Solstice

Orthodontic Transition of Care for you or your child is as easy as 1...2...3..

1. Advise your orthodontic provider that you have switched your dental carrier to **Solstice, A UnitedHealthcare Company.**

2. Provide the necessary transition of care form below for them to complete.

3. Let your provider know to submit your claim along with the transition of care form to our claims address:

   P.O. Box 21157
   Eagan, MN 55121

Our team is committed to making this process as easy as possible for you. Your dental office team will submit all claims on your behalf - all you need to do is complete the steps listed above.

Your dental provider will submit the following items on your behalf to transition your dental care to Solstice:

- American Dental Association Claim Form
- EOB from previous carrier
- Transition of care form completed
- Submit claim to -
  P.O. Box 21157
  Eagan, MN 55121 or payor ID 76578

1-844-224-4903 **mcccd@solsticebenefits.com** **wwww.smilemaricopa.com**

Solstice
Attn: Claims Department
P.O. Box 21157
Eagan, MN 55121
Tel: 1-844-224-4903 | Fax: 954-370-1701

APPLICATION FOR DENTAL TRANSITION OF CARE

Dental Transition of care is a service that enables you to continue dental treatment already in progress.

Please submit this form, attaching ALL Explanation of Benefits (EOB's) from your prior dental Provider and documents from your dentist that verifies the qualification requirements.

Employee Information	Employee Name:	Subscriber ID:
Address:	City/State:	Zip:
Home Phone No.	Work Phone No:	Employer Name:
Plan Effective Date:	Patient Name:	Patient Date of Birth

Dental Provider Information

Practice Name:	Treating Dentist:
Office Tax ID:	Treating Dentist NPI#:
Treating Location:	City:
State/Zip:	Phone Number:

Treatment Information

Initial Treatment Start Date		Length of Treatment	
Billed ADA Code		Remaining Months of Treatment	
Banding Date (Orthodontia)		Total balance due to the Provider	
Prior Carrier Paid Amount		Amount Already Paid by the Member	
Prior Insurance Contracted /Allowed Amount		Prior Insurance in-network or out-of-network	

Authorization to release records

I authorize my dental provider to provide Solstice information concerning my treatment. This information will be used to determine the patient's elibgibility for transition of care benefits under the new plan.

Fraudulent Statement

Any Person who knowingly and with the intent to injure, defraud, or receive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Patient's Signature / Parent or Guardian's Signature if Applicant is a minor Date

ADA American Dental Association®

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

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Solstice Benefits, Inc.
PO Box 2057
Farmington Hills, MI 48333

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐M ☐F ☐U	8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐M ☐F ☐U	15. Policyholder/Subscriber ID (Assigned by Plan)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐M ☐F ☐U	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	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.)

☐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

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

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

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of 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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35).

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

IMPORTANT CLAIM NOTICE

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.

Arizona Residents: or your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Solstice

Solstice Orthodontic Transition of Care **FAQ**

1. Q: How do you handle transition of care (TOC) for employees who began orthodontic treatment with our prior dental insurance carrier?

A: Solstice provides coverage for orthodontic transition of care. To determine the employee's remaining orthodontic benefits, Solstice will need the prior insurance carrier's Explanation of Benefits (EOB) and a TOC application that provides:

- ✓ Patient information
- ✓ Treating orthodontist's name and contact information
- ✓ Date the original treatment started
- ✓ Type of orthodontic services the member received

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2. Q: Will the employee's orthodontic treatment be covered by Solstice if he or she started orthodontic treatment prior to the transition but did not elect benefits with the previous carrier?

A: The orthodontic treatment would not be covered by Solstice because this is considered a treatment already in progress. Transition of care is when the employee moves benefits from one insurance company to another.

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3. Q: With transition of care, does the employee need to change their orthodontist to receive benefits once the Solstice plan becomes active?

A: No, if the member is transitioning from a dental PPO plan to a Solstice dental PPO plan, the employee will receive orthodontic benefits. Coverage amounts will be impacted based on the remaining months of care, and whether the provider is in- or out-of-network. If the member is transitioning to a dental HMO plan, he or she will receive benefits only if the treating orthodontist is an in-network DHMO provider.

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4. Q: What's the process if an employee wanted to transfer to an in-network DHMO orthodontist to continue orthodontic care?

A: The employee is eligible for orthodontic benefits. We will consider the remaining months at the negotiated rate of the in-network DHMO provider minus the amount paid by the other carrier and any copayments paid by the member.

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5. Q: How do you determine an employee's benefits once we switch over to Solstice?

A: Here's the calculation for determining an employee's orthodontic benefits when transition of care occurs:

A. **Take current orthodontic lifetime maximum** – **Total amounts** already paid by prior carrier = Remaining orthodontic benefit

B. **Take remaining orthodontic maximum** ÷ **Remaining months** of ortho treatment = Monthly orthodontic payment amount

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6. Q: How are orthodontic payments made?

A: We pay for orthodontic cases on a prorated basis. The remaining months of treatment are automatically paid monthly for the remainder of the member's orthodontic treatment. Payment can be sent either directly to the employee or to the provider based on the employee's preference.

- To calculate your copay on the DHMO, take the copay of $2,250 for adolescents or $2,350 for the adult and divide that by 24 months then multiply that figure by the remaining months of treatment.
- For the PPO, you have a $2,000 lifetime orthodontia benefit. On the PPO plan, we will reimburse the remaining balance of up to $2,000. We identify this amount from the transition of care form. If your previous carrier paid $750 towards your orthodontia treatment, Solstice will pay up the $1,250 remaining benefit. Please remember each scenario varies by the amount of benefit left and remaining treatment time.

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7. Q: Are new hires eligible for transition of care?

A: 1. Transition of Care is available for new hires that have started orthodontia and were being covered by insurance prior to moving over to Solstice.

2. Transition of Care will not be available to employees that have started orthodontia previously and were not covered by an insurance when moving over to Solstice.

3. All orthodontic cases started after becoming a Solstice member where you have not been "banded" previously will be treated as a new case. Transition of Care does not apply.

- For example, "banding" is the first step in orthodontic treatment and the first payment is made after this step. "Banding" is the placement of the orthodontic brackets.