



## GUARANTY ASSURANCE COMPANY

### People's Health Network

Choices 65 #14-1 (HMO) for Metro New Orleans, Choices 65 #14-2 (HMO) for St. Tammany, Choices Plus (HMO), Choices Select (HMO), Choices Platinum #009 (HMO) for Orleans and Jefferson, and Choices Platinum #012 (HMO) for East Baton Rouge

\$50 Annual Deductible  
**Deductible does not apply to services listed in the  
 Diagnostic or Preventive categories (exams, x-rays or cleanings)**  
 \$1500 Maximum Annual Benefit per Calendar Year  
 No Out of Network Benefits

Procedure Code	Procedure Description	Frequency	Member Co-Pay	Total Provider Reimbursement
<b>Diagnostic</b>				
<b>Clinical Oral Evaluations</b>				
D0120	Periodic Oral Evaluation	1/6 months	\$0.00	\$21.00
D0140	Limited Oral Evaluation	1/12 months	\$0.00	\$30.00
D0150	Comprehensive Oral Evaluation - new or established	1/12 months	\$0.00	\$35.00
<b>Radiographs/Diagnostic Imaging</b>				
*D0210	Intraoral - Complete Series (including bitewings)	1/12 months	\$0.00	\$57.00
D0220	Intraoral - Periapical first film	1/12 months	\$0.00	\$10.00
D0230	Intraoral - Periapical each additional film	1/12 months	\$0.00	\$6.00
D0240	X-rays Intraoral-Occlusal Film	1/12 months	\$0.00	\$14.00
D0270	Bitewings, single film	1/12 months	\$0.00	\$12.00
D0272	Bitewings, two films	1/12 months	\$0.00	\$17.00
D0274	Bitewings, four films	1/12 months	\$0.00	\$25.00
*D0330	Panoramic film	1/12 months	\$0.00	\$55.00
<b>Preventative</b>				
<b>Dental Prophylaxis</b>				
D1110	Prophylaxis - Adult	1/6 months	\$0.00	\$44.00
<b>Restorative</b>				
<b>Amalgam Restorations (Including Polishing)</b>				
D2140	Amalgam, one surface, primary or permanent		\$47.00	\$52.00
D2150	Amalgam, two surfaces, primary or permanent		\$61.00	\$68.00
D2160	Amalgam, three surfaces, primary or permanent		\$76.00	\$84.00
D2161	Amalgam, four surfaces or more		\$88.00	\$98.00
<b>Resin-Based Composite Restorations - Direct</b>				
D2330	Resin - one surface, anterior		\$63.00	\$70.00
D2331	Resin - two surfaces, anterior		\$85.00	\$94.00
D2332	Resin - three surfaces, anterior		\$106.00	\$118.00
D2335	Resin - four or more surfaces, anterior		\$119.00	\$132.00
D2391	Resin - one surface, posterior		\$71.00	\$79.00
D2392	Resin - two surfaces, posterior		\$103.00	\$115.00
D2393	Resin - three surfaces, posterior		\$126.00	\$140.00
D2394	Resin - four or more surfaces, posterior		\$157.00	\$175.00
<b>Oral and Maxillofacial Surgery</b>				
<b>Extractions (Includes local anesthesia, suturing, if needed and routine postoperative care)</b>				
D7140	Extraction - Erupted tooth or exposed root (elevation and/or forceps removal)		\$67.00	\$75.00
<b>Adjunctive General Services</b>				
<b>Unclassified Treatment</b>				
D9110	Palliative (emergency) Treatment of Dental Pain	1/12 months	\$0.00	\$35.00

Total Reimbursement DOES NOT include lab costs. Lab fees are the member's responsibility.

\*Panoramic Film (D0330) may be taken in place of Intraoral-Complete Series ( D0210)

#### Claims Submission:

1. **Mail:** DINA Dental Plan (Attention: Claims Department)  
 101 Parklane Boulevard, Suite 301  
 Sugar Land, Texas 77478
2. **Fax:** (281) 313-7154
3. **Electronic:** [www.fcl dental.com](http://www.fcl dental.com)  
 Third Party Clearinghouse: Emdeon (Payor ID # - CX090)

# DINA Dental Plan/Peoples Health Network

## DINA Limitations, Authorization and Claim Attachment Guidelines

Below is a list of procedure codes that have additional limitations or require specific information in order to process the claim. These procedure codes are marked with an asterisk (\*) on the main benefit outline(s). Under certain circumstances additional information may be requested in order to process claims for procedures listed below.

### Current CPT Code    Documentation Guidelines

#### **Radiographs/Diagnostic Imaging**

D0210/D0330	Panoramic Film may be taken in place of D0210 (Intraoral-Complete Series) <b>once every twelve (12) months</b>
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#### **Restorative**

D2740	Pre-operative x-rays must be submitted with claim
D2750	Pre-operative x-rays must be submitted with claim
D2751	Pre-operative x-rays must be submitted with claim
D2752	Pre-operative x-rays must be submitted with claim
D2783	Pre-operative x-rays must be submitted with claim
D2790	Pre-operative x-rays must be submitted with claim
D2791	Pre-operative x-rays must be submitted with claim
D2792	Pre-operative x-rays must be submitted with claim

#### **Periodontics**

4341	Periodontal charting must be submitted with claim
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#### **Oral and Maxillofacial Surgery**

D7140	Pre-operative x-rays must be submitted with claim
D7210	Pre-operative x-rays must be submitted with claim
D7220	Pre-operative x-rays must be submitted with claim
D7230	Pre-operative x-rays must be submitted with claim
D7240	Pre-operative x-rays must be submitted with claim
D7241	Pre-operative x-rays must be submitted with claim
D7250	Pre-operative x-rays must be submitted with claim

#### **Prosthodontics**

All prosthodontic procedures will require pre-authorization and proof of completion of treatment.

### General Information

Written Narratives	Must be clear, legible, and provide rationale for the proposed treatment.
Periodontal Charting	Must be comprehensive full mouth, legible, dated, and documented with probing depths (up to six per tooth), recorded in mm. per tooth, labeled right and left, mandibular and maxillary, with classified furcation defects and tooth mobility recorded as 1st, 2nd, 3rd degree.
Quality Radiographs	Radiographs should be dated, mounted, properly labeled left and right, and of diagnostic quality according to accepted standards of care. Radiographs should also be duplicates and less than 36 months old and labeled with the patient's name and the provider's name and address.

- Submit Claims to:**
1. Mail: First Continental Life (Attn: Claims Department)  
101 Parklane Boulevard, Suite 301  
Sugar Land, Texas 77478
  2. Fax: (281) 313-7154
  3. Electronically: Web - [www.fcl dental.com](http://www.fcl dental.com)  
Third Party Clearinghouse: Emdeon (Payor ID # – CX090)