diagnosis and a point of reference to support future treatment.

Preventive Treatment
(D1000–D1999)

Example SOAP Template:

S:

- **Patient here for routine cleaning; no concerns.**

O:

- **Prophylaxis completed. Moderate plaque and calculus noted. Fluoride varnish applied.**

A:

- **No active decay. Mild gingivitis in posterior region.**

P:

- **Six-month recall recommended. Reviewed home care techniques.**



Mention if fluoride varnish was applied — some carriers limit frequency or age eligibility.

Restorative Treatment: Fillings

(D2000–D2499)

Example SOAP Template:

S:

- **Patient reports cold sensitivity on lower left molar.**

O:

- **Caries on occlusal surface of tooth #18 confirmed by bitewing X-ray.**

A:

- **Diagnosis: Occlusal decay, tooth #18.**

P:

- **Decay removed. Composite placed. Patient advised to avoid chewing hard foods for 24 hours.**



State how decay was diagnosed (visual? radiographic?), and always list tooth numbers.

Restorative Treatment: Crowns & Bridges
(D2500–D2999)

Example SOAP Template:

S:

- **Patient says crown on upper left feels loose. Patient reports crown placed 15+ years ago, exact date unknown.**

O:

- **Crown on tooth #14 is loose with decay at the margin.**

A:

- **Diagnosis: Recurrent decay under crown, tooth #14.**

P:

- **Removed crown, cleaned decay, placed temp crown. Final crown scheduled in 2 weeks.**



Document age of the crown or bridge, even if it's estimated — most insurers require this every single time in order to get paid for replacements.

Endodontics

(D3000–D3999)

Example SOAP Template:

S:

- **Severe pain in lower right molar, especially at night.**

O:

- **Tooth #30 shows radiolucency at apex. Cold test negative.**

A:

- **Diagnosis: Necrotic pulp with periapical abscess, tooth #30.**

P:

- **Root canal initiated. Canals cleaned and filled with gutta-percha. Temporary restoration placed. Patient to return for crown prep.**



If RCT is staged over multiple visits, note the next step. Insurers want to see full treatment intent.

Periodontal Therapy
(D4000–D4999)

Example SOAP Template:

S:

- **Bleeding with brushing, sensitivity in lower front teeth.**

O:

- **4–5 mm pockets noted. Radiographs confirm bone loss in lower anteriors.**

A:

- **Diagnosis: Periodontitis Stage II, Grade B.**

P:

- **SRP completed in quads 1 & 2. Total chair time: 65 min. Scheduled for re-eval in 4 weeks.**



If diagnosis occurred at a previous appointment, add “as observed on exam (date)” to the objective section. Attached current periodontal charting and FMX confirming bone loss. And be sure to document staging and grading per AAP guidelines.

Removable Prosthetics
(D5000–D5899)

Example SOAP Template:

S:

- **Patient reports lower denture is loose and makes chewing difficult. Original placed over 20 years ago.**

O:

- **Denture is worn. Poor retention observed. Panoramic confirms ridge resorption.**

A:

- **Diagnosis: Denture instability due to bone loss and age of appliance.**

P:

- **Took impressions for new denture. Fitting scheduled in 2 weeks.**



The reason for replacement, and estimated original date or age of the appliance must always be sent to insurance regardless of prior coverage. Replacements need a reason. Include age, wear, function, or discomfort.

Implants
(D6000–D6199)

Example SOAP Template:

S:

- **Follow-up for missing tooth #19. Tooth extracted 6 months ago due to fracture.**

O:

- **CBCT shows 8mm width, 12mm height. Adjacent teeth healthy.**

A:

- **Implant chosen to preserve adjacent teeth, avoid removable options and therefore altering adjacent teeth.**

P:

- **4.5mm x 10mm titanium implant placed. Suture removal scheduled in 2 weeks.**



Always indicate why an implant was placed versus another type of fixed prosthetic, or removable prosthetic. The reasons may vary, but insurance will always want to know. Include all missing teeth on the claim form.

One Template to Rule Them All

Universal SOAP Template

(Any Procedure)

Use This When:

- You don't want to flip back and forth between templates
- The procedure is complex and spans multiple categories

Full Template:

S – Subjective:

- Chief complaint
- Medical history updates
- Reason for today's visit

O – Objective:

- Exam and radiograph findings
- Periodontal charting
- Restoration status or complications

A – Assessment:

- Diagnosis with rationale
- Tooth #s involved
- Tools used to assess (X-ray, intraoral photo, cold test, etc.)

P – Plan:

- Treatment provided
- Materials and anesthesia used
- Document how the patient tolerated the procedure and any post-op instructions provided (verbal or written).
- Provider & assistant names

This template is great for multi-step treatments or anytime you need a comprehensive record on the fly.

A word about attachments....

The fastest path to payment is
great notes PLUS great attachments.

Include these with every claim:



Intraoral photos (before, during, and after for crowns/restorations)

Radiographs — diagnostic quality only (especially for SRP, RCT, crowns)



Periodontal charting with bleeding points and pocket depth



Narratives that spell out clinical need, age of restorations, and alternatives considered

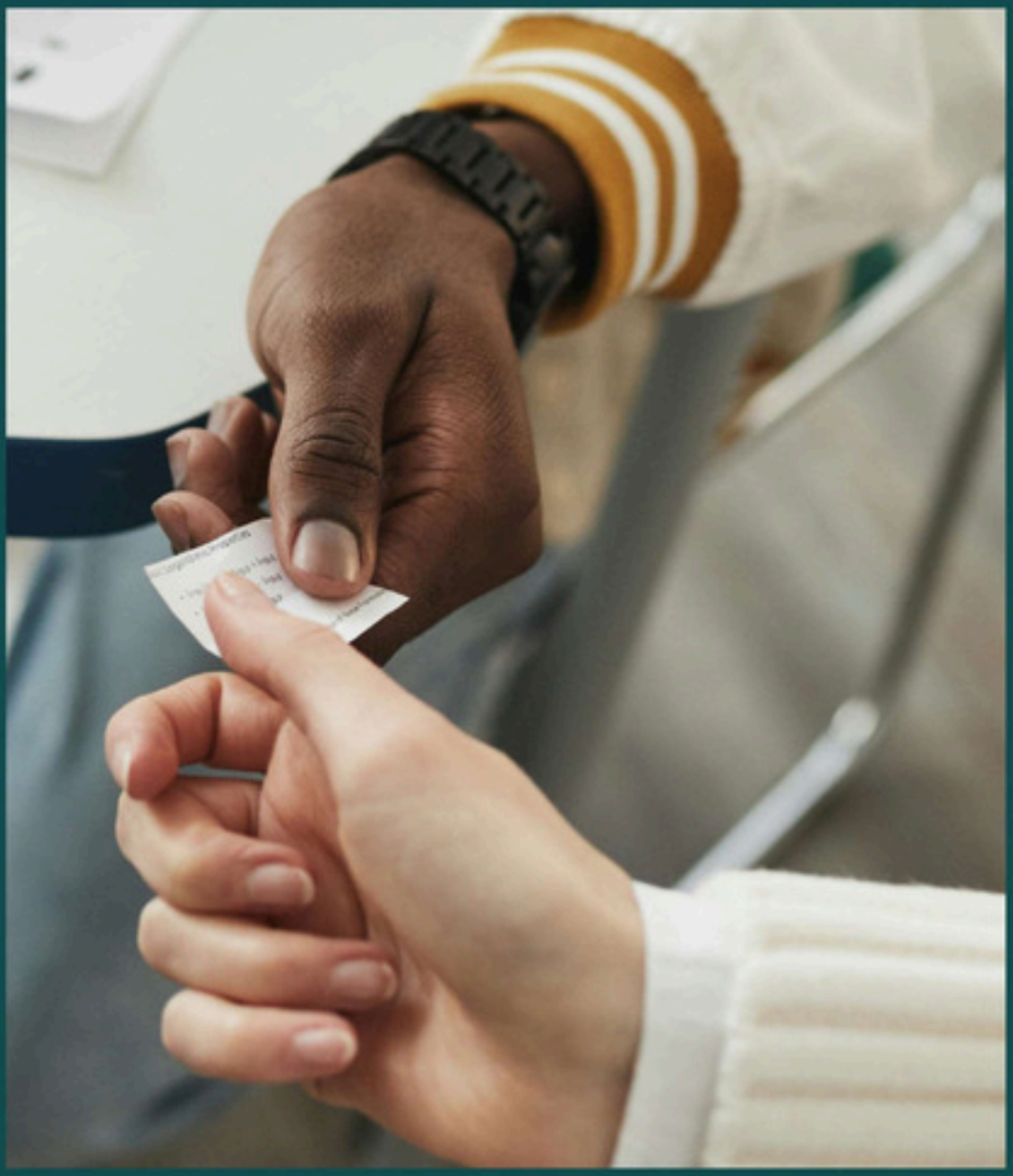
Re-check for: missing attachment IDs (like NEA numbers), outdated X-rays, or lack of narrative detail.

These are top reasons we see claims kicked back.

wisdom

Dental Billing Cheat Sheets

Insider shortcuts, revenue boosters, and scripts



withwisdom.com

We know how tough dental billing can be, we deal with it every day.

That's exactly why we've put together these cheat sheets to help you cut through the red tape and save valuable time. Whether it's finding those elusive insurance fax numbers or using ready-to-go templates and scripts, we've packed this ebook with the tools we rely on ourselves. We're sharing them with you because we get it—you've got patients to care for, and insurance billing shouldn't stand in the way. We're here to help you streamline the process and keep your practice running smoothly.

Table of Contents

Oral Cavity Codes 35

Dental Claims Attachment Cheat Sheet 36

Collecting at Time of Service 37

Scaling and Root Planing: Prep! 38

Scaling and Root Planing: Notes 39-40

Insurance Company Fax Numbers 41-51

Oral Cavity Codes



01 Maxillary	**02** Mandibular
10 Upper Right Quadrant	**20** Upper Left Quadrant
30 Lower Left Quadrant	**40** Lower Right Quadrant

Dental Claims Attachment Cheat Sheet



Crown/Inlay/Onlay	• Pre/Post Op Xrays (include Endo reports if applicable) • Pre/Post Op Photos • Narrative: Diagnosis AND treatment • Notate/Include original placement date if applicable
Implants/Removable Prosthetics	• Full Mouth Series Xray (Pano or FMX) • Missing Teeth • Narrative: Diagnosis AND treatment notes
Endodontic Treatment	• Pre/Post Op Xrays • Pre/Post Op Photos • Narrative: Diagnosis AND treatment notes
Scaling and Root Planing	• Full Mouth Series (FMX within 2 years) • Perio Chart • Narrative: Diagnosis AND treatment notes
Guards (Occlusal)	• Narrative: Diagnosis AND treatment notes • Indicate Upper/Lower - Ensure notes match code • Specify: Bruxism, or periodontal
Extractions	• Pre/Post Op Xrays • Narrative: Diagnosis AND treatment notes • Coronal remnants/ surgical MUST have attachments

Patient Payment Checklist: Smooth Checkouts



Reminders

- ☐ Make sure to collect family balance including previous balances and balances from other family members. Don't just collect today's portion due.
- ☐ Make sure to $0-out estimated insurance payment on any procedures not covered by insurance before batching claim to collect that $ at time of service. (I.E. Vel., laser, adult FL, D4910, guards, etc)
- ☐ When reviewing treatment plans, let patients know that their estimated portion is due at the time of service, so there won't be any surprises. Even better- collect when you schedule that appointment (before they come in) Options: offer 3%/5% pre-pay discount (depending on credit card or cash/check). Not only does this help KEEP their appointment, it also helps us from chasing down payment.
- ☐ You can collect for treatment BEFORE the patient goes back into the treatment room. (Present it as a courtesy to THEM)
- ☐ Make sure every team member is on the same page and follows the same protocols for collections.

Scaling and Root Planing: Prep!



Tip

Ensure you have a recent (less than 2 years maximum, ideally less than 1 year) full mouth series for diagnosis, and to submit with the claim(s). If frequency disallows this, we recommend taking a new one and writing it off if there is a concern to patient adversity. You will recoup the cost in timely SRP claim payments.

Tip

If diagnosis only occurs in one visit, and the patient returns later for SRP, ensure you use the "Scaling and root planing: notes" clinical note example template above the placeholder for anesthesia to notate the diagnosis as outlined.

Tip

Insurance companies do NOT find treating all 4 quads in one visit to be appropriate and will almost always deny when they see this, under some other reason code. If you perform more than 2 quads in one visit, document why, such as the patient requested it, sedation was used, etc.

Wisdom clients experience:

100%
Insurance Revenue Increase

-50%
Reduction in Accounts Receivable

+10%
Increased Patient Satisfaction

Scaling and Root Planing: Notes



Clinical Note Template: Diagnosis - Use “S O A P”

Subjective

What is the patient's chief complaint? What has the patient told you?

Objective

What do the doctor and clinical team see during the exam?

These are the facts that have been observed. (staging and grading, and perio charting apply)

Assessment

What does the doctor recommend based on the S and O? (Diagnosis)

Plan

What is the treatment plan for the patient?

Scaling and Root Planing: Notes



Example Clinical Note Template for Treatment:

Patient presented with active chronic periodontal disease impacting teeth #s _____, as evidenced by generalized bleeding upon probing, clinical attachment loss, radiographic bone loss (input MM) , and inflammation of the gingival tissue.

(quad/tooth #) Stage:
(quad/tooth #) Grade:

There is generalized supra and subgingival biofilm which is further harbored by subgingival calculus throughout. (if interproximal or subgingival calculus is not visible on full mouth series state why) Additional risk factors are (if applies, smoker, health or medication issues, etc)

(Total anesthetic and what kind by quad - if only topical state pt declined injections), Deep root scaling was used to remove deep calculus from the teeth (note tooth numbers, break out different sections for different quadrants) via hand instruments and cavitron, pt was in chair (enter minutes)

Finish: Add the rest of what your standard office template looks like for instructions and next visit.

Insurance Company Fax Numbers

Aetna	859-455-8650
Allied Benefits (+90 only)	312-261-9363
Always Care/Unum	888-843-5872
AlwaysCare/Colonial life	855-400-9307
Ameritas	402-309-2580
Ameritas Appeals	402-467-7336
Anthem - PO BOX 1115	877-261-2132
Anthem Federal	888-859-3046

Insurance Company Fax Numbers

Anthem NY Dental	888-859-3046
Anthem Payor ID 84105	888-817-3698
ANTHEM (Payor ID 84105)	888-817-3698
Assurant HEALTH	414-299-6802
Assurant Supplemental	317-284-7281
BCBS FEP Dental	800-977-7943
BCBS of Alabama	205-220-2146
BCBS of Arizona	833-517-1939

Insurance Company Fax Numbers

BCBS of Arkansas	888-667-8388
BCBS of GA Fed Employee	888-859-3046
BCBS of IL	618-222-6111
BCBS of KC Federal	816-395-3811
BCBS of Michigan	262-834-3589
BCBS OF TX FEP	888-368-3406
Beam Dental	877-405-3639
Best Life & Health Insurance	208-893-5040

Insurance Company Fax Numbers

Blue Cross of Idaho	208-286-3752
Capital Blue Cross	833-517-1939
Cigna PPO	859-550-2662
Cigna State CT	18605173530
COMPANION LIFE	563-557-3350
CoreSource(Trustmark)	913-681-0886
Dearborn National	618-222-6111
Delta Dental of AR	800-500-8991

Insurance Company Fax Numbers

Delta Dental of AZ	602-588-3636
Delta Dental of CA (Tricare Retiree)	916-851-1559
Delta Dental of CO	303-741-2116
Delta Dental of Hawaii (Hawaii Dental Service)	866-590-7988
Delta Dental of Iowa (IA)	888-264-1440
Delta Dental of KS	316-462-3392
Delta Dental Of Massachusetts (MA)	617-886-1199
Delta Dental of (MO)	314-656-2900

Insurance Company Fax Numbers

Delta Dental of (NJ)	800-324-7939
Delta Dental of TN	615-244-8108
Delta Dental of WY	307-632-7309
Delta Dentof Virginia (VA)	claims 540-491-9717 appeals 540-795-4590
DentaQuest	262-834-3575
Dominion/Kaiser	888-208-8290
Dominion National	833-517-1939
Ebix	801-269-9734

Insurance Company Fax Numbers



EMI Health	801-269-9734
Encore Dental	281-313-7154
Feedom Life Insurance	844-650-1899
FIDELIO	215-576-5849
First Continental Life	281-313-7154
GHI/Emblem	212-510-3184
Guardian Group	509-468-6393
Guardian Individua	916-388-3604

Insurance Company Fax Numbers

Healthplex - UHC	516-227-1143
HealthScope Benefits inc	915-581-7537
Humana Specialty Claims	888-556-2128
Kansas City Life	512-233-7719
Liberty Dental Plan	949-270-0103
Lincoln Financial	877-843-3945
Local 655 Welfare	314-966-9848
Manhattan Life	713-583-2738

Insurance Company Fax Numbers

Marpai Health (Maestro)	704-845-5629
Meritain	763-852-5057
Metlife	859-389-6505
Metlife TDP (Tricare)	859-389-6505
Mohegan Tribe Contract Health	860-862-6154
Mutual of Omaha	402-550-1933
NN NJ Appeals	973-285-4095
Physicians Mutual Insurance Company	402-467-7336

Insurance Company Fax Numbers

Principal	866-301-1502
Regional Care	308-635-2018
Reliance Standard	402-467-7336
Southland	205-409-2538
Standard Insurance Co.	866-335-3969
Sunlife	563-242-0184
Teamsters	203-624-8866
UHC Dental Appeals	714-364-6266

Insurance Company Fax Numbers

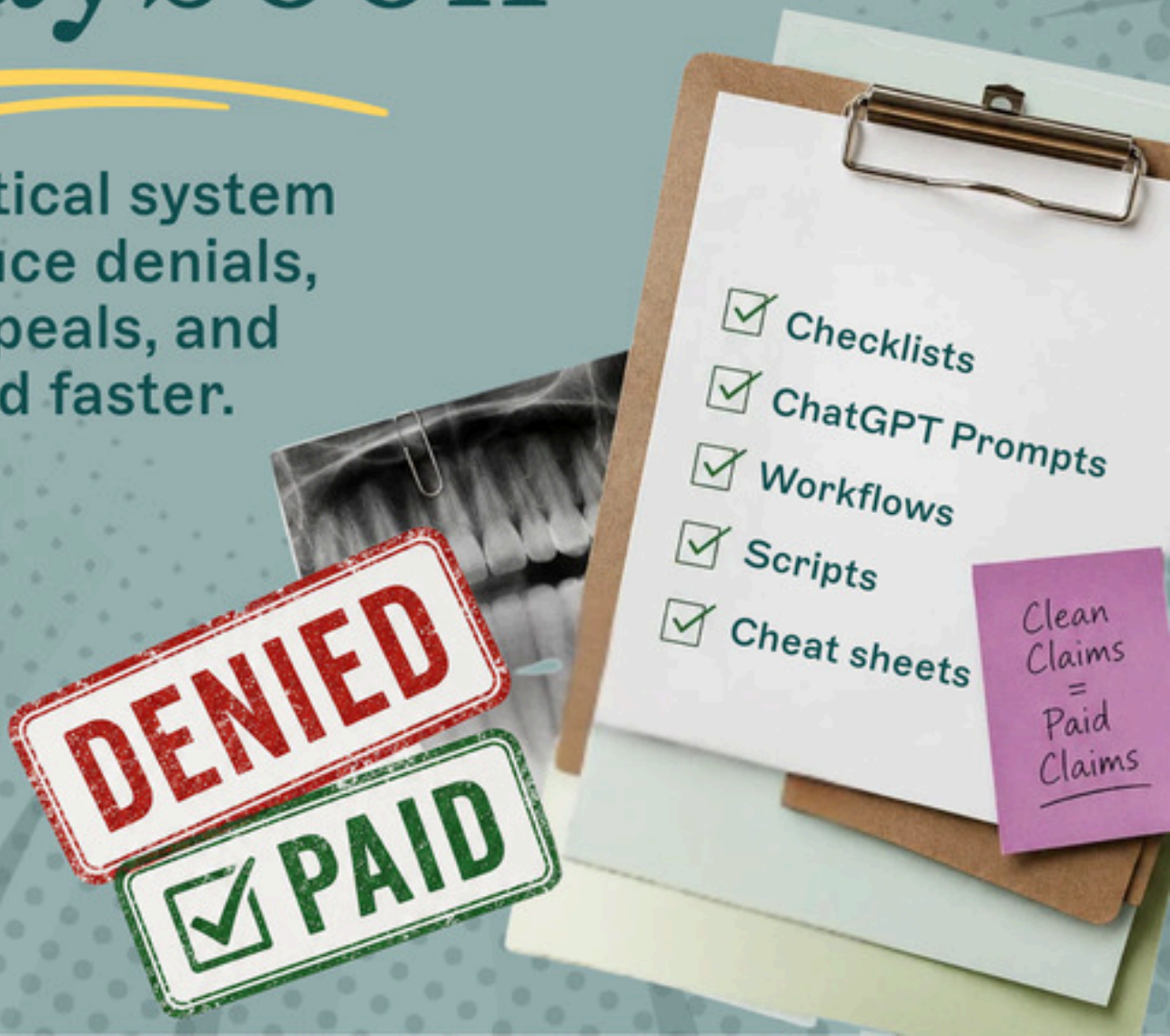
UMR	877-292-0792
United Concordia	866-335-3969
United Healthcare	248-733-6372
United Healthcare Appeals	888-517-7113
UNUM	225-400-9307

*List up to date as of 10/1/2024. For a modifiable spreadsheet version of the fax numbers documents, email us at info@withwisdom.com

wisdom

The Denial Buster Playbook

A practical system to reduce denials, win appeals, and get paid faster.



INTRODUCTION

Stop losing revenue to preventable denials.

Across dentistry, rejections, denials, and unpaid claims cost practices 10-20% of their revenue annually, adding up to nearly 16 billion dollars. Most practices assume this loss is just part of insurance, but truth be told, most of this revenue loss is preventable.



The practices that get paid faster aren't necessarily working harder, they just have efficient systems for documentation, claim submission, follow-up, and appeals.

And now you do too.

This workbook is split into two sections:

STOP THE DENIALS

Prevent claim issues before submission through stronger systems, documentation, and workflows.

WIN THE APPEALS

Recover unpaid revenue through structured follow-up, appeals, and insurance communication.

Table of contents

Part 1: Stop the Denials 54-65

Part 2: Win the Appeals 66-73

PART 1

Stop the Denials

Prevent claim issues before submission through stronger systems, documentation, and workflows.

Inside:

Roles & Responsibilities in the Office 56

Documentation Framework 57-58

Checklist: Procedure Code Attachments 59-60

Common Attachment Denials 61-63

Proactive vs Reactive Billing 64

Pre-Submission Checklist 65

Clean claims start before you submit

Unlike rejections - claims that never make it to the insurance company at all - denials are claims that were received, reviewed, and not paid.

The biggest cause of denials is:

“Dirty Claims” = claims submitted without the documentation, attachments, or details insurance needs to approve payment.



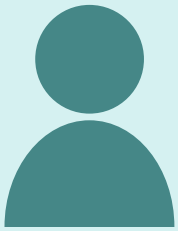
of denials are due to preventable administrative errors, leading to unnecessary patient charges, or worse, writing off claims that would otherwise be paid.

The right systems and checklists will help your practice take control of these errors.

WORKSHEET

Roles & Responsibilities in the Office

Getting paid is a team sport — everyone in the office has a specific role to play in collections, production, and claim success.



DOCTORS

Diagnosis, thorough clinical notes, documentation, clinical justification for treatment



ASSISTANTS & HYGIENISTS

Photos, x-rays, attachment readiness, perio charting, findings



ADMINISTRATIVE TEAM

Benefit breakdowns, verification accuracy, patient estimates, follow-ups, accurate claim submissions

Hold quick daily huddles with clear checklists of what x-rays, photos or documentation is needed for today's treatment on the schedule (see page X for the full list), so the front and back office are working toward the same numbers.

Clean claims happen when the entire office works together, not when one department tries to fix problems after the denial already happens.

When roles are defined, denials decrease.

TEMPLATE | CLINICAL NOTES

Document the ‘Why’

Strong clinical notes follow the SOAP framework:

S

SUBJECTIVE

What the patient reports

O

OBJECTIVE

Clinical findings, x-rays, observations

A

ASSESSMENT

Diagnosis

P

PLAN

Treatment completed + next steps

The more specific the documentation, the easier it is for insurance to understand medical necessity.



For a more in depth look at how to write great clinical notes, check out our Clinical Notes Blueprint.

Scan the QR code to download!

CLINICAL NOTES IN ACTION

Specificity Matters

Specificity matters. If insurance can't clearly understand why treatment was needed, payment delays and denials become more likely. The more details the better here!

BAD



"Crown due to decay"

BETTER



"Crown due to recurrent caries and fracture"

BEST



"Tooth #4 presents with recurrent mesial/distal caries and fractured lingual cusp."

WORKSHEET

Procedure Code Attachment Checklist

Clean claims start before submission

CROWN (D2740, ETC)

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

CORE BUILDUP (D2950)

- □ Pre-op x-ray
- □ Pre-op photo
- □ Mid-prep photo (showing missing structure or fractured cusps)
- □ % of tooth structure missing documented
- □ Clear explanation why buildup necessary to retain the crown

SRP (D4341/D4342)

- □ Recent FMX (not a pano)
- □ Full Periodontal charting
- □ Bone loss, recession and bleeding points clearly documented
- □ Clinical justification in notes with periodontal staging and grading
  - Anesthesia used and appointment length

IMPLANTS (D6101, ETC)

- □ FMX and/or Pano and/or CBT
- □ Extraction dates of all missing teeth (if applicable)
- □ List all missing teeth in both arches
- □ Clinical documentation supporting necessity

ROOT CANAL THERAPY (D3310, ETC)

- □ Pre-op, Mid-Op and Post- op Diagnostic-quality x-ray
- □ Apex visible
- □ Clinical notes supporting diagnosis
- □ Referral document if necessary

EXTRACTIONS (D7140, ETC)

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

OCCLUSAL GUARDS (D9944, ETC)

- □ Upper or lower arch specified
- □ Bruxism documented or perio surgery (if applicable)

WORKSHEET

Common Attachment Denials (and What They're Telling You)

A denial isn't the end, it's a clue
Most denials fall into predictable categories. When you know what to look for, you stop reacting emotionally — and start responding strategically.

FREQUENCY/LIMITATIONS

EX: "Perio maintenance (D4910) not covered – frequency exceeded"

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

Do not assume insurance is correct.

MISSING PRIOR PLACEMENT DATE (CROWNS)

If crown is replacement:

- □ Include original placement date in clinical note
- □ Resubmit with additional documentation
    - □ Reference the original claim number from the insurance company in the remarks section



Make prior placement part of your crown clinical note template.

BUILDUP DENIED AS "INCLUSIVE"

EXTREMELY COMMON!

Before adjusting:

- □ Confirm clinical documentation supports necessity
- □ Include intraoral photos [Pre-Op and Mid-Op)
- □Include % of tooth structure removed
- □ Appeal (If Cigna, call and give the seat date over the phone)

If in-network and EOB says you cannot bill patient, appeal before adjusting. At minimum, this should be the patient's responsibility if your documentation supports the need for a build-up in order to retain the crown.

SRP DENIALS

Often denied for insufficient documentation

- □ Include recent FMX
- □ Include full periodontal charting
- □ Document bone loss, recession and bleeding points clearly
- □ Avoid relying on pano, BW or PAs alone
- □ Clinical documentation including but not limited to periodontal staging and grading, anesthesia used, appointment length, and bone loss [especially when not clearly visible on radiographs]

If documentation supports it, appeal.

IMPLANT CLAIMS

Common issues:

- Missing FMX, PANO, or CBT scan
- Missing tooth documentation
- Missing extraction dates of missing teeth

Attach complete clinical story before resbumitting

Remember: Double check codes before submission. Not all claims that need attachment will automatically get flagged by your clearinghouse.

Don't just resubmit if it didn't go through the first time – resubmitting the same thing, the same way twice won't fix your problem!

WORKFLOW MINDSET

Proactive Practices Get Paid Faster

REACTIVE BILLING

- Resubmitting the same claim repeatedly, the same way
- Appealing preventable denials
- Chasing missing attachments or details after submission

PROACTIVE BILLING

- Reviewing claims before submission
- Using standardized templates
- Sending complete documentation the first time

The fastest way to improve collections is not working harder after claims are denied. It's slowing down long enough to send cleaner claims the first time.

CHECKLIST

Pre-Submission Claim Quality Check

Before clicking submit:

- ☐ Double-check each and every procedure code on your schedule
- ☐ Confirm attachment and documentation BEFORE you hit send electronically
- ☐ Confirm payer ID is correct
- ☐ Confirm documentation on the claim matches clinical notes... or better yet, attach your entire clinical note to the claim
- ☐ Confirm attachments actually transmitted electronically
- ☐ Confirm NEA/DXC numbers populate and update claim status note with that information

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.

PART 2

Win the Appeals

Since we're facing the root issues and are only sending clean claims going forward, here's what you need to know about the appeals process.

Inside:

Proven Appeals Process 67

Script: Get the Patient Involved 68

Template: ChatGPT for Appeals 69-70

Payment Posting & Denial Tracking 71-72

How Wisdom Handles Appeals..... 73

WORKFLOW PROCESS

Proven Appeals Process

Appeals should be proactive and consistent, worked weekly at a minimum:

- Set aside denied EOBs & info requests when posting payments each day
- Look for the appeals address on the denied EOBs
- Update claim status notes with exactly what you sent/where you sent your appeal
- Upload the appeal into the patient's document center
- Have ready to go templates with no patient info or use ChatGPT as a tool
- Fill in what is needed with all including:
  - X-rays, chart notes, photos
  - Circle the decay/fracture/etc

Quick appeal tips:

Call and ask the insurance company what the reviewing DDS noted as the complete denial reason. What did they need to see? Request the highest level supervisor.

Have the doctor provide additional documentation clinically based on that info. Ask for the license # & name of the reviewing DDS

If the next appeal is denied, request a peer-to-peer & the license number of the previous reviewing DDS.

Get the patient or their HR department involved.

SCRIPT

Get the Patient Involved

A straightforward script to use with patients

“We’ve really been fighting on your behalf to get this claim paid and have sent in additional documentation showing why the treatment was necessary, but unfortunately your insurance company is still pushing back on payment.

Can you help us by calling the number on the back of your insurance card and asking them to review the claim again?

It’s frustrating because this is exactly the type of treatment insurance should be helping cover, and we do not want their decision to unfairly leave you stuck with the full balance.”



And remember... if insurance still refuses to pay after all of this, the patient isn’t frustrated with you.

They’re frustrated with the insurance company that collected premiums but refused to help cover necessary treatment.

PROMPT TEMPLATE

Using ChatGPT for Appeals

Appeals and denial responses often feel overwhelming because you're starting from scratch, but ChatGPT can help eliminate the blank page.

Think of ChatGPT as a drafting assistant, but remember to protect patient privacy and use your own judgement to maintain accuracy.

- ✓ Draft appeals
- ✓ Organize workflows
- ✓ Clarify policies
- ✗ Verify benefits
- ✗ Confirm plan limitations
- ✗ Replace clinical documentation
- ✗ Make judgment calls

Step-by-Step Walkthrough:

1. Go to: https://chat.openai.com
2. Create a free account (phone + email)
3. Copy & paste the prompt below in ChatGPT

Dental Insurance Appeal Prompt

Act as a dental billing and insurance appeals expert. Help me write a professional dental insurance appeal focused on medical necessity and CDT intent. Use credible sources including the American Dental Association (www.ada.org).

I will provide for you next: CDT code, doctor's clinical notes, denial reason from EOB.

Provide for me: A ready to submit appeal letter, clear justification of medical necessity, rebuttal language specific to the denial, recommended documentation, next steps if denied again.

Use professional dental billing terminology.
Ask clarifying questions only if needed
No legal advice

WORKSHEET

ChatGPT Best Practices

Never enter:

- ✗ Patient name
- ✗ Date of birth
- ✗ Subscriber ID
- ✗ Social security number
- ✗ Claim number
- ✗ Any identifying information

Instead use:

- ✓ “Tooth #19”
- ✓ “DOS: 01/01/2026"
- ✓ “Patient”
- ✓ “Insurance carrier”

PRESUBMISSION CHECKLIST

Before you send anything, always:

- □ Remove all patient identifiers
- □ Rewrite in your office’s tone
- □ Confirm it aligns with the actual plan benefits
- □ Attach correct documentation
- □ Add claim status note

CHECKLIST

Payment Posting & Denial Tracking Workflow

The appeals process begins the moment an EOB is posted, NOT when someone finally notices an unpaid claim. The person posting payments plays a critical role in identifying:

- Which claims need additional information
- Which claims need formal appeals
- Which trends are repeatedly causing delays

Separate Resubmissions from Appeals

Resubmission:
Usually fixable with more information

Insurance company is asking for:

- Missing attachments
- Clinical notes
- Additional documentation

≠

Appeal:
Requires escalation + supporting evidence

Insurance company reviewed the claim and denief payment based on:

- Medical necessity
- Frequency limitations
- “Inclusive” procedures
- Clinical justification

GOAL: Identify patterns/trends and use them to improve systems moving forward.

CHECKLIST

Payment Posting Checklist

When posting insurance payments:

- ☐ Set aside all denied EOBs
- ☐ Identify whether claim needs:
  - Resubmission
  - Appeal
  - Adjustment
- ☐ Add detailed claim status notes
- ☐ Track denial reason
- ☐ Flag repeated denials by:
  - Insurance
  - Procedure code
  - Provider
- ☐ Notify doctor if additional documentation is needed
- ☐ Add appeal/resubmission to tracking system

Talk about your denials with your team every single month during team meetings. If you keep repeating the same denials over and over, that is not just an insurance problem, it is a systems and communication problem.

WORKFLOW

How Wisdom Handles Appeals

The best appeals don't stop after one try.

1	Denial Received	The EOB is posted and the denial is flagged instead of immediately adjusted, written off or billed to the patient.
2	Classify the Issue	We idenitfy denial type and documenation gap
3	Build the Clinical Story	We collect what's needed to support the claim (clinical notes, attachments, medical necessity language, etc)
4	Submit First Appeal	We submit a strong, well-documented appeal with all supporting documentation attached
5	Follow-Up with Insurance	We contact the payer to confirm appeal received, what the reviewing DDS noted, whether anything else is needed, timeline for reprocessing
6	Escalate when Needed	We follow-up persistently to track the claim; may request supervisor review, peer-to-peer review, or push for reprocessing
7	Track & Analyze Trends	Each denial is tracked by insurance company, procedure code, provider, and denial reason to help identify whether the issue is a one-off or a larger system problem
8	Bill/Adjust Only When Appropriate	We write off only when all options are exhausted

The strongest appeals strategies are proactive, persistent, and collaborative — keeping providers, billers, and patients aligned throughout the process.

wisdom

Insurance Aging Checklists



11 PRINTABLE TOOLS

to unstick & reclaim lost revenue!

Insurance aging can feel overwhelming — especially when your team is working hard and the numbers aren't moving.

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 so you can unstick and reclaim lost revenue.

When these systems are used consistently, insurance aging becomes more predictable, manageable, and far less stressful.

If this feels like a lot to manage, that's where Wisdom comes in. We take insurance billing and follow-ups off your plate so nothing gets missed.

Table of contents

Insurance Aging Checklist 76

Common Rejections 77

Claim Status Notes 79

Script: How to Call Insurance 80

Checklist: Common Denials 81

Appeals Best Practices 83

Procedure Code Attachments 85

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

Claim status note format:
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

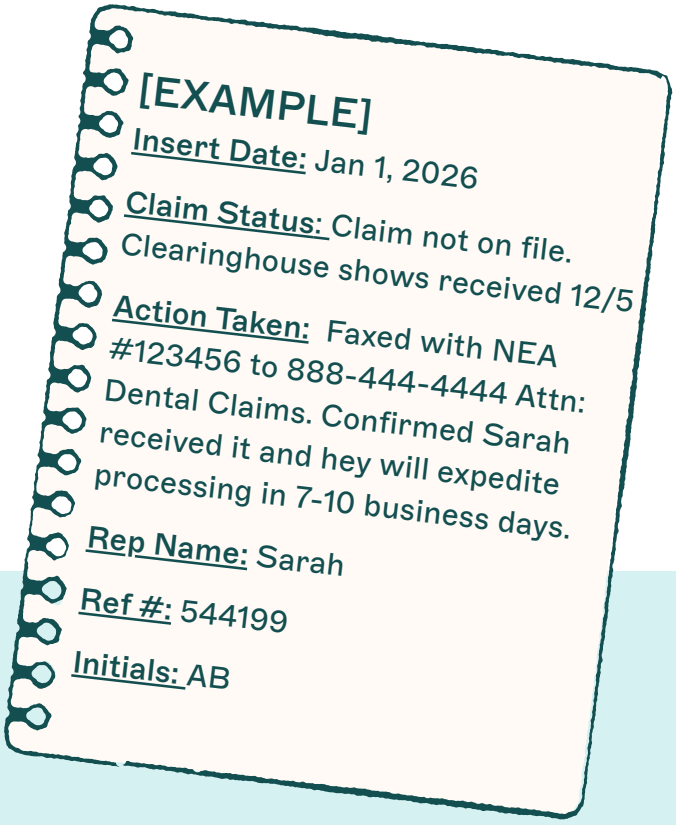
Your note must read like a story. If your notes are vague or incomplete, you start over every time.

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.

wisdom

Dental Billing Self-Audit

DIY guide to understand your numbers and fix what's broken.



withwisdom.com

Running a dental practice today is harder than ever.

You're juggling patients, insurance, billing, a million little tasks, and somewhere in the chaos, money is slipping through the cracks.

In fact, dentists in the U.S. lose an estimated $16 billion a year in uncollected revenue. You may ask yourself, "Where exactly is that money going?" We have good news and bad news.

The bad: There's no straightforward answer because where your money is hiding shows you exactly where your systems are breaking down.

The good: This guide will show you step-by-step how to find that missing cash and how to maximize your collections using information you already have access to.

We broke down the process with:

- What numbers to pull from your software (your raw inputs)
- How to use those numbers to calculate key billing metrics like collection rate and AR aging
- How to compare those metrics against industry benchmarks to see what's healthy vs. what's not
- What each number tells you, and how to spot problems hiding in plain sight
- How to fix what's broken in your systems or processes

That being said, this process can be quite complicated, so if you're not the DIY type, we're more than happy to take this task off your plate so you can focus fully on your main job.

Now that that's out of the way, let's get started on diagnosing your practice's revenue health and finding your practice's missing money.



wisdom tip:

Prefer to outsource your problems?

Get in touch!

Table of contents

Why Your Practice Revenue Health Matters 90

The Numbers You Need (and how to pull them) 92

How to Calculate 98

What the Numbers Are Telling You 103

What A Healthy Billing System Looks Like 107

How Wisdom Helps 109

Why Your Practice Revenue Health Matters

In the dental industry, collections often don't reflect production and the gap is where practices lose thousands (or more!) every month.

EXAMPLE: An office that produces $100K a month is typically only collecting $90K and leaving the other $10K on the table.

Even busy, well-staffed practices with great production numbers can silently bleed revenue due to:

- Old claims that were never followed up
- Insurance denials that no one appealed
- Write-offs that shouldn't have happened
- Uncollected patient balances
- Claims never even sent

Auditing your practice's revenue health helps give you the data to take action by retraining your team, outsourcing your billing, or cleaning up your AR (Accounts Receivable).

The 4 Things A Practice Audit Will Reveal

1. How much money is tied up in AR and whether your team is following up on claims consistently
2. How accurate your patient estimates are
3. Incorrect write-offs and adjustments
4. If your systems are working against you

Once you identify where the problems are, you can:

- Fix claim workflows
- Retrain team members
- Clean up your AR
- Appeal denied claims
- Collect more accurate patient balances
- Or delegate all of it to someone else



It's not about complex financial modeling or spreadsheets, but rather understanding whether you're collecting what you've earned and why some claims aren't getting paid.

Think of it like running diagnostics on your car. You don't need to be a mechanic to understand something's wrong when the warning lights come on.

This audit gives you visibility into your billing engine and shows you where it needs a tune-up.

The Numbers You Need (and how to pull them!)

Healthy practices don't guess, they track.

Here are the top 4 metrics you'll track to understand your practice's financial health:

Collection Percentage:

The percentage of your production that actually turns into collected revenue; are you actually collecting what you earn?

Over 90-Day Insurance AR Percentage:

The portion of your insurance claims that are more than 90 days old.

Over 90-Day Total AR Percentage:

The percentage of all unpaid balances (insurance + patient) that are over 90 days old; how much money is aging out?

Insurance vs Patient Collections Split:

The percentage of your revenue coming from insurance vs. patients; are claims being paid, or is it all falling on patients?



wisdom tip:

You don't need fancy software to start. Just pull the basics and start tracking. That alone will change how you operate.

You've learned which numbers matter, now let's talk about how to actually find them in your software so you can gather the data you need to conduct your own revenue health check.

These reports exist in every major dental practice management system (Dentrix, Eaglesoft, Open Dental, Ascend, etc.), though exact naming may vary.

What You Need From Your Software

Here are the essential reports and where to find them:

Total Collections & Net Production

Why You Need It:	To calculate your Collection % (how much of your production actually got paid).
Where to Find It:	Your month-end or year-to-date financial summary report, often called a daysheet or month end report.
Tip:	Look for "Net Production", not "Gross". Calculate Net Production by taking your Gross Productions and subtracting your adjustments and write-offs. Use Total Collections (not just insurance).

Adjustment Summary

Why You Need It:	Shows what's being written off—whether legit in-network adjustments or preventable losses.
Where to Find It:	Often under "Production/Collection Summary" or "Adjustments by Type."
What To Look For:	Watch for excessive "patient discounts," "write-offs due to insurance," or manual adjustments with unclear reasons. Every adjustment should have a note attached.

Insurance Aging Report

Why You Need It:	This is the #1 report to monitor. It shows unpaid insurance claims and how long they've been sitting.
Where to Find It:	"Insurance Aging," "Outstanding Claims," or similar.
Pro Tips:	• In Open Dental, run it by date of service (not just date submitted) for a true picture. • Include claim status notes if your software allows it (e.g., Dentrix). • Status notes should show who followed up, when, what the rep said, and what was done.

Unsent/Unresolved/Unattached Claims

Why You Need It:	These are often the most collectible dollars—but they're invisible if no one's tracking them.
Where to Find It:	Most systems show this on your homepage dashboard (e.g., "Unsent Claims", "Unattached Procedures").
What To Look For:	• Claims that haven't been sent due to errors or missing info • Secondary claims that were not submitted when primary payment was posted • Claims that were rejected but not corrected, usually sitting in your clearing house • Attachments (x-rays, narratives) that are still missing

Patient Aging Report

Why You Need It:	To understand how much patients owe you—and how much is collectible.
Where to Find It:	"Aged Receivables," "Patient AR Report," or "Accounts Receivable by Billing Type."
Pro Tips:	• Exclude uncollectible billing types (e.g., family/friends, sent to collections). • Sort by aging bucket: 0–30, 31–60, 61–90, and 90+ days.

Statement Submission Report

(If your PMS Allows - not all PMS's offer this report)

Why You Need It:	Shows how often you're sending patient statements—and by what method.
Where to Find It:	"Statement Log" or "Statement Submission History."
What to Check:	• Are statements being sent at least every week? • Are they being sent electronically or via mail? • Are walkout statements being printed consistently? • Are we collecting patient balances at time of services?

Average Monthly Insurance Collections

Why You Need It:	Helps you understand your insurance collection stream and set targets—or compare to outsourcing costs.
Where to Find It:	Look at past 3–6 months of collections and average it out.

Recommended Reports Checklist

Here's a quick reference of what to pull:

Report	What You're Looking For
Total Collections	Monthly total collected (from all sources)
Net Production	Production after write-offs and adjustments
Adjustment Summary	Volume/type of adjustments or write-offs
Insurance Aging Report	% of claims unpaid > 90 days
Patient Aging Report	% of patient balances unpaid > 90 days
Unsent/Unresolved Claims	Claims stuck due to errors or inaction
Statement Submission Report	Frequency and format of patient statements
Monthly Insurance Collections	3–6 month average of insurance collections

How to Calculate

1. Collection Percentage

The percentage of your production that actually turns into collected revenue.

Formula:

```
(Monthly Total Collections ÷ Monthly Net Production) × 100
```

Target Benchmark: 98% or higher

Why It Matters:
If you're producing a lot but collecting less than 98%, there's a breakdown somewhere:

- Patients aren't paying at the time of service.
- Claims are sitting unresolved.
- Adjustments are too high (possibly unnecessary).
- Payment tables may be outdated, leading to inaccurate patient estimates.

2. Over 90-Day Insurance AR Percentage

The portion of your insurance claims that are more than 90 days old.

Formula:

```
(Total Insurance AR Over 90 Days ÷ Total Insurance AR) × 100
```

Target Benchmark: Under 5% (Over 10% = major concern

Why It Matters:
Once claims hit 90+ days, insurance companies are counting on you to forget about them. This is where money gets lost.

What a High Number Signals:

- Denied claims are not being appealed.
- Claims are not followed up regularly.
- Rejected claims are not being corrected or resubmitted.

Every claim should have a follow-up note every 14–21 days. If your claim status notes are blank, no one's working on it.

3. Over 90-Day Total AR Percentage

The percentage of all unpaid balances (insurance + patient) that are over 90 days old.

Formula:

```
(Total AR Over 90 Days ÷ Total AR) × 100
```

Target Benchmark:
Under 10% (over 20% = likely a backlog)

Why It Matters:
Old balances drain resources and make it harder to collect current ones. If your system generates weekly patient statements, uncollectible old AR will waste time and confuse patients.

How to Fix It:

- Change billing types for balances you're not actively pursuing.
- Clean up the report so it reflects only what's collectible.
- Segment AR by age and tackle the oldest and largest balances first.

4. Insurance vs. Patient Split Collections

The percentage of your revenue coming from insurance vs. patients.

Formula:

```
(Insurance Collections ÷ Total Collections) × 100
(Patient Collections ÷ Total Collections) × 100
```

Typical Benchmark:

~50% insurance / 50% patient (for most practices that accept insurance)

Why It Matters:

This ratio gives insight into:

- Whether your insurance workflows are working
- How much responsibility you're shifting to patients
- Whether your team is undercollecting at time of service

What to Watch For:

- High patient %, low insurance % = insurance claims might not be getting paid or are being sent too late.
- For out-of-network practices, a higher patient % is expected, but insurance should still be followed up on if patients assign benefits.

For practices accepting primarily government-funded plans, a higher insurance % is expected.

How to Calculate
(in chart form)

Metric	What It Tells You	Formula	Target Benchmark	What a Bad Number Means
Collection Percentage	Are you collecting what you produce?	(Total Collections ÷ Net Production) × 100	≥ 98%	Patients aren't paying, claims aren't being followed up, or too many unnecessary adjustments.
Over 90-Day Insurance AR %	Are your insurance claims getting stuck?	(Insurance AR > 90 ÷ Total Insurance AR) × 100	< 5%	Old claims aren't being worked, denied claims aren't appealed, rejections aren't corrected.
Over 90-Day Total AR %	How much of your money is overdue?	(Total AR > 90 ÷ Total AR) × 100	< 10%	You've got a backlog—uncollectible patient and insurance balances are clogging your system.
Insurance vs. Patient Collection Split	Where your money is coming from	(Insurance or Patient Collections ÷ Total Collections) × 100	~50/50 (for most insurance accepting practices)	A low insurance % could mean claims aren't being paid. A high patient % could mean high out-of-network or under-collecting from insurance.

What the Numbers Are Telling You

Pulling reports and calculating metrics is the first step.

But the real value of conducting a revenue health audit lies in knowing what those numbers mean and what they reveal about your systems, staff, and bottom line.

If your collection percentage is under 98%, you're not getting paid for the work you're doing.

Likely Causes:

- Patients aren't paying at the time of service
- Claims are getting denied or never followed up on
- You're writing off too much, sometimes unnecessarily
- You're incorrectly posting payments leading to false credits or over-adjustments
- Unsent or unresolved claims are piling up
- Your insurance payment tables are outdated, leading to incorrect patient estimates

If your over 90-day insurance AR Is greater than 5%, the insurance money is stuck and at risk of being lost.

Likely Causes:

- Rejected claims haven’t been corrected
- Denied claims weren’t appealed
- No one’s following up every 14–21 days
- Claims were submitted incorrectly or missing key documentation

If your over 90-day insurance AR Is greater than 10%, your system is clogged with uncollected balances — both insurance and patient.

Likely Causes:

- High insurance AR (see above)
- Patients aren't paying after insurance processes
- Statements aren’t being sent regularly
- You’re not collecting accurately at time of service
- You haven’t cleared out balances that are uncollectible (e.g. old family discounts, charity care)
- You’re not reaching out to patients consistently who have an overdue balance

If your insurance vs. patient split looks off (one is much higher than the other, your collection workflows aren't balanced.

Likely Causes:

- If insurance is low, claims aren't being worked or patients are being asked to pay everything up front
- If patient is low, you may be undercollecting at time of service or failing to follow up on balances
- If you're out of network, a higher patient % is expected—but insurance still needs to be tracked if patients assign benefits
- If you accept mainly government-funded insurance plans, a higher insurance % is expected

Additional Red Flags to Look Out For

Issue	What It Signals	Fix It By...
Many Unsent or Unresolved Claims	Claims are stuck before they even reach insurance	Review unsent/unresolved claims weekly, correct errors, and ensure attachments are added
Too Many Adjustments	Your team may be writing off revenue that should be collected	Audit your adjustment types. Look for trends in write-offs for denials that could've been appealed
Unapplied Credits on Accounts	Patient balances appear falsely low or high	Apply credits at the time of posting to keep ledgers accurate
Virtual Credit Card Payments	You're paying fees just to receive insurance payments	Opt out and request no-cost check or EFT payments directly from insurers
Too Many Patient Credits	Incorrect payment tables or inaccurate posting of payments	Review patient credits at least 1x a quarter if not monthly. Self-audit any ledger that ends with a credit after posting payments for accuracy.

Next Steps

Clean up your AR	Reclassify old balances, start working claims oldest to newest, and remove uncollectible balances from patient statements.
Audit your claims	Check for frequent rejection reasons and train your team or billing partner to avoid them.
Appeal more claims	If a claim was denied but it should've been covered don't just write it off.
Update payment tables	Make sure patient estimates are accurate to reduce the need to chase balances later.
Schedule weekly claim reviews	Whether in-house or with a partner like Wisdom, your AR should be touched weekly.

What A Healthy Billing System Looks Like

When a system is healthy, you'll see:

- Fewer write-offs
- Lower AR
- Faster claim payments
- Happier team members (and fewer patient complaints)

Element	Why It Matters	Healthy Habit
Daily claim submission	Delays add up. Submitting the next business day keeps cash flowing.	Claims are submitted daily with the correct attachments, narratives, and documentation.
Weekly aging reviews	Every claim should be touched every 14–21 days.	Your aging report should show consistent downward movement not stagnation.
Claim status notes	Record who was contacted, when, what they said, and what was done.	Healthy systems use notes as a living communication log.
Statement cadence	New patient balances should be billed at least weekly—not once a month.	Weekly statements and updated payment tables for accurate estimates.
Updated payment tables	Ensures patient estimates are accurate, reducing under-collection.	Healthy offices update payment tables when posting daily so they are able to accurately collect at time of service.
Appeals process	Not all denials are final. Appeal covered procedures to avoid unnecessary write-offs.	Healthy billing systems appeal denials every time the procedure should have been covered.
Consistent team communication	Billing shouldn't happen in a silo. A shared tracking system creates accountability.	If any piece is off, the system catches it immediately.

How Wisdom Helps

Most dentists didn't go to school to chase claims, but that's what billing often becomes: a constant source of stress, denials, and aging AR. Wisdom changes that.

We're not just a billing vendor, we're your revenue partner. We clean up your systems, submit claims daily, follow up every 14–21 days, and appeal what others might write off. Every action is documented and visible to your team.

With Wisdom you get:

- Daily claim submission with all attachments
- Smart follow-up and detailed status notes
- Real-time reporting and payment posting
- Support from a dedicated team (no long-term contracts)

Here's what front office teams tell us after the transition to Wisdom:

Before	After
Constant backlog of unpaid claims	Claims submitted daily, followed up weekly
No time to appeal denials	Appeals handled for them, with documentation
Guesswork about claim status	Shared notes updated in real-time
Inconsistent statement cycles	Weekly electronic statements handled
Stress from being blamed for AR	Shared accountability and visibility
Long nights playing catch-up	More time for patients and scheduling

Whether you choose Wisdom or choose to go at it alone, we hope this ebook has given you the tools to spot problems, understand your numbers, and take the next step.

But if you'd rather not do it alone, we're ready when you are.

wisdom

Dental Billing Glossary



withwisdom.com

A

ACH (Automated Clearing House)

An electronic network that moves money between banks. Dental offices use ACH to receive insurance payments via direct deposit, known as an EFT: Electronic Funds Transfer.

Attachment Control Number (ACN)

Reference number for attachments linked to a claim.

Accounts Receivable (AR):

Total money owed to a practice from both patients and insurance, typically categorized by age (0–30, 31–60, 61–90, 90+ days). Healthy AR is critical to cash flow.

We monitor AR daily and escalate aging claims to reduce cash delays. If an account goes unpaid, we follow up to keep your receivables on track.

Adjustment

Any change to a balance in the ledger — includes write-offs, discounts, or corrections.

Allowed Amount

The maximum amount insurance will pay for a procedure. This may be lower than the office fee or even the contracted amount, based on plan limitations.

Attachments

Supporting documents for claims (e.g., X-rays, perio charts, photos, clinical notes). Missing attachments are a top cause of delays.

Wisdom ensures every claim includes the correct documentation by payer and procedure.

B

Balance Billing

Charging a patient the difference between your fee and the insurance's allowed amount. Not permitted for in-network providers.

Batch Processing

Submitting multiple claims at once for efficiency and tracking. Wisdom processes claims in clean daily batches to catch errors early.

Benefit Breakdown

A detailed summary of a patient's insurance plan: deductibles, coverage %, frequency limits, and much more. Wisdom recommends a full group plan breakdown each and every benefit year for accurate estimates.

Benefit Year vs Calendar Year

The 12-month window when benefits apply. Some plans reset January 1, others reset based on a fiscal year or plan start date.

Birthday Rule

A COB guideline for dependents: the parent whose birthday (month and day) comes first holds the primary insurance. Wisdom confirms and documents COB—including birthday rules—during verification.

Bundling

When insurance combines two procedures and pays for only one (e.g., separate x-rays counted as a single service).

C

Claim

A request to insurance for payment of dental services. Must be accurate and complete to be accepted.

Claim Form

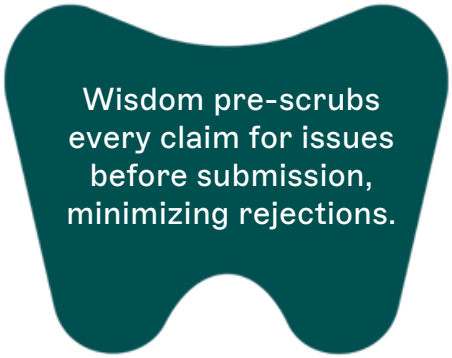
The standardized format for submitting a claim (electronic highly recommended). Must include complete and correct data to prevent denials and/or rejections.

Claim Status Notes

Updates in the PMS tracking a claim's journey: submission date, follow-up actions, payer responses, and more.

Clean Claim

A claim that's submitted correctly the first time—no missing fields, errors, or attachments.



Clearinghouse

A third-party service that transmits claims and attachments to insurance payers digitally.

COB (Coordination of Benefits)

Determines which plan pays first when a patient has multiple coverages. COB errors are a major denial cause. Wisdom verifies and records COBs up front.

D

Deductible

The amount a patient must pay before insurance begins to cover treatment.

Denial

A claim that was processed but not paid. Can result from coding errors, plan exclusions, or missing documentation. Wisdom tracks denial trends, fix root issues, and escalate appeals.

E

Explanation of Benefits (EOB)

A payer's statement outlining what was paid and why. Essential for payment posting and reconciling balances.

Eligibility Verification

Checking insurance status, plan dates, and coverage before treatment. Wisdom Shoutout: We verify eligibility 48 hours ahead of appointments and store it in your PMS.

Electronic Remittance Advice (ERA)

A third-party service that transmits claims and attachments to insurance payers digitally.

F

Fee Schedule

A list of fixed fees a dentist agrees to charge for specific procedures under an insurance contract. Review and update in your PMS at least once a year to ensure accurate billing and estimates.

Frequency Limitation

A plan’s limit on how often a procedure can be covered (e.g., two cleanings per year).

L

Ledger

A patient’s transaction history, including charges, payments, and adjustments.

M

Missing Tooth Clause (MTC)

A provision in some dental insurance plans that excludes coverage for the replacement of teeth that were missing before the policy's effective date.

N

Narrative

A clinical explanation that supports the need for treatment on a claim. Must align with SOAP notes documented in your PMS.

NEA Attachment Number

A unique ID linking an attachment to a claim via National Electronic Attachments. DentalXchange uses DXC attachments but "FastAttach NEA" is most widely recognized by payers. At Wisdom, we use NEA consistently to track and confirm attachments are received.

P



Patient Billing

The process of collecting what patients owe, before and after insurance payment.

Payer ID

A code used to route claims to the correct insurance payer via a clearinghouse.

Payment Table

A PMS tool that estimates insurance payments for procedures based on their specific limitations and guidelines. Must be updated daily upon posting for accurate patient estimates according to a plan's specific guidelines, downgrades and/or exclusions.

Posting

Recording payments into the PMS accurately by date, source, and procedure. Wisdom's posting team ensures payments and write-offs follow correct contract rules, are reconciled to the correct provider, as well as providing extremely detailed notes.

Primary Insurance

The plan that pays first when a patient has more than one insurance policy.

Procedure Codes

ADA Codes (CDT Codes)

Standardized codes for dental procedures published by the American Dental Association. Required for claim submission.

CDT Books

Annually updated reference books containing the official procedure codes for dental billing. Using outdated codes can result in claim rejections.

ICD-10-CM (Diagnosis Codes)

Codes used to describe patient conditions and diagnoses. While not always required for dental claims, ICD-10-CM codes are essential for medical-dental crossover billing and for documenting medical necessity.

X12 / ANSI 835

Electronic standards used in healthcare to exchange claim and remittance data between systems.

R

Revenue Cycle Management (RCM)

The full lifecycle from eligibility verification to final payment. RCM is a Wisdom specialty. We run clean, consistent billing systems that scale with you.

Remark

Codes on an EOB that explain claim decisions or denials
1. This could also be known as the section on a claim form to add in additional details such as “x-rays, clinical documentation and photos attached”. Item #35 on a claim form : [more here]
2. Remarks on an EOB are different as said above: Remittance Advice Remark Codes (RARCs) are used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing.

S

Secondary Insurance

A second plan that pays after the primary insurance has processed a claim.

SOAP Note

A clinical note format: Subjective (patient-reported), Objective (clinical findings), Assessment (diagnosis), Plan (treatment). Strong SOAP notes support faster payments and cleaner claims.

T

Timely Filing Limit

The time window (e.g., 90–180 days) within which claims must be submitted. Late = denial.

U

Usual, Customary, Reasonable Fees (UCR)

Benchmark fees used by insurers to decide how much to pay in a geographical area, especially for out-of-network providers. Note: UCR fees may be lower than the practice's actual fees.

Unbundling

Opposite of bundling – separating procedures that are normally combined. This can trigger denials if not justified (e.g., buildups not inclusive to crown procedures).

V

Verification of Benefits (VOB)

A deep dive into a patient's plan to confirm rules, limits, and coverage levels.

W

Waiting Period

The time a patient must wait before certain procedures are covered after enrolling in a plan.

Write-Off

The portion of a fee that won't be collected—usually due to contract agreements or plan limits. Wisdom applies write-offs only after accurate posting, avoiding phantom losses



wisdom

You focus on patients. We'll fight for payment.

Dozens of steps, so much follow-up, too much time. Every minute your team spends chasing denials is a minute they're not with patients.

Let Wisdom handle the appeals, the calls, the paperwork, and the persistance so you can get back to doing what you love.

With Wisdom you get:

- ✓ Clean Claims
- ✓ Insurance Verification
- ✓ Denials and Rejections
- ✓ Aging Reports
- ✓ Patient Billing

Book a demo and get started today!