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DentalCare
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Insurance and UCR Explanation

During the past three decades, dental benefits have become an integral part of health care planning for many families. Dental benefit plans are made available to employees or members through companies, unions and associations, and may vary considerably from one plan to the next.

The range of benefits depends solely on what the plan purchaser wishes to offer to employees or members. Some plans cover as little as 30% or as much as 100% of the fees for dental services, with most falling into the 50% to 80% range. Some plans exclude certain types of services, such as orthodontics, while other plans cover a full range of dental services.

Some plans base the amount of benefit on a chart or schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage of the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the usual and customary (UCR) cost of dental treatment, it means 80% of the fee as determined by the insurance company, not necessarily the actual fee charges by me.

As the number of patients covered by dental plans has increased, certain assumptions have become evident. I would like to make the principles of my practice, as well as the types of service and care I provide my patients, very clear:

- My fees are based on the overhead involved in my practice, your individual treatment plan, and the time it takes me to provide you with the necessary dental care. I do not believe that it is in either of our best interests for me to compromise my recommended treatment to accommodate a dental plan's maximum benefits. However, I am happy to discuss the advantages and disadvantages of different treatment plans to accommodate you in the decision-making process.

- The type of treatment you need and receive from me is based on my professional judgment and not on whether you are covered by a dental benefits plan.

- As a courtesy to you, my staff will complete the dental portion of your claim form and submit it to your carrier within 24 hours following treatment. To expedite processing, make sure that we have all your insurance information correct.

- We will bill your insurance carrier using current American Dental Association coding for correct reporting of procedures. If necessary we will re-file your insurance a second time within a 60-day period. We will accept payment from your carrier and keep track of balances.

- If your dental benefits plan requires a "pre-determination" or "prior authorization", I will submit a treatment plan for review by the third-party payer. However, please remember that the financial obligation for dental treatment is between you and this office. Your insurance company is responsible to you, and not this office.

- You are responsible to pay any fees not covered by your insurance plan at the time of treatment, and to pay any account balance not paid by insurance after two billing attempts.

- We will help you file your claims, handle insurance queries, process follow-ups or lost claims, etc. Don't hesitate to ask about your treatment, benefit plan, or statement. We are here to help you.