# ONLINE CLAIM ENTRY

## Dental (ADA) Claims

Office Ally has the ability to submit to thousands of insurance companies (payers). To review the list of payers we have a connection with, please visit our Payer List under Resource Center > Payer Lists, or by clicking here.



## PRE-ENROLLMENT REQUIREMENTS

Certain payers require pre-enrollment to be completed before submitting claims electronically through a clearinghouse. If the necessary steps are not taken, your claims may be rejected back until pre-enrollment has been completed. You can find the necessary payer enrollment forms under Resource Center > Payer EDI Enrollment Forms, or by clicking here.
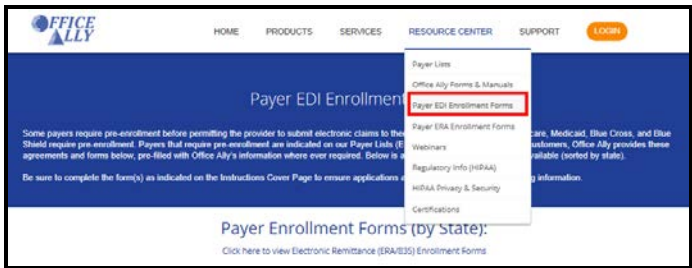


Payer EDI enrollment forms will be separated based on the state they're for. If a payer is not state specific, it will be listed under the "ALL or Multiple States Payer Enrollment Forms" section.

Payers with the ability to return Electronic Remittance Advice (ERA/835) may also require enrollment be completed before ERA's will be returned. The ERA enrollment forms can be found under Resource Center > Payer ERA Enrollment Forms, or by clicking here. ERA enrollment forms will be listed alphabetically.
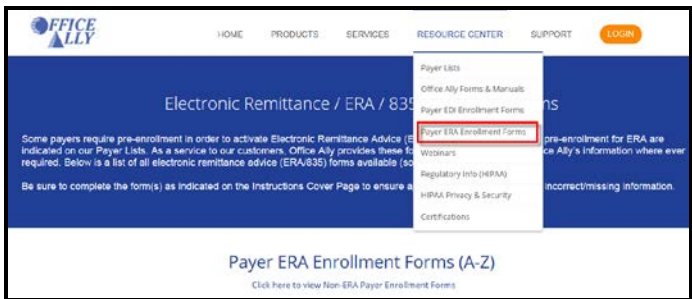


If a payer is not able to receive electronic claims or we don't yet have them available on our payer list, Office Ally can send paper claims on your behalf. In order to activate this feature, the Update Printing Option form will need to be completed. This form is located under Resource Center > Office Ally Forms & Manuals > Account Management.

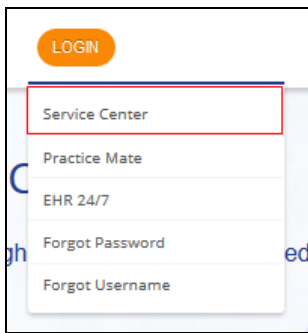If you'd like to see a new payer connection made available on our payer list, you can send in a New Payer Connection Request Form and we will attempt to set the connection up (adding the requested connection is not guaranteed).
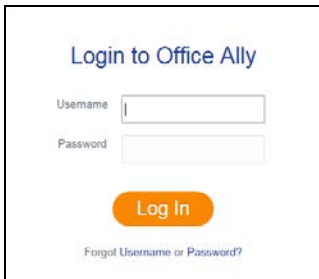
1. Go to www.officeally.com.



2. Hover your mouse over the **Login** button and select **Service Center**.



3. Enter your **Username** and **Password** (password is case sensitive) and click **Log In**.



## ONLINE CLAIM ENTRY (DIRECT DATA ENTRY)

Once logged into the Office Ally website, hover your mouse over **Online Claim Entry**. There will be multiple claim form options to choose from. The **Create Dental (ADA) Claim** option will allow you to begin completing the online claim form immediately. If you do not see the **Create Dental (ADA) Claim** option on the drop down list, contact OA Customer Service and request it be added (360-975-7000 Option 1).
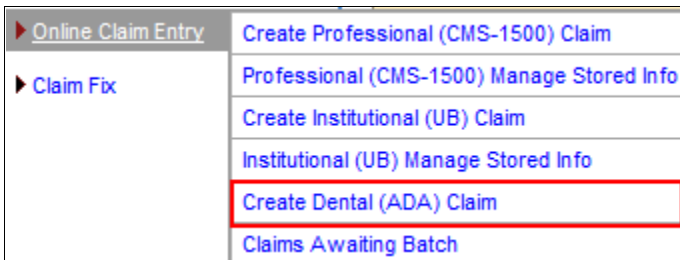
After selecting **Create Dental (ADA) Claim**, a blank Dental (ADA) claim form will appear. Enter the payer (insurance company), patient, provider information, etc. into the appropriate fields before clicking on **Update** to submit the claim electronically. Once the claim is submitted, the patient and provider information will automatically store within **Dental (ADA) Managed Stored Information**.

## ADA Dental Claim Form - [New Claim]

**HEADER INFORMATION**

**1. Type of Transaction (Mark all applicable boxes)**
- ☐ Statement of Actual Services  ☐ Request for Predetermination/Preauthorization
- ☐ EPSDT/Title XIX

**2. Predetermination/Preauthorization Number**

**Load Stored Info**

☐ This Is a SECONDARY Claim

**INSURANCE COMPANY / DENTAL BENEFIT PLAN INFORMATION**

**3. Company / Plan Name, Address, City, State, Zip Code**
- Payer ___ ...
- Address Line 1 ___  Payer ID ___
- Address Line 2 ___
- City ___  State ___ Zip ___

**OTHER COVERAGE**

**4. Other Dental or Medical Coverage?** ⦿ No (Skip 5-11)  ○ Yes

**5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)**
- Last ___  First ___  MI ___ Suffix ___
- Address Line 1 ___
- Address Line 2 ___
- City ___  State ___ Zip ___

**6. Date of Birth (MM/DD/CCYY)** ___  **7. Gender** ○ M ○ F  **8. Policyholder/Subscriber ID (SSN or ID#)** ___

**9. Plan/Group Number** ___  **10. Patient's Relationship to Person Named in #5** ○ Self ○ Spouse ○ Dependent ○ Other

**11. Other Insurance Company / Plan Name, Address, City, State, Zip Code**
- Company ___  Payer ID ___
- Address Line 1 ___
- Address Line 2 ___
- City ___  State ___ Zip ___

**POLICYHOLDER / SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

**12. Policyholder/Subscriber Name (Last, First, MI, Suffix), Address, City, State, Zip Code**
- Last ___  First ___  MI ___ Suffix ___
- Address Line 1 ___
- Address Line 2 ___
- City ___  State ___ Zip ___

**13. Date of Birth (MM/DD/CCYY)** ___  **14. Gender** ○ M ○ F  **15. Policyholder/Subscriber ID (SSN or ID#)** ___

**16. Plan / Group Number** ___  **17. Employer Name** ___

**PATIENT INFORMATION**

**18. Relationship to Policyholder/Subscriber in #12 Above** ○ Self ○ Spouse ○ Dependent ○ Other  Copy From Subscriber  **19. Student Status** ○ FTS ○ PTS

**20. Name (Last, First, MI, Suffix), Address, City, State, Zip Code**
- Last ___  First ___  MI ___ Suffix ___
- Address Line 1 ___
- Address Line 2 ___
- City ___  State ___ Zip ___

**21. Date of Birth (MM/DD/CCYY)** ___  **22. Gender** ○ M ○ F  **23. Patient ID/Acct # (Assigned by Dentist)** ___

**RECORD OF SERVICES PROVIDED**

| | 24. Procedure Date (MM/DD/CCYY) | 25. Area Oral Cavity | 26. Tooth Sys | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

**33. MISSING TEETH INFORMATION** (Place an 'X' on each missing tooth)

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary: A B C D E F G H I J / T S R Q P O N M L K

**31a. Other Fee(s)** ___
**32. Total Fee(s)** ___

**DIAGNOSIS CODE (Relate Items A, B, C, OR D To Item 29a By Line)**

**34. Diag. Code List Qualifier** ___

**34a. Diagnosis Code(s)** (Primary Diagnosis in "A")
- A(1) ___ ...  B(2) ___ ...  C(3) ___ ...  D(4) ___ ...

**35. Remarks** ___

**AUTHORIZATIONS**

**36.** Patient/Guardian Signature  Date ___
Signature On File? ○ Yes ○ No

**37.** Subscriber Signature  Date ___
Signature On File? ○ Yes ○ No

**ANCILLARY CLAIM / TREATMENT INFORMATION**

**38. Place of Treatment** ○ Provider's Office ○ Hospital ○ ECF ○ Other

**39. Number of Enclosures (00 to 99)** Radiograph(s) ___ Oral(s) ___ Mode(s) ___

**40. Is Treatment for Orthodontics?** ○ No (Skip 41-42) ○ Yes (Complete 41-42)  **41. Date Appliance Placed (MM/DD/CCYY)** ___

**42. Months of Treatment Remaining** ___  **43. Replacement of Prosthesis?** ○ No ○ Yes (Complete 44)  **44. Date Prior Placement (MM/DD/CCYY)** ___

**45. Treatment Resulting from** ○ Occupational illness/injury ○ Auto Accident ○ Other Accident

**46. Date of Accident (MM/DD/CCYY)** ___  **47. Auto Accident State** ___

**BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)**

**48. Name, Address, City, State, Zip Code**
- Name ___ ...
- Address Line 1 ___
- Address Line 2 ___
- City ___  State ___ Zip ___

**49. NPI** ___  **50. License Number** ___  **51. SSN or TIN** ___

**52. Phone Number** ( ___ ) ___ - ___  **52A. Additional Provider ID** ___

**TREATING DENTIST AND TREATING LOCATION INFORMATION**

**53. Signed (Treating Dentist)**
- Last ___  First ___  MI ___ Suffix ___ ...
- Provider Sig Date ___

**54. NPI** ___  **55. License Number** ___

**56. Address, City, State, Zip Code**  **56A. Provider Specialty Code** ___
- Address Line 1 ___
- Address Line 2 ___
- City ___  Zip ___

**57. Phone Number** ( ___ ) ___ - ___  **58. Additional Provider ID** ___

**Update**   **Cancel**

1. To Add, Edit, or Delete stored information, click on **Create Dental (ADA) Claim** and then click on **Load Stored Info**. The below screen will appear.



2. Enter the Insurance, Patient, Subscriber, Other Subscriber's (COB) data, etc. under the **Stored Patients** section.

3. Enter the Billing Provider Name, Address, Tax ID, NPI, etc. under the **Stored Billing Providers** section.



4. Enter the Rendering Provider Name, Address, NPI, etc. under the **Stored Rendering Providers** section.



Below is and example of how **Managed Stored Info** is used to create a claim with the stored data you have entered.

1. From each drop down list, you will select the data that you would like to be automatically filled in on the claim form. Once the information is selected, click on the **Create New Claim** button.

After you have created the claim form from **Managed Stored Info**, there will still be required fields needing to be completed that cannot be populated from the stored information (i.e. Procedure Date).

After you enter all necessary claim data, review the claim for errors and then click the **Update** button at the bottom of the claim form. The program will alert you if you missed certain required fields. If all required fields were completed, clicking on **Update** will put your claim in the **Claims Awaiting Batch** section.



## CLAIMS AWAITING BATCH

After you've updated your claim, the process of submitting the claim has been completed. Your recently submitted claim is sent to the **Claims Awaiting Batch** (OLE submitters). Your claim(s) will sit in there until Office Ally picks them up for processing (occurs every 3 hours). From this section of Office Ally you can edit, print, or delete the claim before the claim is sent to the insurance company.

In order to access this section, hover over **Online Claim Entry** and select **Claims Awaiting Batch**.

**Online Entry - Waiting to be Batched**

| Form Type | Processed | FileID | Claim ID | Patient Name | Total Charges | From DOS | Payer | Secondary | Print | Correct | Delete |
|-----------|-----------|--------|----------|--------------|---------------|----------|-------|-----------|-------|---------|--------|
| ADA | 4/19/2017 | ONLINE | 541325 | Smith, John | 50.00 | 4/18/2017 | | N | 🖨 | Correct | Delete |

Need assistance entering Secondary (COB) claim data on a Dental (ADA) claim? Click HERE.

Don't forget to review the reports Office Ally sends back to ensure your claims were accepted.
If a claim rejects, it is your responsibility to correct and resubmit the claim for processing.

# CONTACT INFORMATION & SUPPORT OPTIONS

**Business Hours: Monday thru Friday 5:00am PST to 9:00pm PST**
**Saturday and Sunday 6:00am PST to 5:00pm PST**

**Email:**  info@officeally.com or support@officeally.com

| | |
|---|---|
| **Customer Service:** | (360) 975-7000  Option 1 |
| **Technical Support:** | (360) 975-7000  Option 2 |
| **Enrollments:** | (360) 975-7000  Option 3 |
| **Accounting:** | (360) 975-7000  Option 4 |
| **Scheduling (FREE Training Appointments):** | (360) 975-7000  Option 5 |

| | |
|---|---|
| **General Fax Number:** | (360) 896-2151 |
| **Enrollments Fax Number:** | (360) 314-2184 |
| **Accounting (Auto Pay) Fax Number:** | (360) 953-8427 |

**Live Chat Available (6am – 5pm PST):** Click HERE or enter https://support.officeally.com/ into your browser to access Live Chat, Claim Rejection Solutions, Troubleshooter, News and more!

**Online Video Tutorials:** Click HERE or enter https://cms.officeally.com/Home/VideoLibrary.aspx into your browser to access video tutorials covering Online Claim Entry, Inventory Reporting, Secondary Claims and more!

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