# Training Manual
# Insurance Training

*The information in this manual is very important and should be reviewed regularly on an ongoing basis by every team member.*

*As new memos, policies, procedures, and educational materials are obtained and distributed, this manual will be updated accordingly.*

These job descriptions have been carefully thought out and planned. Job descriptions help avoid miscommunication and frustration in the office. These manuals are viewed as guides and we expect everyone to work as a team. **If you are good enough to work at Thrive you are good enough to handle any task asked of you. Saying "it's not my job" should never be uttered by our team members**. We pride ourselves on being a team and therefore you must be the best team player possible. We do whatever it takes to support everyone in the office to allow an outstanding patient and staff experience.

**We have very high expectations for our team members.**
Our employees have an extremely high attendance rating. Many employees have never missed a day of work and they are the ones who advance the highest at Thrive. If you have a serious emergency you **MUST COVER FOR YOURSELF**. Do not burden the managers with having to find someone to fill in for you. You should have a list of fellow employees and call every person on that list to help you during your emergency. Once all avenues are exhausted then you can contact your Office Manager for help in coverage during your absence.

# Thrive Standards

Before anything, let's review our standards here at Thrive

1. **SERVANT LEADERSHIP**. We are servant leaders who lead with love. We always take the initiative. We care deeply and elevate the people around us.

2. **COMPASSION**. Always show compassion and empathy to patients and one another.

3. **SMILE**. Always. We always answer the phone with a smile. We greet our patients with a smile, and we always call them by their names.

4. **WELL-GROOMED**. We are in a highly professional environment with high standards. We must look the part. This means looking sharp, good hygiene, dressed professionally, and with light makeup and hair done.

5. **POSITIVITY**. Create a positive and family spirit. We are are family! We choose to have a positive attitude and help our team succeed.

6. **HIGHEST STANDARDS**. We insist on only the highest standards. This includes the highest standards of dental care, customer service, professionalism, accountability, promptness.

7. **INTEGRITY**. We do everything with absolute integrity. We do not tolerate dishonesty or violation of HIPPA protocols.

8. **PROMPTNESS**.  Promptness is an absolute requirement. No excuses. We want to be prepared ahead of time for our patients' arrival.

9. **TEAMWORK**. We always take the initiative to help our team succeed. If the bathroom needs to be cleaned, clean it. We never say, "that's not my job."

10. **EXPERIENCE**. We do everything in our power to deliver an awesome AWESOME experience for our patients EVERY time. Every team member asks the patient, "How was your experience?" (3 times total)

11. **ASSURANCE**. We comfort dental fears with loving care. We reassure our patients that they are in the best hands. We constantly check in with our patients, showing concern for their comfort and well-being.

12. **COMMUNITY**. We build strong and healthy communities. We serve our communities with love and generosity. Each of us represents the Thrive name. Tell everyone about us!

13. **GROWTH**. Commit to constant growth and learning. At Thrive, we empower each team member to become the servant leader they were created to be.

14. **FUN**. Have fun and dream big!

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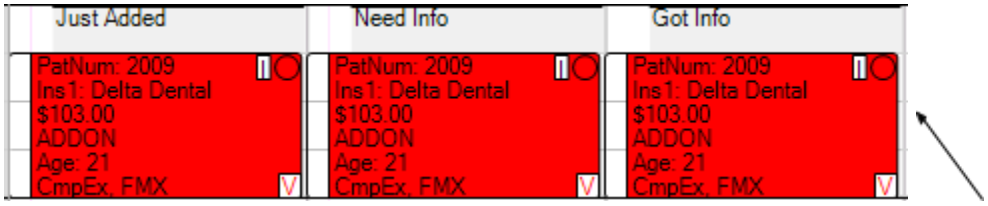
## A. Job Description

Insurance provider payments are the life and blood of Thrive. The insurance verification step is the marker that dictates how, when, and how much work the clinical staff is able to do. We need this information to be accurate and reliable. Mistakes at this step in the process can cost us thousands of dollars. Traditional dental offices offer limited assistance to patients to help them determine what their dental insurance benefits offer. Thrive Dental employs rooms full of trained dental insurance experts specifically to make understanding dental benefits easier for our patients. Where the typical dental office may wait until after a patient has been diagnosed to contact the insurance company for information on the patients' coverage relating to the one or two procedures they are planning on potentially performing on a follow-up appointment, we collect a comprehensive "breakdown of benefits" for every patient before their initial visit in preparation for accomplishing any treatment necessary that the patient may be interested in having completed that same day. Our diligence in insurance verification is one of many standards that display our respect for every patients' time and schedule. While your trainer will review in detail the insurance verification process and help you understand the terms and nomenclature, below are instructions to guide you if/when a trainer is unavailable. Additionally, the insurance verification form also serves as an aid to order the "breakdown of benefits" provided by the insurance company representative.

**We expect that each employee has a "Whatever It Takes" mentality. Your job is never a "9 to 5" job.** Every day, you must come to work "dressed for success". Everyone is expected to do what it takes to support the success of the entire practice and have a constant awareness of daily goals. Enthusiasm is a top priority for your job. We are a busy office and everyone is expected to operate in a busy and efficient manner. High energy and a positive attitude are a must for you to be successful at your position. Although you perform your job description 90% of the time, you know other positions in the office and help out when needed. Everyone should always have a patient, friendly attitude. All patient encounters should be friendly and happy. When a patient is unhappy or dissatisfied with some aspect of our service, it is your responsibility to do what is necessary to satisfy the patient. Show the patient that you care.

## B. Opening Duties

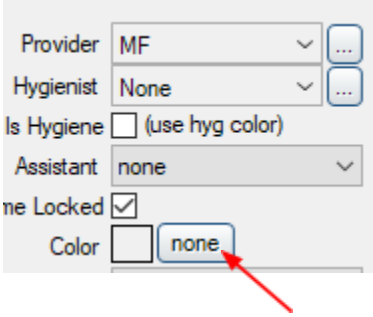
- Clock in
- Check the email for any new "Fax Backs" or insurance information
- Review your schedule to make sure there have not been any last minute "add on" patients or patients that have returned phone calls with additional insurance information needed




All Add on's should be in Red with a blockout above it so that it is not missed.

Any appointments that still need additional information should have a blockout about the appointment and notes inside the appointment that the insurance coordinator has tried to contact the pt.

Once the appointment is completely verified, the provider color should be changed by selecting the “none” button next to the color:




- Adjust schedules accordingly for the day if a team member is out sick or on vacation
- Coordinate lunches for the day between team members with Supervisor / Office Manager. If there are two people working in the same location, ideally they should not go to lunch together.

**Any special arrangements should be approved by the Office Manager.

## C. Time Management & Communication

When it comes to Insurance Verification, time management is extremely important to guarantee sufficient patient flow and satisfaction. The insurance verification step is the marker that dictates how, when and how much work the clinical staff is able to do. We need this information to be accurate and reliable. Mistakes at this step in the process can cost us thousands of dollars. Therefore, following guidelines, staying systemic and proper communication throughout the day is mandatory to ensure every patient in each location’s insurance is verified **prior** to their appointment.

- Continuously monitor the schedule of the location that you are assigned to for the day and make yourself aware of any add-on patients
- All insurance **MUST** be verified **prior** to leaving for the day

  **Only exception is if there is missing information and all references have been exhausted

  - ❖ Organize your time and schedule wisely. Identify all patients that have the same insurance carried so that you can stay on the phone with one carrier at a time.
  - ❖ Multi-task!
    - ➢ If you are on hold with an insurance company, enter the patient’s insurance information, use insurance answers plus, request fax back at one time, log in online & get a breakdown / eligibility information, scan etc.
    - ➢ DO NOT sit around talking when you can be doing multiple things at once.

- Communicate with other offices if there are any problems regarding their patients in a timely manner.
  (Communication should be through slack)
- Any appointments that cannot be verified due to missing information:
  - Use all of your references **FIRST** - DO NOT just give up and leave it unverified waiting for the patient to call you back
  - Search IAP (Insurance Answers Plus)
  - Search online
  - Ask other team members (they may be familiar with the plan / group)
  - Contact the patient or leave a detailed message and document your notes in the appointment and the commlogs
  - Put a blockout on the schedule above the patient's appointment
- You MUST communicate with other team members, Supervisor and Office Manager if there are any problems getting your schedule verified.
- It is UNACCEPTABLE to communicate issues at the last minute or 30 minutes before closing. Communication should be constant throughout the day.

**Communication speed and efficiency are the key**

## D. Insurance Verification

- We are "In-Network" with all PPO and Medicaid providers.
- We do not accept any HMO / DHMO / DMO policy's
- Blue Cross Blue Shield MEDICAL coverage is commonly and mistakenly identified by patient's as their DENTAL insurance coverage. Usually their coverage is with Metlife or Delta Dental.
- All representatives will ask for each locations Doctor / Business Name, Tax ID, NPI, Address, Phone # and sometimes a provider ID#. Have this information ready before contacting the insurance company for a breakdown.

**Insurance information needed:**

- The insurance company name
- The subscriber's employer, date of birth and social security number (the subscriber may be different from the patient - ie. the patient's parent or guardian, husband, wife, etc.)
- The subscriber's relationship to the patient
- The member/subscriber ID #
- The group number
- Zip code of the primary subscriber
- The provider / customer service phone # from the patient's insurance card
- If patient isn't comfortable with giving out personal information (such as, social security number) over the phone explain three things:
  - Social security number is usually necessary to verify insurance and is secured by HIPPA law
  - We submit insurance claims on behalf of the patient as a courtesy to them and the social security number is needed to do so.

    - It can take up to 45 minutes to verify insurance so that if they wait to provide it the day of the appointment, they should arrive at least an hour early.

**Resources:**

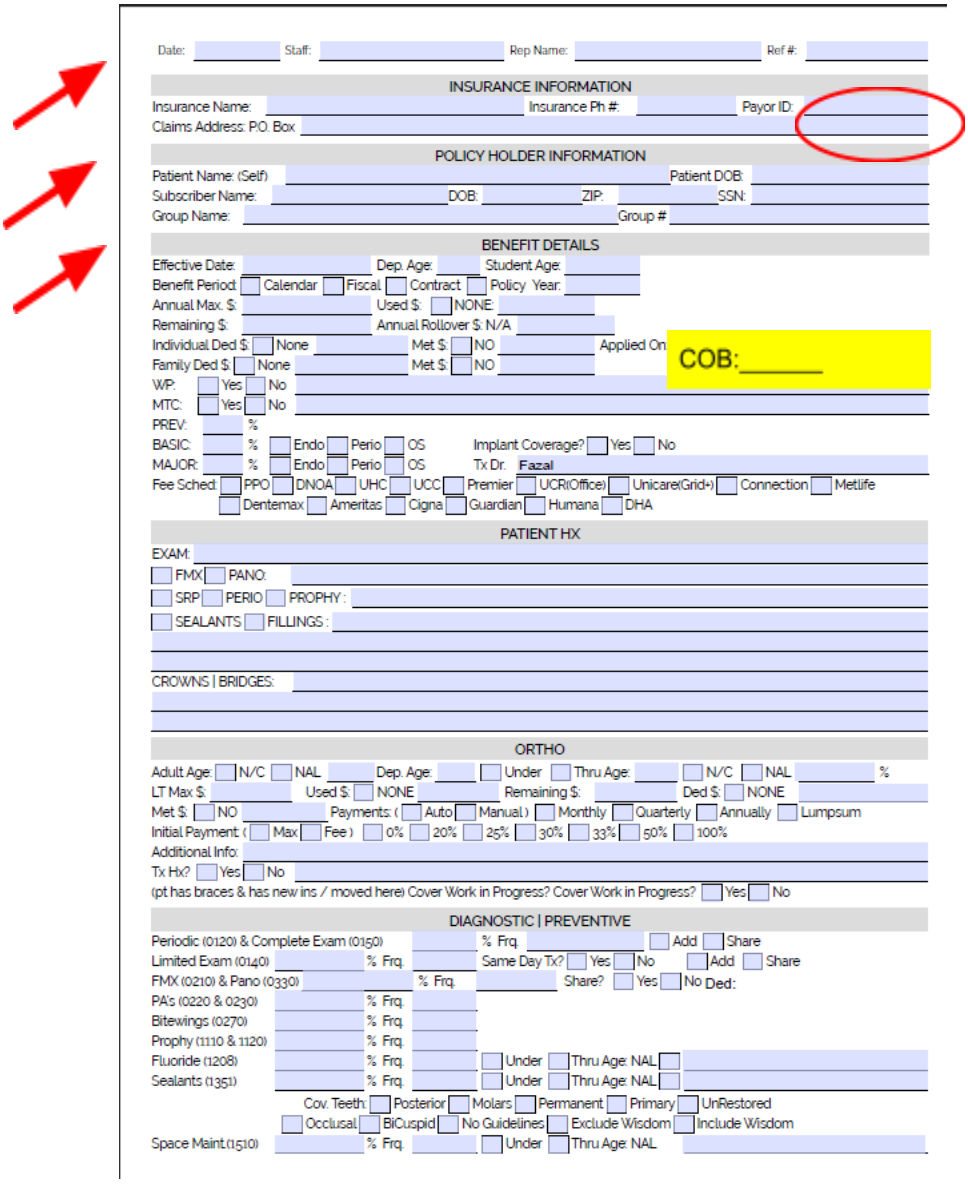
- Use all of your resources to get as much information needed on the breakdown / eligibility form or to find a patient's insurance.
    - Fax back
    - Online (Individual insurance websites)
    - Insurance Answers Plus

**New Patient Steps:**

- Faxback
- Full breakdown
- Add insurance plan into patient's chart or add a new plan
- Create / update benefit information accordingly
- Add NP Short Notes to Plan Notes
- Update patients appointment by removing the color from the patient appointment
- Scan fax back, online information and breakdown into the patient's "insurance" folder

**It is very important that each location has a copy of the patient's breakdown. If the scanning feature is not working use other resources such as fax or email.

**Breakdown Form:**



Date: Staff: Rep Name: Ref #:

INSURANCE INFORMATION

Insurance Name: Insurance Ph #: Payor ID:

Claims Address: P.O. Box

POLICY HOLDER INFORMATION

Patient Name: (Self) Patient DOB:

Subscriber Name: DOB: ZIP: SSN:

Group Name: Group #

BENEFIT DETAILS

Effective Date: Dep. Age: Student Age:

Benefit Period: Calendar Fiscal Contract Policy Year:

Annual Max. $: Used $: NONE:

Remaining $: Annual Rollover $: N/A

Individual Ded $: None Met $: NO Applied On

Family Ded $: None Met $: NO

COB:_____

WP: Yes No

MTC: Yes No

PREV: %

BASIC: % Endo Perio OS Implant Coverage? Yes No

MAJOR: % Endo Perio OS Tx Dr: Fazal

Fee Sched: PPO DNOA UHC UCC Premier UCR(Office) Unicare(Grid+) Connection Metlife

Dentemax Ameritas Cigna Guardian Humana DHA

PATIENT HX

EXAM:

FMX PANO:

SRP PERIO PROPHY:

SEALANTS FILLINGS:

CROWNS | BRIDGES:

ORTHO

Adult Age: N/C NAL Dep. Age: Under Thru Age: N/C NAL %

LT Max $: Used $: NONE Remaining $: Ded $: NONE

Met $: NO Payments: ( Auto Manual ) Monthly Quarterly Annually Lumpsum

Initial Payment: ( Max Fee ) 0% 20% 25% 30% 33% 50% 100%

Additional Info:

Tx Hx? Yes No

(pt has braces & has new ins / moved here) Cover Work in Progress? Yes No

DIAGNOSTIC | PREVENTIVE

Periodic (0120) & Complete Exam (0150) % Frq. Add Share

Limited Exam (0140) % Frq. Same Day Tx? Yes No Add Share

FMX (0210) & Pano (0330) % Frq. Share? Yes No Ded:

PA's (0220 & 0230) % Frq.

Bitewings (0270) % Frq.

Prophy (1110 & 1120) % Frq.

Fluoride (1208) % Frq. Under Thru Age: NAL

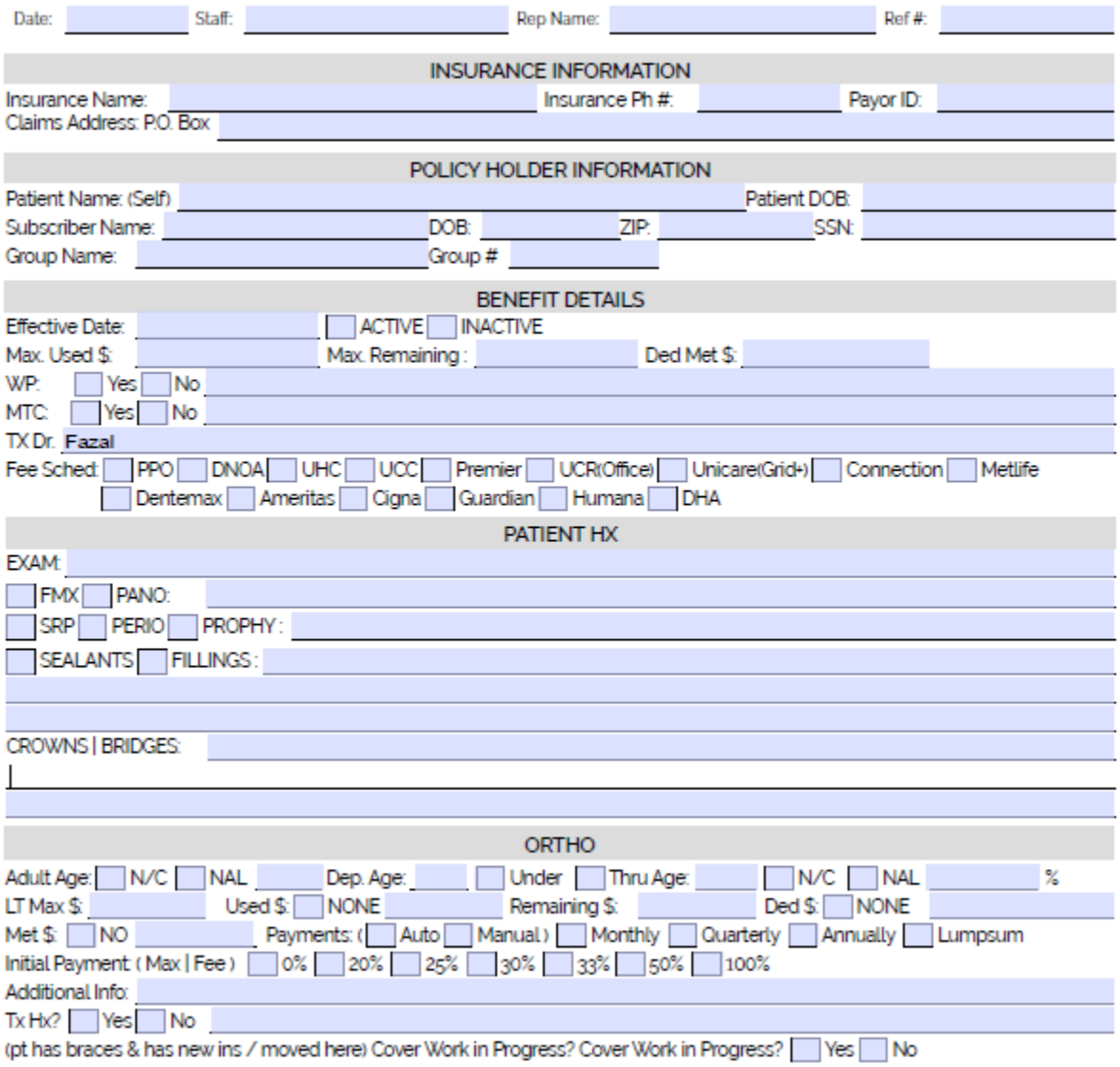
Sealants (1351) % Frq. Under Thru Age: NAL

Cov. Teeth: Posterior Molars Permanent Primary UnRestored

Occlusal BiCuspid No Guidelines Exclude Wisdom Include Wisdom

Space Maint.(1510) % Frq. Under Thru Age: NAL

**Eligibility Form (Recall / Treatment Patients)**



Date: Staff: Rep Name: Ref #:

INSURANCE INFORMATION

Insurance Name: Insurance Ph #: Payor ID:
Claims Address: P.O. Box

POLICY HOLDER INFORMATION

Patient Name: (Self) Patient DOB:
Subscriber Name: DOB: ZIP: SSN:
Group Name: Group #

BENEFIT DETAILS

Effective Date: ☐ ACTIVE ☐ INACTIVE
Max. Used $: Max. Remaining : Ded Met $:
WP: ☐ Yes ☐ No
MTC: ☐ Yes ☐ No
TX Dr. Fazal
Fee Sched: ☐ PPO ☐ DNOA ☐ UHC ☐ UCC ☐ Premier ☐ UCR(Office) ☐ Unicare(Grid+) ☐ Connection ☐ Metlife
☐ Dentemax ☐ Ameritas ☐ Cigna ☐ Guardian ☐ Humana ☐ DHA

PATIENT HX

EXAM:
☐ FMX ☐ PANO:
☐ SRP ☐ PERIO ☐ PROPHY :
☐ SEALANTS ☐ FILLINGS :
CROWNS | BRIDGES:

ORTHO

Adult Age: ☐ N/C ☐ NAL Dep. Age: ☐ Under ☐ Thru Age: ☐ N/C ☐ NAL %
LT Max $: Used $: ☐ NONE Remaining $: Ded $: ☐ NONE
Met $: ☐ NO Payments: ( ☐ Auto ☐ Manual ) ☐ Monthly ☐ Quarterly ☐ Annually ☐ Lumpsum
Initial Payment: ( Max | Fee ) ☐ 0% ☐ 20% ☐ 25% ☐ 30% ☐ 33% ☐ 50% ☐ 100%
Additional Info:
Tx Hx? ☐ Yes ☐ No
(pt has braces & has new ins / moved here) Cover Work in Progress? Cover Work in Progress? ☐ Yes ☐ No

**Add on's**

The schedule should be monitored throughout the day so that add ons are done in a timely manner.

Since a breakdown can take anywhere from 10-45 minutes use all of your resources for Add On's

As soon as you verify the patient's effective date and that they are on their plan, communicate that information ASAP (Phone call or place a blockout on the schedule) so the patient may be seated. A FULL BREAKDOWN does not have to be done for the patient's appointment to get started (Pano, Xrays, Exam)

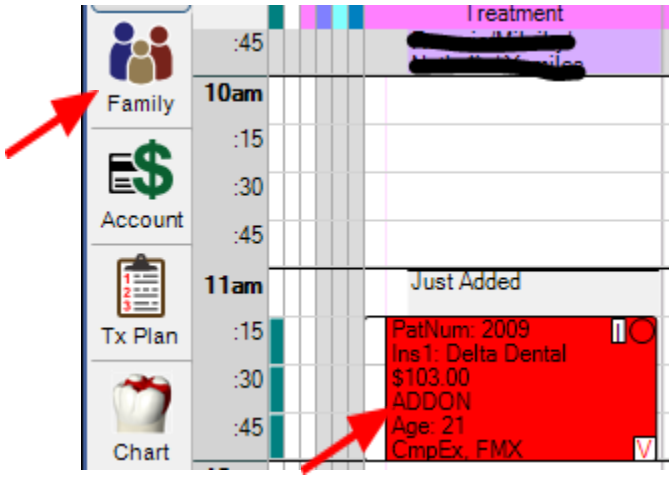
- It is highly important to get all of the information filled out thoroughly and accurately on the Insurance Breakdown Form.

- Fill in what information you can on the breakdown form from your other resources first. This will help speed up your time on the phone with the insurance rep.
  **If at any time the information given from the insurance rep seems incorrect, ask to speak to a different rep or end the call and call back.
- Always get the rep's name and a reference # for your phone call
- Make sure you do not miss any of the important (most used) information on the breakdown and get detailed information:
  - Claim mailing address & Payor ID #
  - Does the plan have a COB (Coordination of benefits) rule with a secondary plan?
  - Are AOB (assignment of benefits) accepted?
  - Policy holder information (Make sure you have the correct primary subscriber info)
  - Fees: Does the plan pay on a fee schedule or pay on UCR (usual and customary) fees?
  - Waiting period: Does it apply to preventive, basic, major?
  - Missing tooth clause
  - Replacement clause: Applies to what? For how long?
  - SRP: Patient history, Frequency and quadrant limitation
  - Oral Surgery: Does this procedure go to medical or dental?
  - Make sure to get all downgrades, frequencies and special procedure guidelines
  - Patient History is a MUST: If a patient has used some of their max or met their deductible, ask what the benefit were used on (what procedure met their deductible?) and when was the date of service. Take detailed notes.

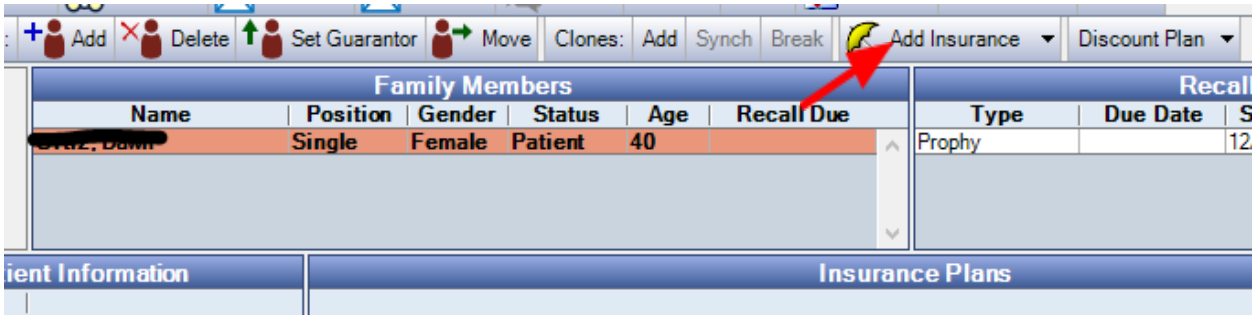
## E. Patient / Insurance Activation & Information

New Patients:

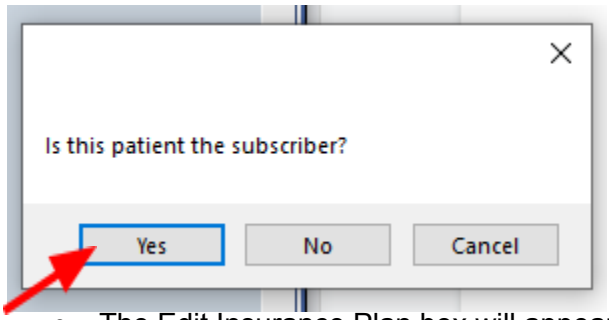
- Once the breakdown is complete, you will need to activate the patient / family file.
- Select the patient from the appointment module, click on "Family"



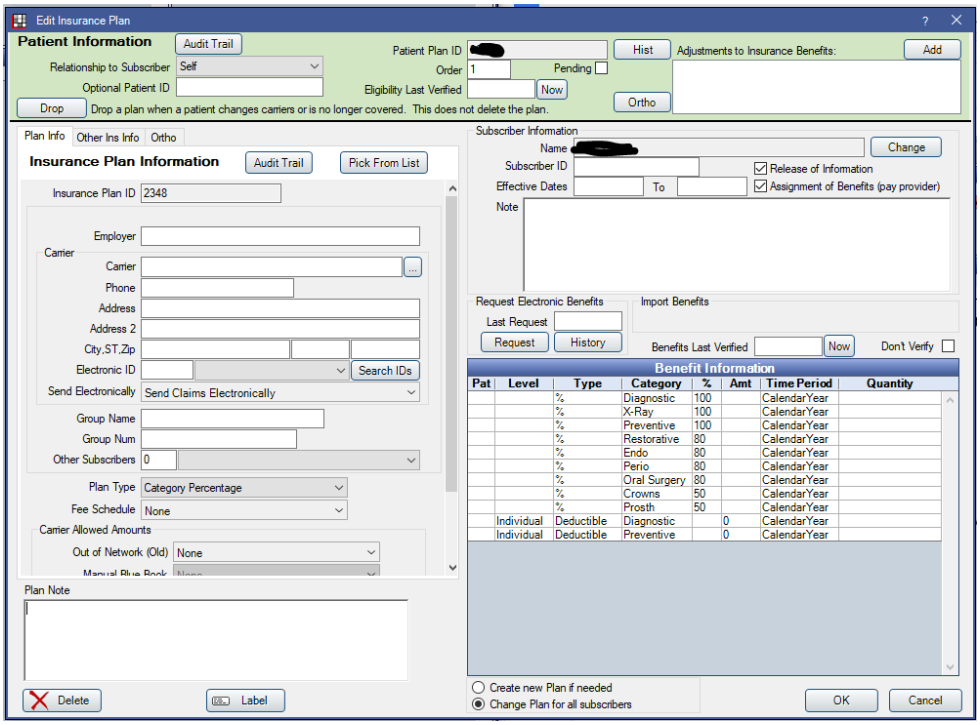
- This will open the patient's family chart
- In the upper right, click "Add Insurance"



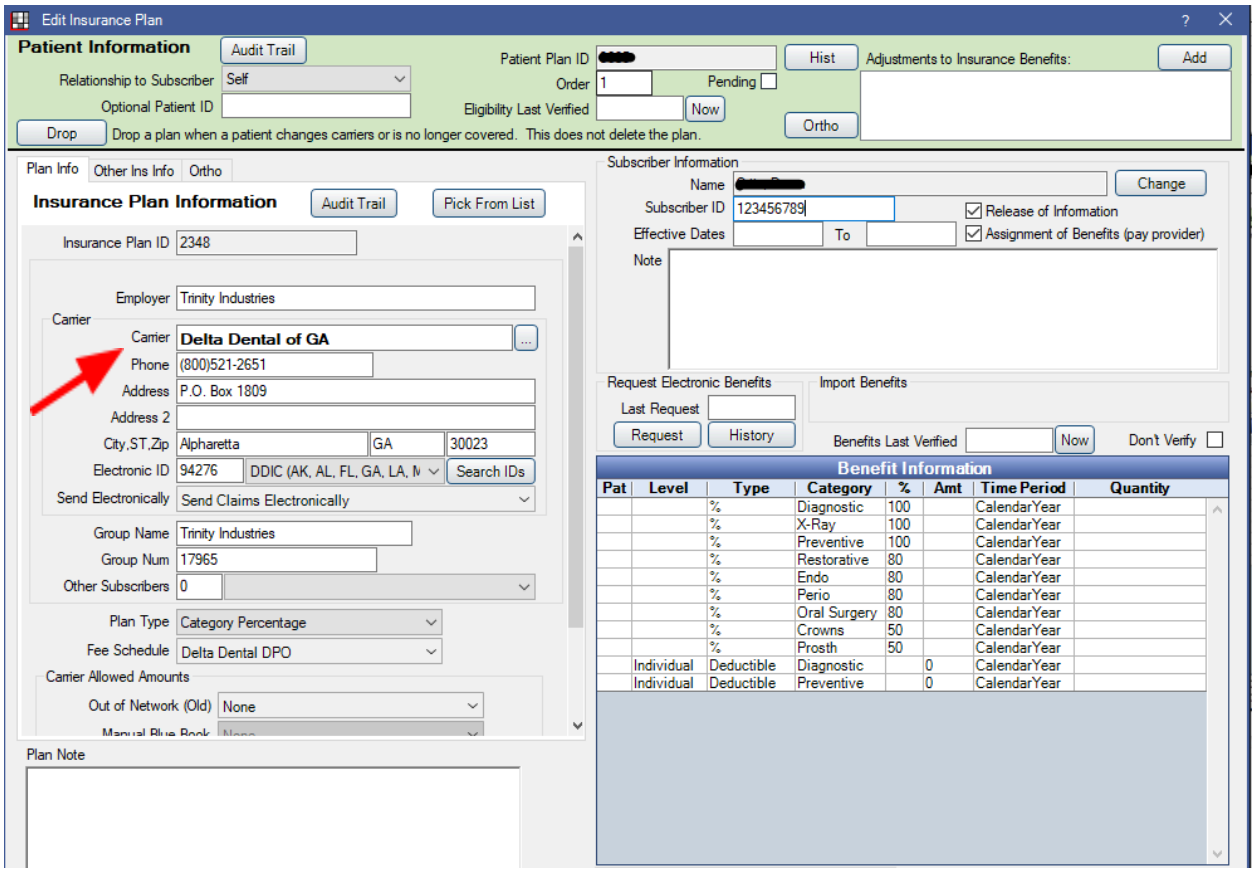

- A new box will pop up asking if the patient is the Subscriber. If the patient IS the subscriber, click yes. If not, click No and it will have you select the subscriber or enter in a new family member:



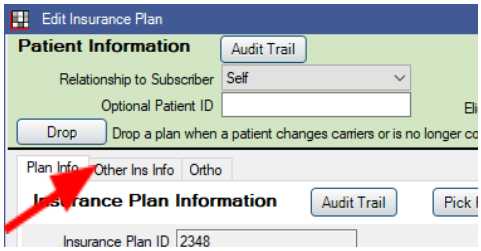

- The Edit Insurance Plan box will appear where you will enter all of the information from your breakdown:



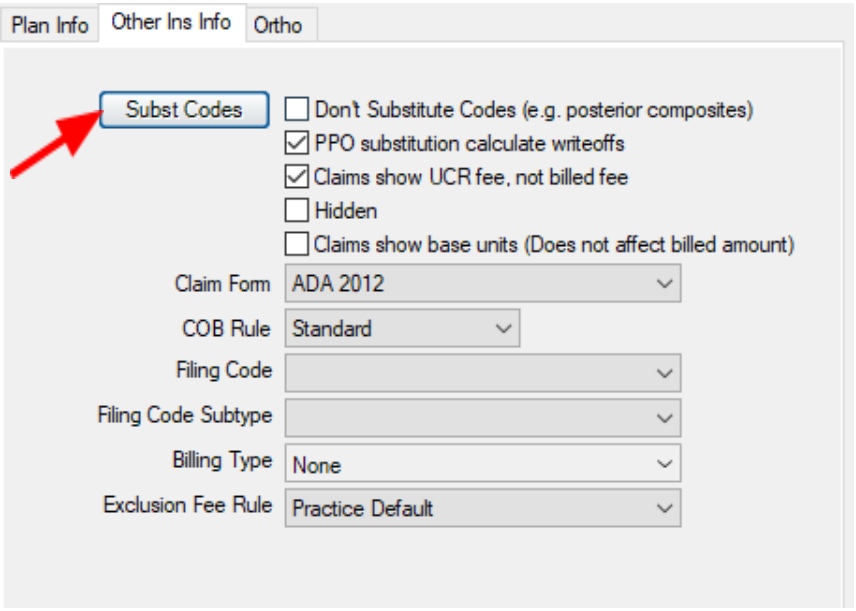

- Fill in all of the information on this page following the breakdown as follows:

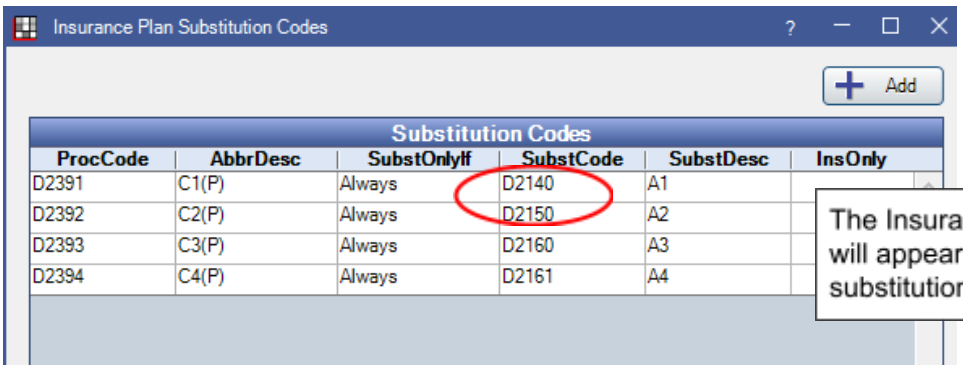



- Once the **INSURANCE INFO** is entered, you will enter the downgrades in the “Other Ins Info” tab:

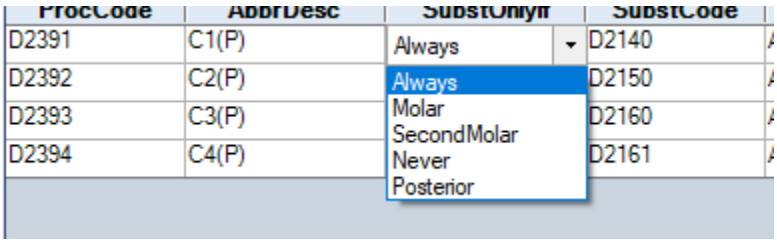


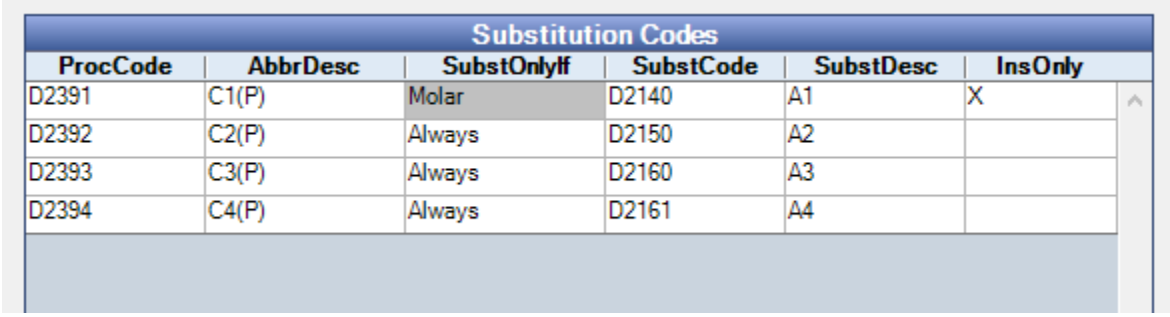

- Here you will enter if the plan Downgrades for things like: Fillings, crowns, bridges etc.
- If the plan **DOES** downgrade For something click “Subst Codes”



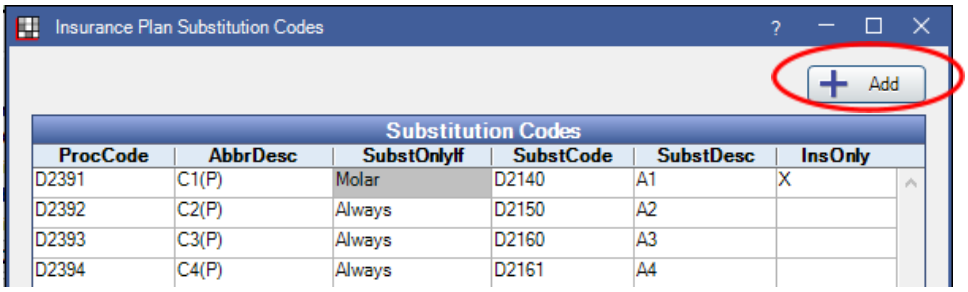



From here you can change the "SubstOnlyIf" to whatever the insurance companies guidelines are. For example: D2391 downgrades only on molars, you would click the dropdown box and change it to say "molars only"

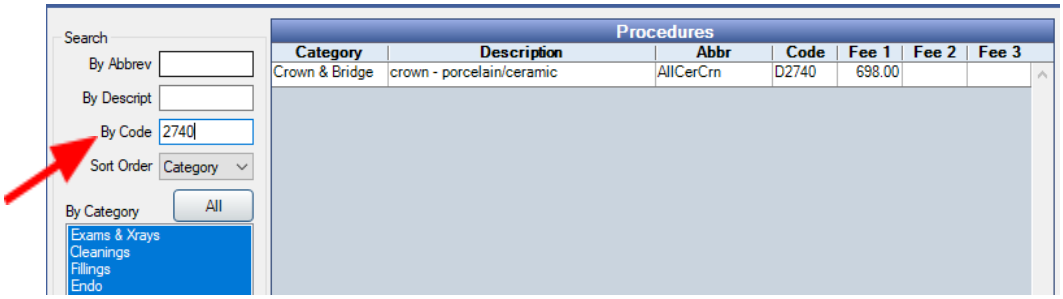


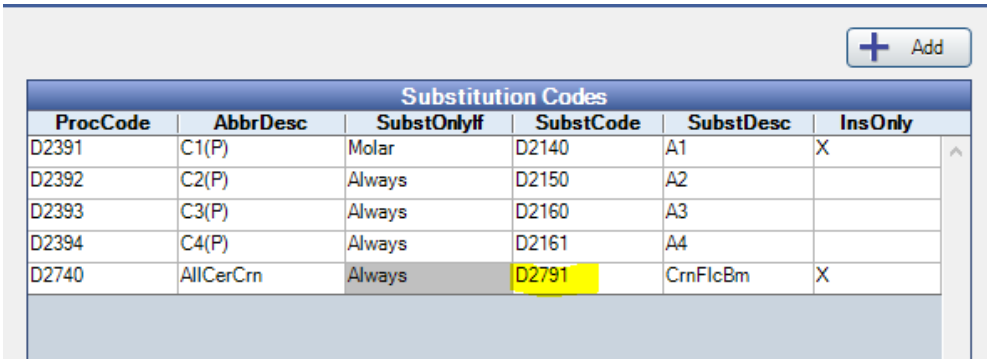

- Additionally, if a code that is not shown in this screen also downgrades such as a crown code, you can add the code manually and add the code that it downgrades to as well by selecting "+Add" in the upper right corner:



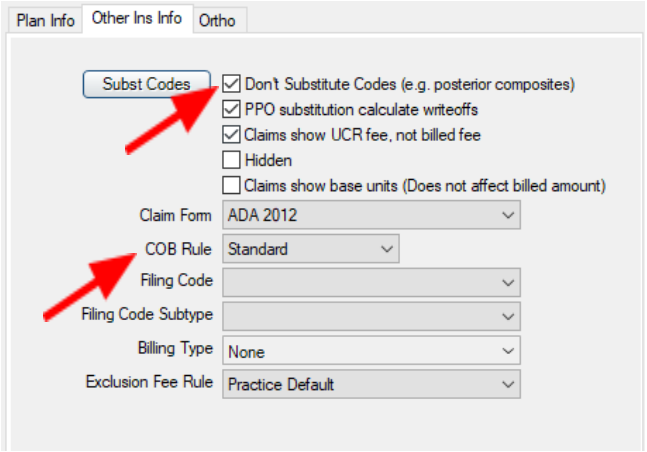

- From there, the procedure code list will appear where you can search by code, description or abbreviation to find the code you are looking for:



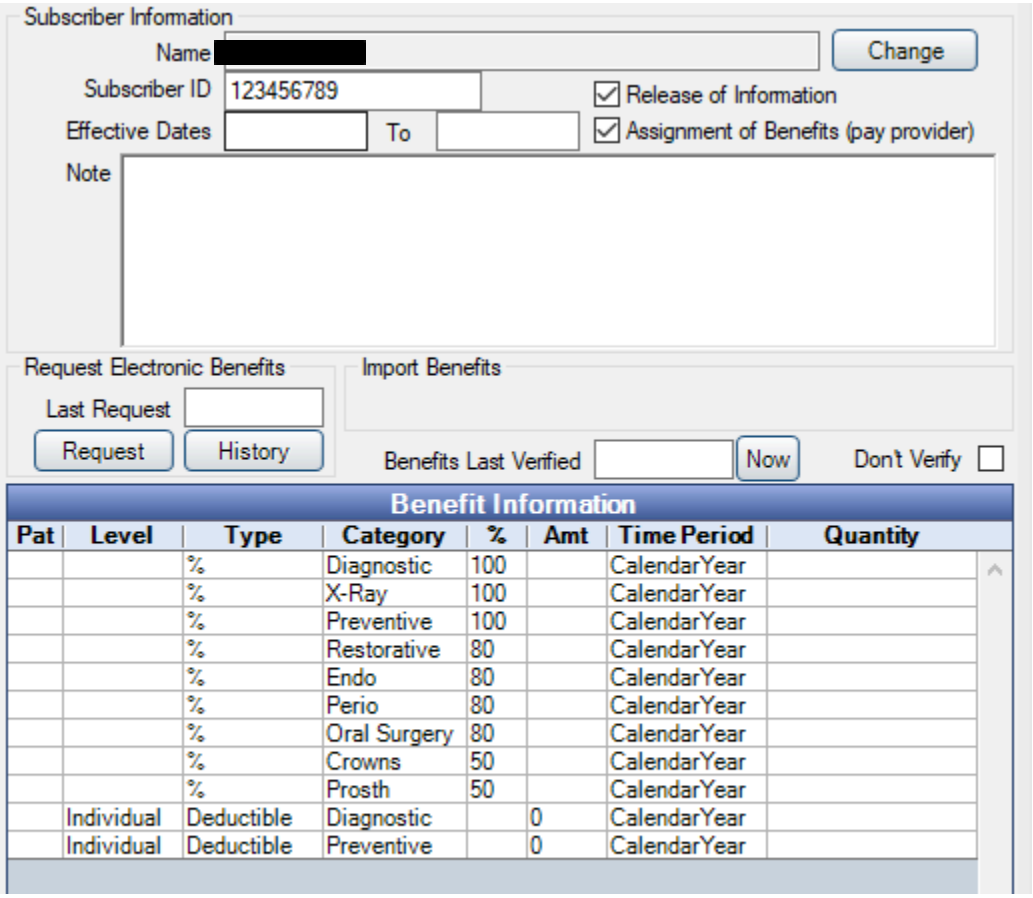

- Double click on the procedure you are looking for that is the code that *downgrades*
- Then, back into the Insurance Substitutions box enter the SubstCode:



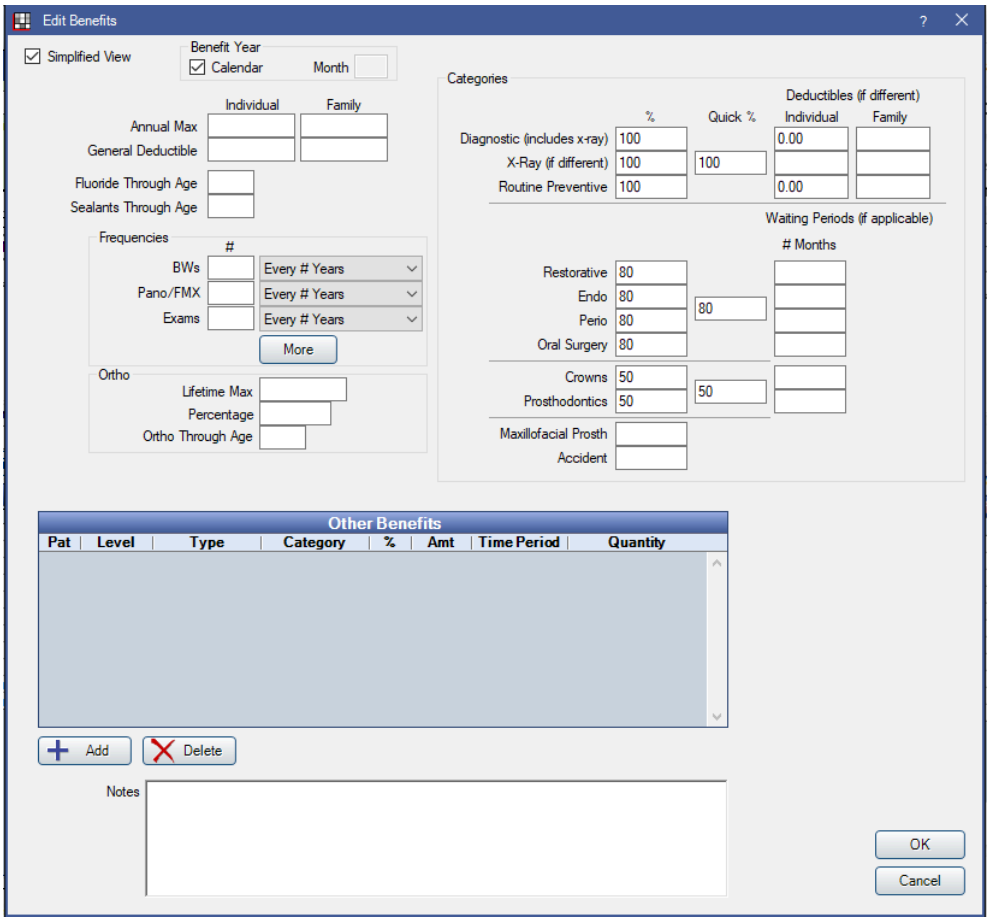

- From here, you can add when the code substitutes (Molars, Always, Premolars, etc) and then click “OK” when done
  ****IF CODES DO NOT DOWNGRADE****
  Simply check the box that states “Don’t Substitute Codes”



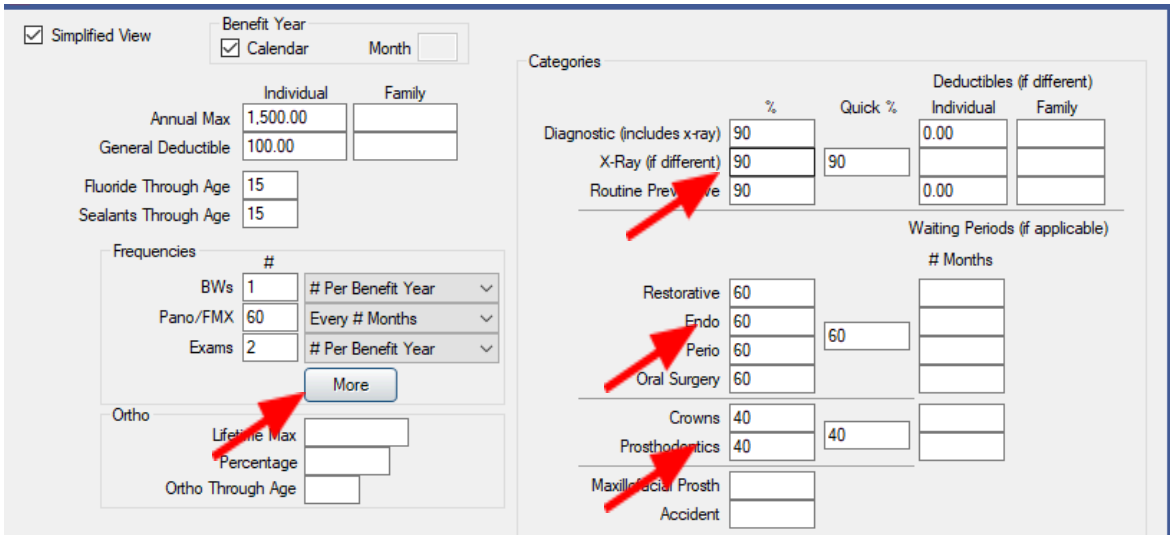

Once any downgrades are entered or set as “do not downgrade” move onto the “benefit information portion of the Insurance Plan:




- To open the benefit information, simply double click anywhere inside the box and the “Edit Benefits” box will appear:



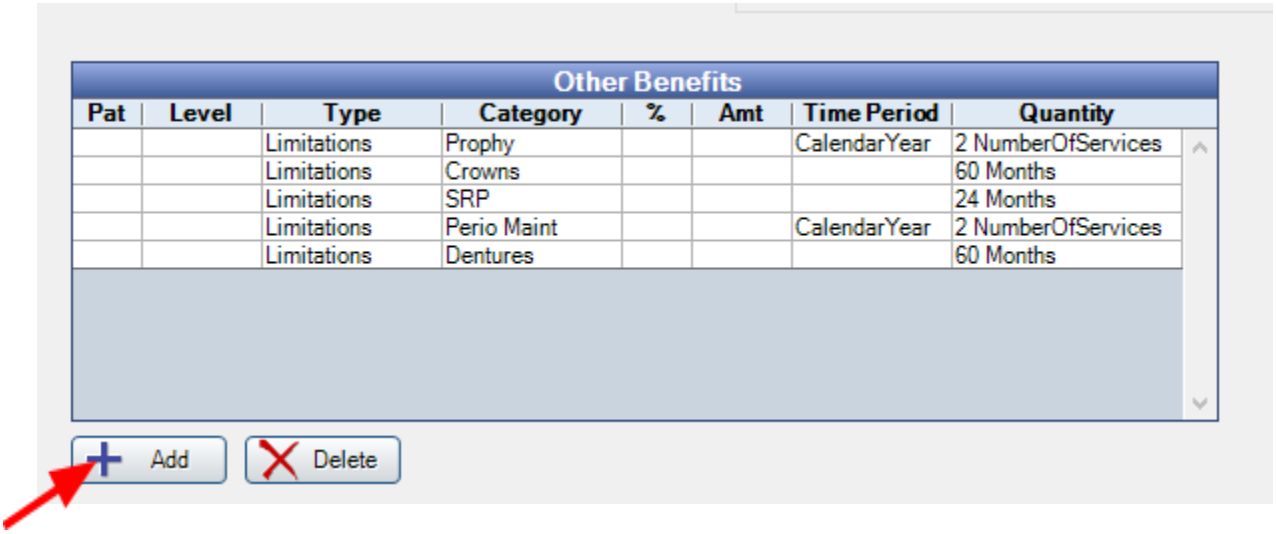

- Here is where you will enter the patient's coverage. Be sure to pay close attention and enter everything accurately to the breakdown of benefits you have on paper. For example, our system automatically populates that Preventive is 100%, Basic is 80% and Major is 50%. If that is not the case, this will need to be updated:



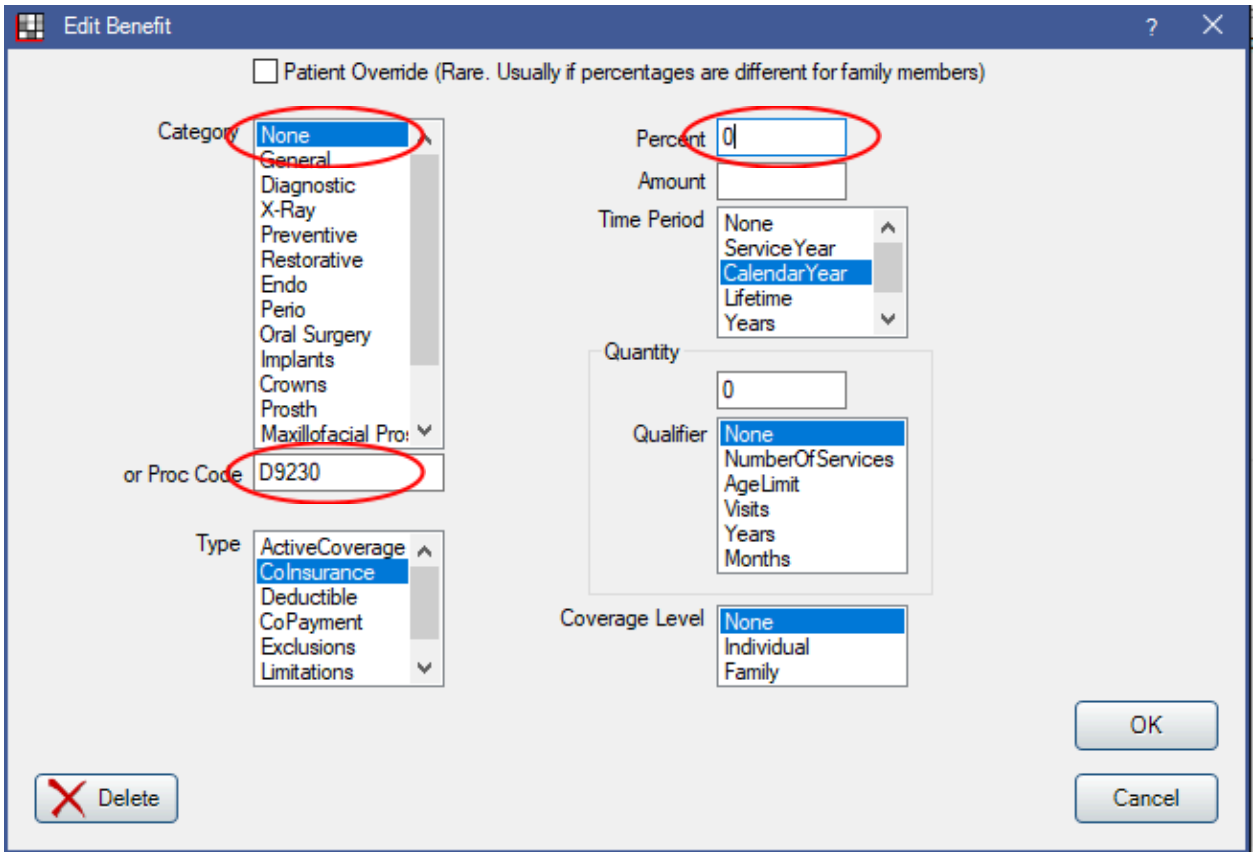
- Be sure to also click on the “More” button under the frequencies so that you can enter frequencies for things like crowns and SRP’s. Remember that this will need to be 100% accurate to what the insurance rep told you.
- Once that is entered and checked for accuracy, move down to the “Other Benefits” section
    - This box will show any procedure codes that may need to be altered individually. For example, insurance typically doesn’t pay for nitrous so we would add in that code as 0%.

**To add codes:**

- Click “Add”



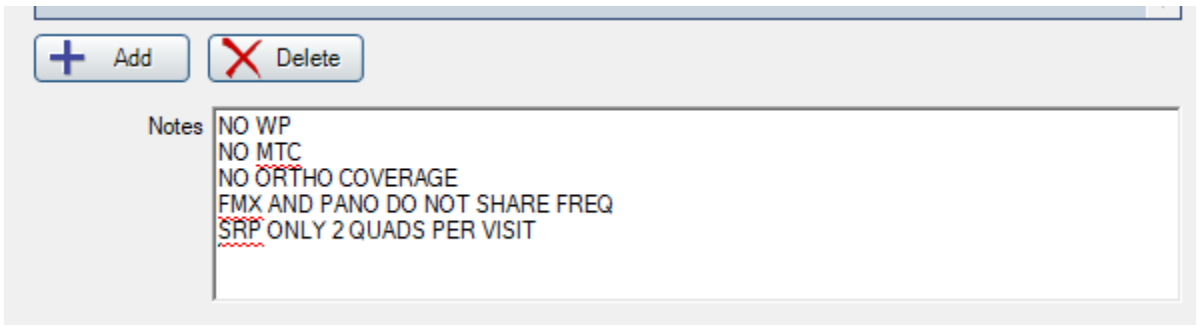

- Under “Category” select None, Proc code enter the procedure code we need to update and in the “Percent” box, enter what the code estimates to pay from insurance. In this instance we are estimating insurance to pay 0%.




- We have a list of zero out codes to put here in this box, these codes are usually unpaid by insurance 99% of the time so by zeroing them out, whenever the treatment coordinator goes in to speak to the patient, the patient knows these particular codes are not covered and patient will pay for them out of pocket. We will still bill these codes to insurance in hopes of getting it paid and reimbursing the patient.

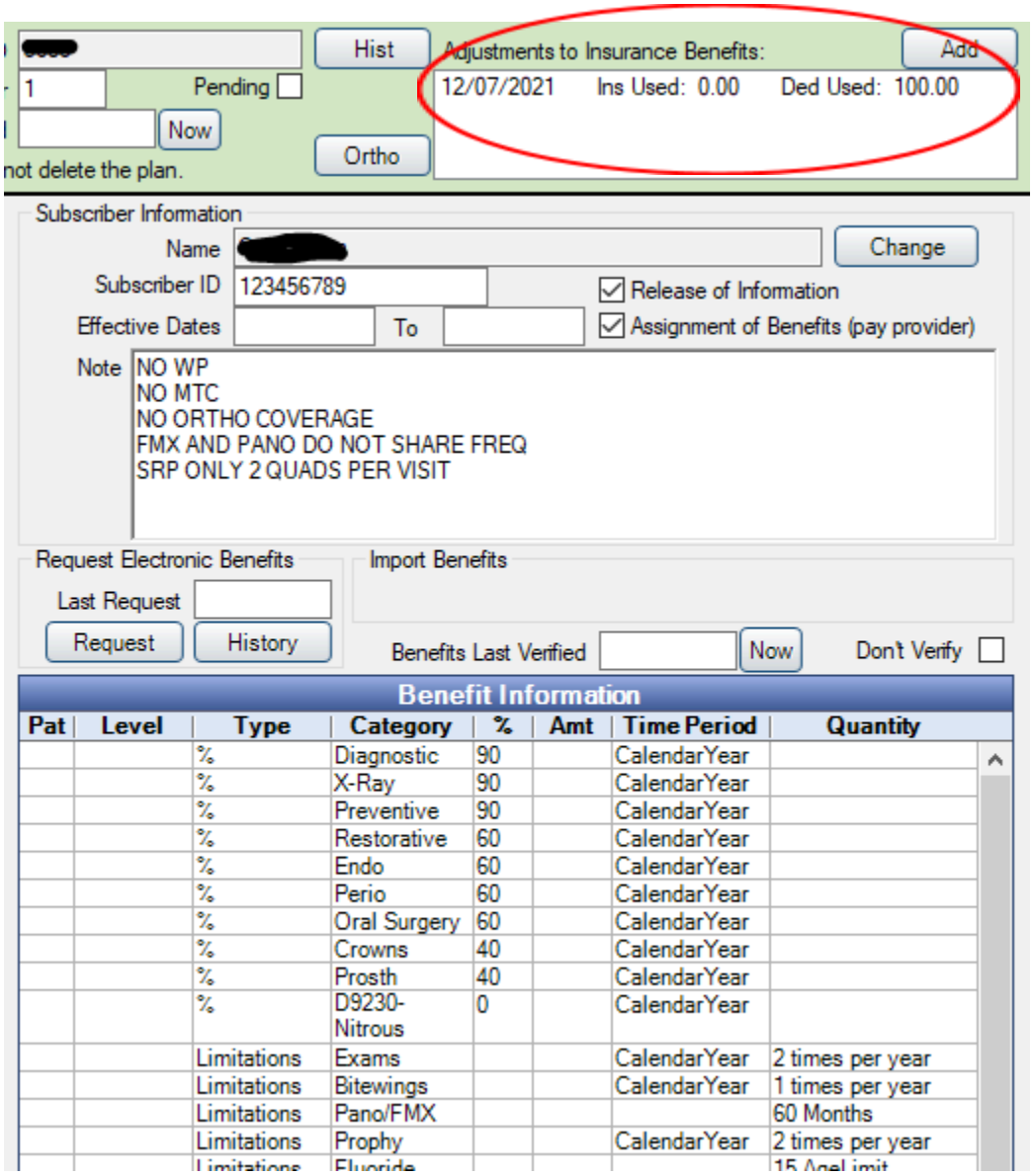
Another reason you may use this is for example, if a crown is covered at 50% but the build up is covered at 40%. You would enter the build up coverage manually. Or if preventive services are covered at 100% but the FMX is covered at 80%, you would enter the FMX manually at 80% so that it will reflect correctly on the treatment plans and patient will know their copays.

- In the bottom in the Notes section is where you will enter any important information that we will need to know prior to going into the room to treatment plan. For example: Waiting periods, Missing tooth clause, Ortho coverage, if SRP pays all 4 quads or not, Pano/FMX information:



It's important to note this because once we finish entering the insurance, this is the information we will copy and paste into the patient's appointment notes along with any history they have on file.

- Once you are done with entering the information, you will click "OK" at the bottom right. Be sure that if the patient has used any of their deductible or maximum **PRIOR** to being seen by our dental office to enter it into the "Adjustments to Insurance Benefits" on the Edit Insurance screen:

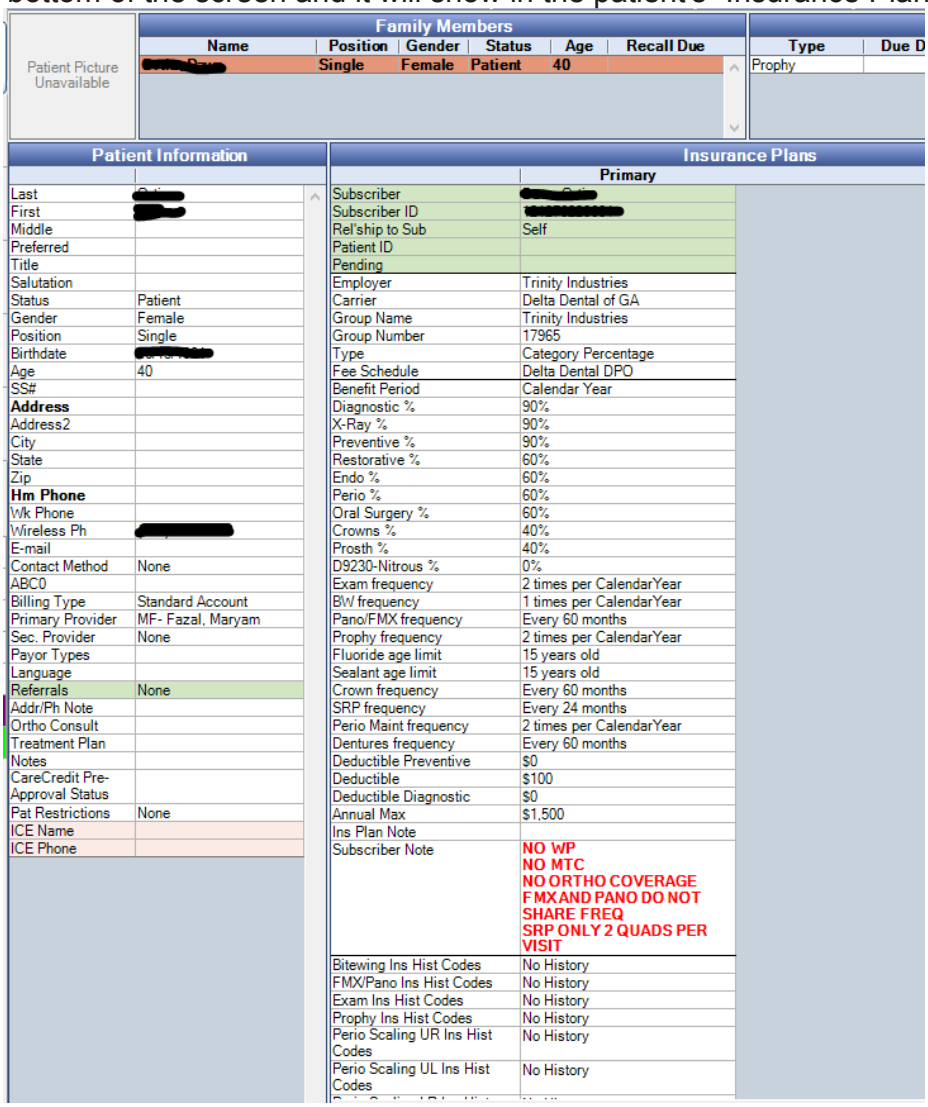



To do this, just click "Add" and you will be able to enter the amount the patient has used out of their maximum as well as their deductible they have used. In this instance, the patient has only met their deductible.

**Zero out codes:**

- D2950
- D2954
- D3120
- D4266
- D4267
- D4381
- D5862
- D6950
- D7921
- D7953
- D9944

Once you are finished with entering everything into the patient's insurance, you can click "OK" at the bottom of the screen and it will show in the patient's "Insurance Plans"



Patient Picture Unavailable

**Family Members**

| Name | Position | Gender | Status | Age | Recall Due |
|---|---|---|---|---|---|
| [redacted] | Single | Female | Patient | 40 | |

| Type | Due D |
|---|---|
| Prophy | |

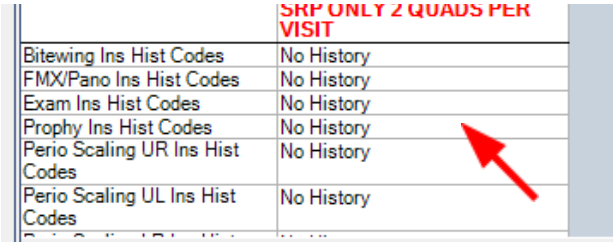
**Patient Information**

| | |
|---|---|
| Last | [redacted] |
| First | [redacted] |
| Middle | |
| Preferred | |
| Title | |
| Salutation | |
| Status | Patient |
| Gender | Female |
| Position | Single |
| Birthdate | [redacted] |
| Age | 40 |
| SS# | |
| **Address** | |
| Address2 | |
| City | |
| State | |
| Zip | |
| **Hm Phone** | |
| Wk Phone | |
| Wireless Ph | [redacted] |
| E-mail | |
| Contact Method | None |
| ABC0 | |
| Billing Type | Standard Account |
| Primary Provider | MF- Fazal, Maryam |
| Sec. Provider | None |
| Payor Types | |
| Language | |
| Referrals | None |
| Addr/Ph Note | |
| Ortho Consult | |
| Treatment Plan | |
| Notes | |
| CareCredit Pre-Approval Status | |
| Pat Restrictions | None |
| ICE Name | |
| ICE Phone | |

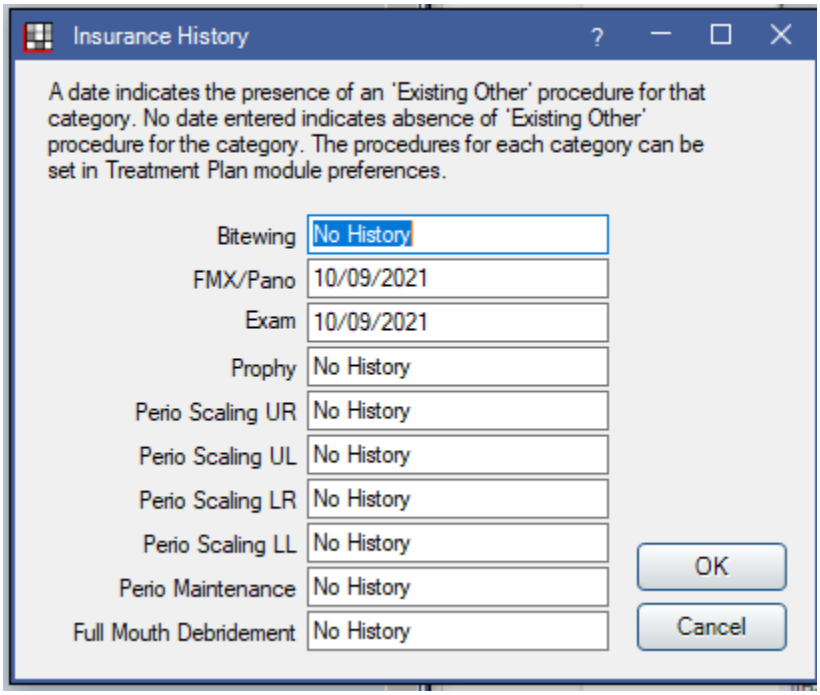
**Insurance Plans**

| | Primary |
|---|---|
| Subscriber | [redacted] |
| Subscriber ID | [redacted] |
| Rel'ship to Sub | Self |
| Patient ID | |
| Pending | |
| Employer | Trinity Industries |
| Carrier | Delta Dental of GA |
| Group Name | Trinity Industries |
| Group Number | 17965 |
| Type | Category Percentage |
| Fee Schedule | Delta Dental DPO |
| Benefit Period | Calendar Year |
| Diagnostic % | 90% |
| X-Ray % | 90% |
| Preventive % | 90% |
| Restorative % | 60% |
| Endo % | 60% |
| Perio % | 60% |
| Oral Surgery % | 60% |
| Crowns % | 40% |
| Prosth % | 40% |
| D9230-Nitrous % | 0% |
| Exam frequency | 2 times per CalendarYear |
| BW frequency | 1 times per CalendarYear |
| Pano/FMX frequency | Every 60 months |
| Prophy frequency | 2 times per CalendarYear |
| Fluoride age limit | 15 years old |
| Sealant age limit | 15 years old |
| Crown frequency | Every 60 months |
| SRP frequency | Every 24 months |
| Perio Maint frequency | 2 times per CalendarYear |
| Dentures frequency | Every 60 months |
| Deductible Preventive | $0 |
| Deductible | $100 |
| Deductible Diagnostic | $0 |
| Annual Max | $1,500 |
| Ins Plan Note | |
| Subscriber Note | NO WP<br>NO MTC<br>NO ORTHO COVERAGE<br>F MX AND PANO DO NOT SHARE FREQ<br>SRP ONLY 2 QUADS PER VISIT |
| Bitewing Ins Hist Codes | No History |
| FMX/Pano Ins Hist Codes | No History |
| Exam Ins Hist Codes | No History |
| Prophy Ins Hist Codes | No History |
| Perio Scaling UR Ins Hist Codes | No History |
| Perio Scaling UL Ins Hist Codes | No History |

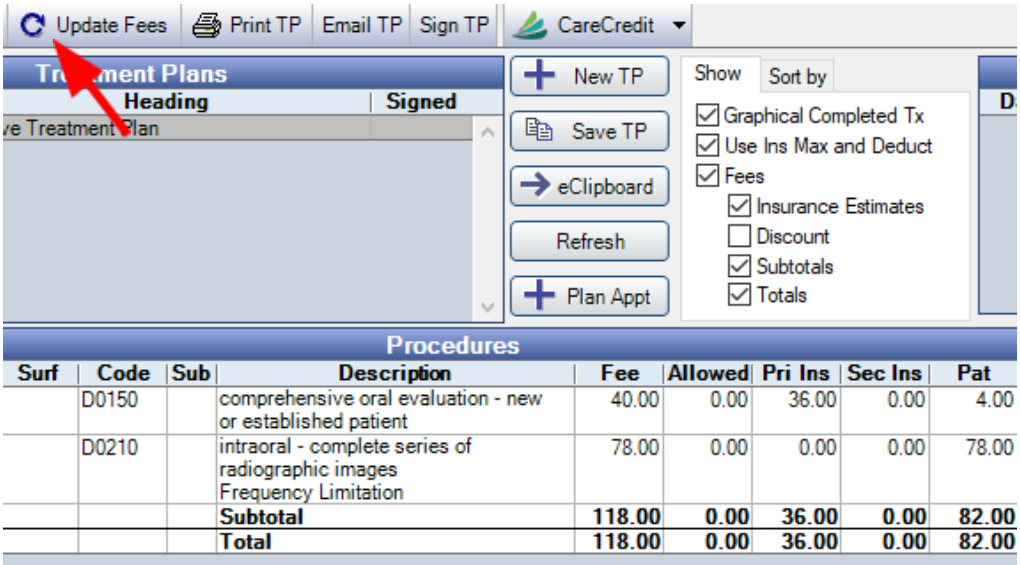
From this screen you will need to enter the patient's history (if any)



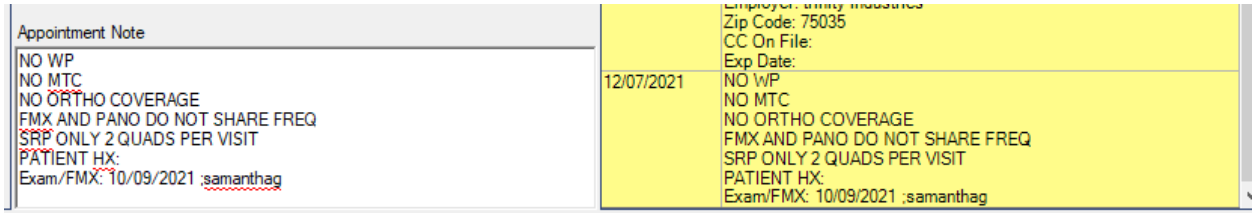

To do so, just double click inside this box and update the history as needed:

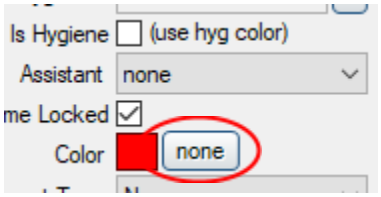



Once done, go into the treatment plan and "**Update Fees**" which ensures we are quoting patients the correct fees:



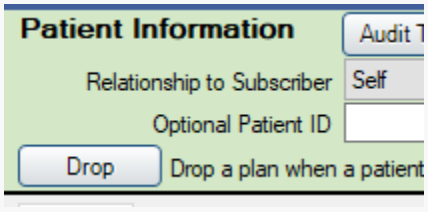
Then, copy and paste the insurance note into the patient's appointment note and commlog along with your initials. Include any history the patient has on file so that the treatment coordinator may be made aware and mark the color of the appointment as "None":




****ALWAYS MAKE SURE ALL BREAKDOWNS ARE SCANNED INTO THE PATIENT'S INSURANCE FOLDER BEFORE MOVING ON TO THE NEXT PATIENT****

**If patient gets a new insurance and we need to remove the old one:**
Simply go into the patient's insurance information, double click the insurance and click "Drop" at the top left hand corner

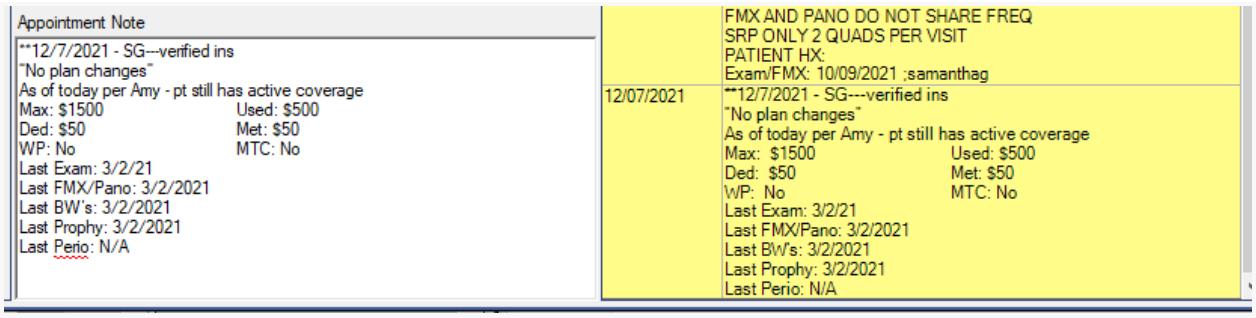



This will remove that insurance company from the patient's chart but won't delete it completely.

**Recall/Treatment Patients:**
Insurance will need to be re-verified for each patient each month. Meaning, if the patient came as a new patient in November and is returning in December for their treatment, we will need to do a recall on that patient's insurance. This is because we never know if the patient went to another dental office between that time or if they got a new job and their insurance was terminated. We always need to have an updated recall sheet on file for each new month that the patient returns.
For patients returning to our office in a new month, once we have called and gathered the recall information over the phone from insurance, we need to ALWAYS enter a new note in the appointment **AND** commlog for each time we re-verify like so:

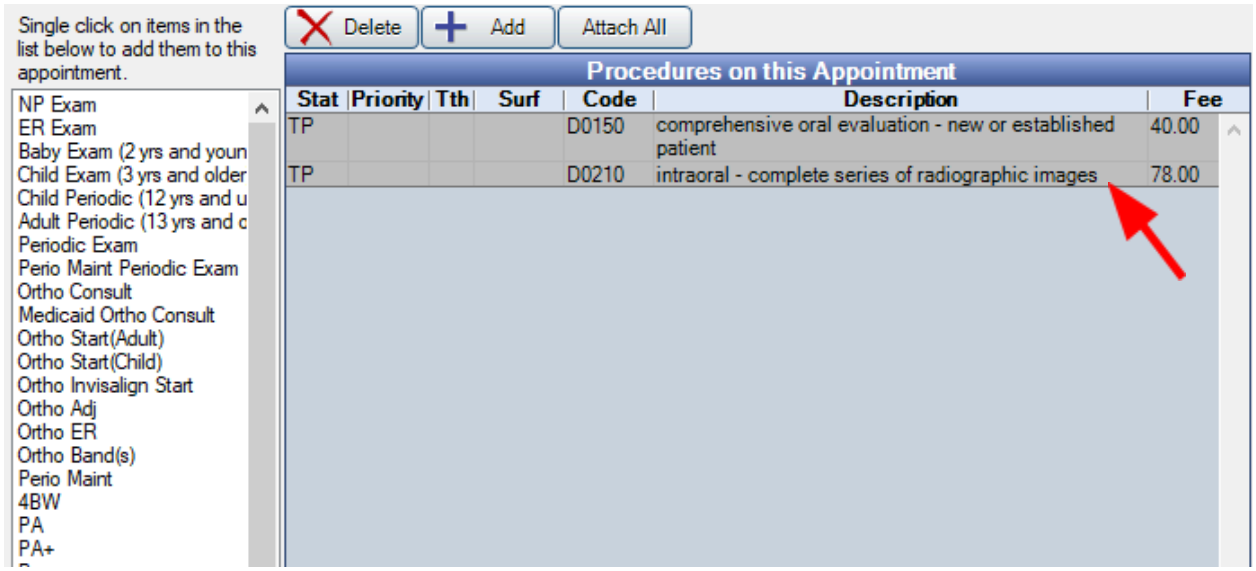
**Insert Dateline and Initials---verified ins
“No plan changes” or “Updated Coverage Changes”
As of today per _(rep name)__ pt still has active coverage
Max: Used:
Ded: Met:
WP: MTC:
Last Exam:
Last FMX/Pano:
Last BW’s:
Last Prophy:
Last Perio:

**EXAMPLE:**

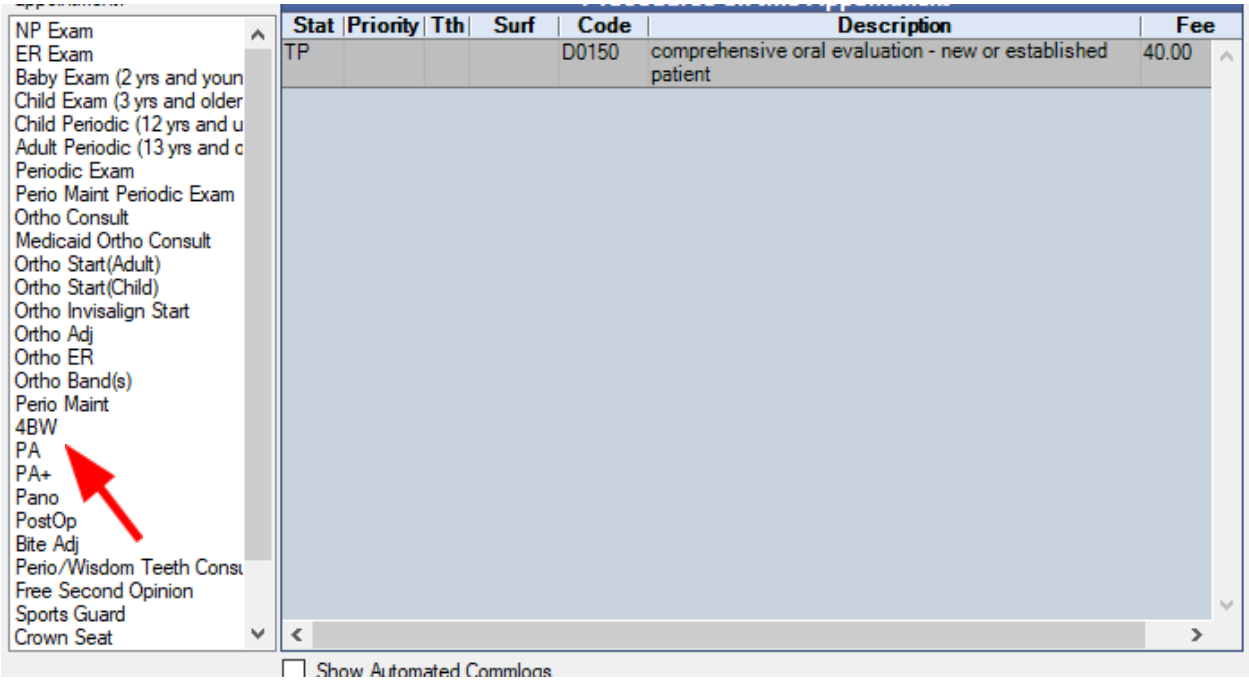



**Updating Patient’s Appointment:**

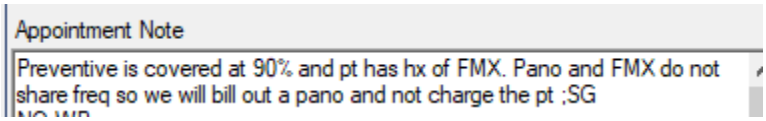
- After the insurance is verified, add or remove any procedure that the patient may or may not be eligible for. (4BW’s & 2PA’s instead of FMX, PA instead of BW etc.)
- Double click the patient appointment and double click on the procedure code you want to delete:



- A new box will appear, click on “Delete” in the bottom left and add in the procedure code you would like to switch it to from the list on the left of the “Procedures on this Appointment” box:

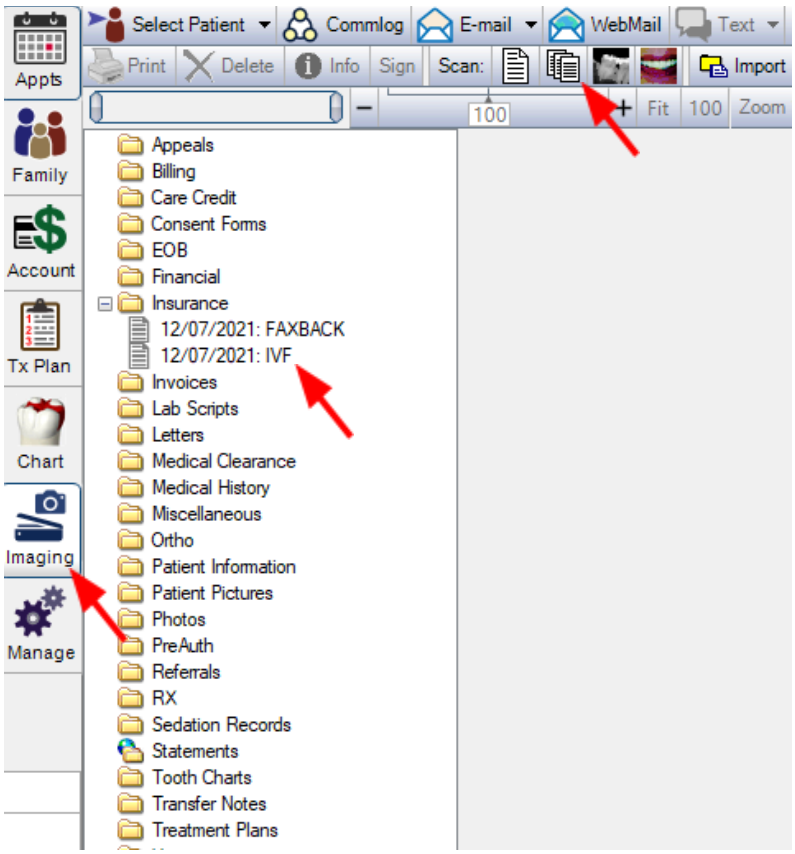



- Once done with this step, put a detailed note in the Appointment Note and commlog:




**Scanning Documents:**

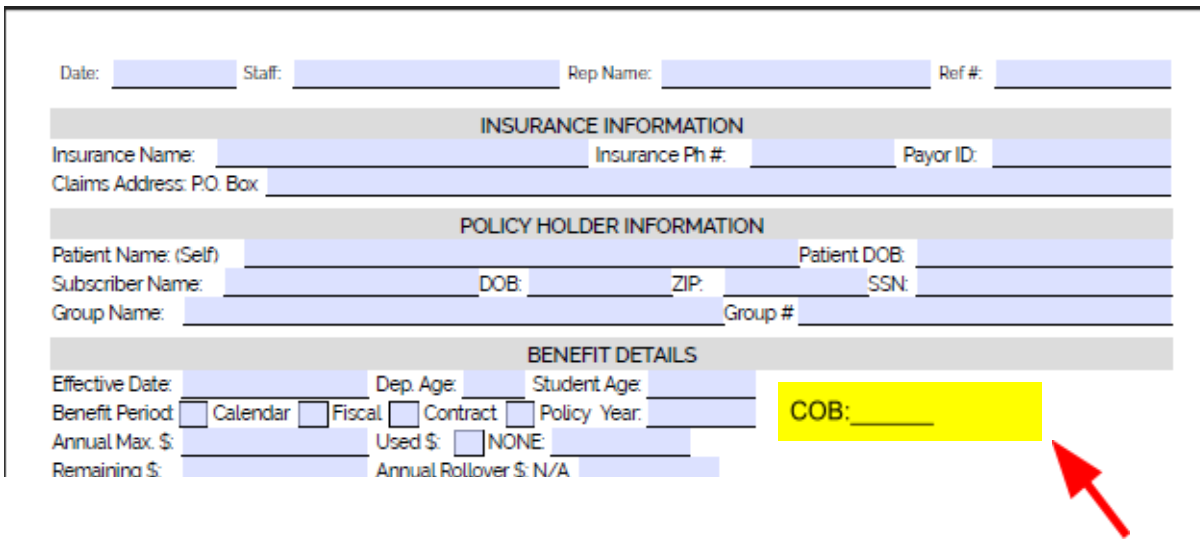
- It is a **MUST** and very important that all locations can view the patients' breakdowns, fax backs, online information and other documents that you have spent time gathering to adequately answer any questions the patients may have regarding their insurance, properly treatment plan and handle insurance claims / payments accordingly. Without this information, several mistakes can be made as well as delayed treatment plans and upset patients.
- If at any time you are having problems with the scanning function or the internet, communicate with your Supervisor / Office Manager and use other resources (email and / or fax) to provide this information to the other locations.




From “Imaging” you can click the multipage function and select “Epson” and save into the patient’s “Insurance” folder

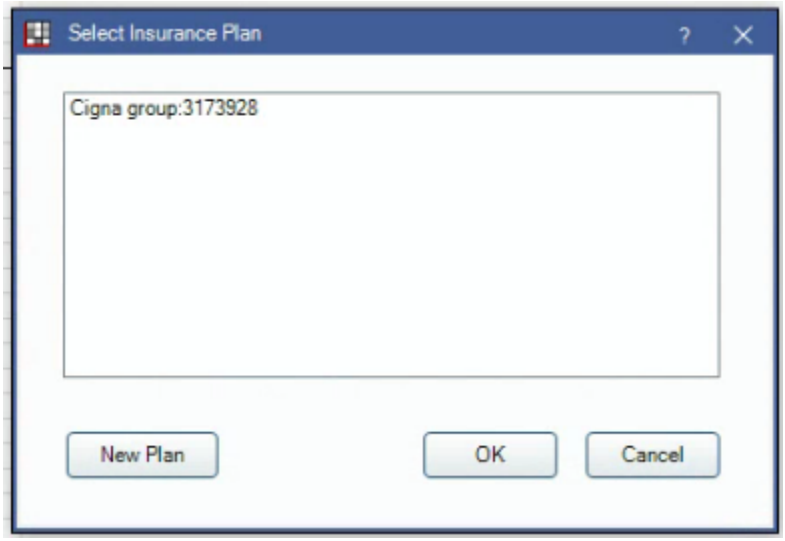
## Entering secondary insurance:

Before entering secondary insurance, it’s important to know the COB (Coordination of benefits). You will gather this information when you are on the phone with the insurance company getting the breakdown of benefits and you will write it in the COB section of the IVF:

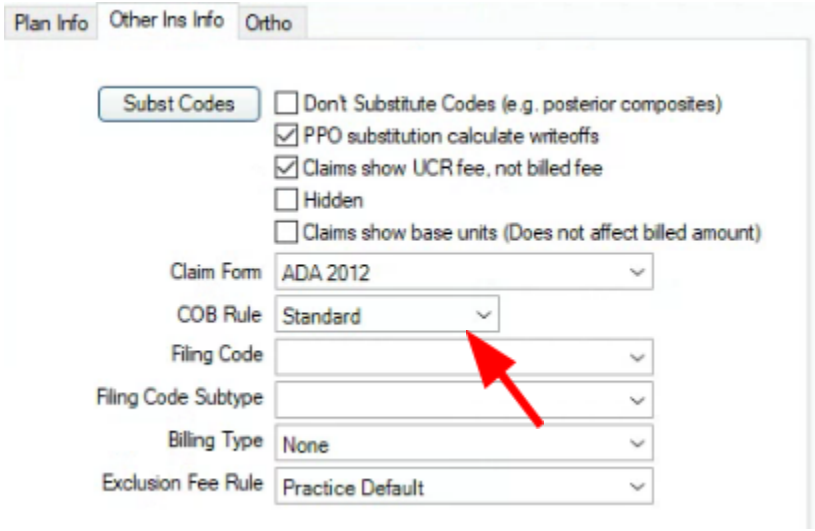



To enter secondary insurance into the patient’s chart, once the primary insurance is entered, simply click the “Add Insurance” button again. It will ask you if the patient is the subscriber, click

yes if the patient is or no if the patient is not. Another box will appear asking you to select an insurance plan, click “New Plan”:




Enter the insurance the same way as the steps above for primary and when you get to the section that shows the COB:




Be sure to enter correctly to what the rep told you so that the treatment coordinator can correctly quote the patient.

## F. Customer Service

**Answering Phones:**

- The Insurance Coordinator position spends a lot of time on the phone and is a very time consuming position. However, it is **EVERYONE’S** responsibility to answer the phone.

    - Anytime you are not on a call or in the middle of something and the phone is not getting answered, you need to answer the phone.
- Headsets are allowed to free hands and make things more comfortable in the call center **BUT** they must be clear. If you are on the phone and an insurance rep has a hard time hearing you, switch to the regular handset.

The clinical team (assistants, hygienists and doctors) are primarily focused on our patient's treatment in the operatories where usually there are no phones. For this reason the "Phone Hierarchy" is as follows:

- 1st ring - Front desk/scheduling coordinator
- 2nd ring - (same as 1st plus…) Treatment Coordinators and Office Managers
- 3rd ring - (same as 2nd plus…) RDA's / RDH's

If someone after you in the hierarchy is forced to answer ahead of you then you've misunderstood the urgency and legitimacy of the hierarchy and therefore your role within the company. The urgency of answering the phone cannot be understated such that the volume of ringers should remain high so as to not be ignored. It is very important to always answer with a smile and that your smile is reflected in your voice.

Always use the standard phone greeting:

***"Thank you for calling Thrive Dental and Orthodontics, this is (your name), how may I help you?"***

After your standard greeting and introduction, manage the call as best you can. Avoid transferring the call unless absolutely necessary and always introduce the call to the person you are transferring to (i.e. "John Smith is on park 1 and has a question about his treatment plan pricing") ***See Transferring / Parking Calls.**

The following is a list of the standard Thrive phone 'virtues' and 'sins'. Although they may seem simple and common sense, they need to be top-of-mind each time you answer the phone because they are our standards.

## Thrive Phone Virtues

1. **LISTEN** : Make sure to listen to the patient and DO NOT TALK OVER THEM. Patients want to feel heard and understood so let them explain.

2. **SPEAK CLEARLY:** Remove any gum, drinks, eating, music etc. from your area.

3. **EMPATHETIC**: Patients call in for all sorts of reasons but one of the top reasons is they are in pain. Be empathetic with patients and feel for them like you would family.

4. **IDENTIFY**: Clearly identify who you are, what location you are at and how you can help the patient.

5. **GRATEFUL**: Patients can choose about a million other offices but they chose Thrive. They are paying your bills and we must be grateful for them.

6. **POLITE**: Be more polite than you would think. Call patients by their first and last name or Mrs/Mr. Smith. We typically will do this until patients become long term patients and want us to call them strictly by their first name.

7. **CONFIDENT**: Be confident when talking. Speak up so patients can hear you.

8. **HELPFUL**: You are best seated to help patients. Find a solution for them.

Contrary to our virtues there is also a list of things you never want to say or do.

## Thrive Phone "Do not dos"

1. **DO NOT TALK TOO FAST**. You may have said the same thing one thousand times but this is the first time the patient has heard it so talk slowly .

2. **DO NOT BE UNPROFESSIONAL**: It is best to start off overly professional and as we slowly develop rapport with patients they may want us to be more casual but that will likely take several visits and getting to know the patient really well.

3. **DO NOT TALK TOO MUCH**: Be concise when talking to patients. Do not overly explain. Most calls should be only a few minutes long at a maximum.

4. **DO NOT LEAVE PATIENTS ON HOLD**. Do not leave patients on hold or park for more than 60 seconds.

5. **DO NOT ENGAGE**: Patients will call us upset for a variety of reasons that may be out of our control. Be professional and courteous to all patients.

6. **DO NOT TALK ABOUT MONEY**. We do not talk about treatment pricing over the phone except for common cash prices for certain procedures and new patient specials. If a patient would like to talk about their specific treatment plan, have a coordinator discuss it with them.

### Transferring / Parking phone calls:

- To place a call on "**PARK**" (Universal Hold) simply press the P1 or P2 button on your phone and the call will be put on hold on the next open line. Your phone will show a red light and any phone in the office can pick up that call.
    - **DO NOT** leave a call on park or hold for more than 1 min. Without either taking a message or letting the caller know what the status is.

- To **TRANSFER** a call to another location, while on the phone with the patient, click the transfer button and dial the other location's phone number. When they answer, explain to them that you are transferring a patient's phone call over to them and let them know what the patient wants and ask them to introduce themselves to the patient so that the patient is aware that the call has been transferred. Click send or B Transfer and the call will be transferred to the other location.

- Placing a call on **HOLD** only places the call on hold on that specific phone. It cannot be picked up from another phone.

## G. Scheduling

**(Refer to Scheduling Manual for detailed training and protocols)**

• The majority of inbound calls are new patients trying to schedule an appointment. This is the successful result of advertising and marketing investments. Therefore, it is the responsibility of whoever answers the phone to be mindful of those efforts and to secure a return on those investments. For this reason, scheduling appointments is one of the most important aspects of our job. If a prospective patient calls and doesn't make it on the schedule, WE'VE FAILED.

• Scheduling should be easy and convenient for patients regardless of their circumstances. Take whatever information they have to offer on the initial phone call (a contact phone number at minimum) and offer to contact them at a more convenient time to note whatever additional information is necessary. Always have a pen and paper prepared for any technical difficulty with computers.

• New patient registration forms are available on our website for patients to download and complete before they arrive for their appointment. We also send the patients a text with a URL link to the new patient forms online. Doing so will save them time on their initial visit.

Never let the phone ring more than 2 times, those are missed opportunities. Always answer the phone with a SMILE!! It sets the tone for the entire conversation. Everyone can tell by a person's voice what mood they are in and the type of person they are. We want the patient to think this is a nice enjoyable place to come to.

***"Thank you for calling Thrive Dental and Orthodontics. This is _____ how may I help you?"***
***"When was the last time you were in one of our offices?"***

(We don't want our patients to feel like we don't know who they are. This gives us the chance to find out if they are a current patient or a new patient.)

**1.** If they are a New Patient, double check that they are attempting to schedule at the location in which they called. Sometimes a patient will call Frisco and

want to schedule in Allen or vice versa. If the patient is calling to schedule at a different location, log in to chrome remote desktop and schedule them at the correct location. If you are busy and unable to remote into the other location, you can transfer them to the correct location and have the front desk schedule them from there (**See Transferring/Parking Calls**)

**2.** Ask the patient if any of their family members are patients here (if they are and they share the same address add them to that family file instead of creating a new patient file)

Always direct the patient to the day & time that you need filled. Don't let the patient direct you. Use your verbal's. Prime time appointments and Saturdays are the easiest to fill and should be offered last.

Be mindful of the number of actual operatory rooms and staff at each location and always try to schedule within each location's time guidelines. Each office has a designated lunch hour, however we do not close the office for lunch and we should not deny a patient an appointment at this time. (Again direct the patient where you need them)

Additional "ghost-op" rooms are used for various reasons in addition to scheduling (double booking when schedule is NOT full)

**We do not want patients waiting due to scheduling errors.**

Get the following information when scheduling a patient and
ALWAYS INITIAL THE APPOINTMENTS YOU MAKE:

**For every new patient you will need the following:**

1. **Patients first and last name.**
2. **Email**
3. **Date of Birth**
4. **Patient's cell phone number.**
5. **The referral source.**
6. The insurance company information.
7. The patient's employer, date of birth, social security information (this is needed for insurance and is HIPAA protected)
8. The primary subscribers' relationship to the patient.
9. The member/subscriber identification number
10. The group number
11. The providers/customer service # from the patient's insurance card
    a. If the patient is not comfortable giving us personal information over the phone let them know to come 45 minutes early to their appointment so we can verify insurance
    b. Also, let the patient know we file insurance as a courtesy to them and in order to do so we need that information or else they will have to pay as a cash only patient.

If you cannot get all of that information at least get 1-5 and book the appointment and **BOOK AN APPOINTMENT**. Ask the patient if you can call back to gather further information. Remind them that if we do not have that information at least 24 hours before their appointment that may extend their appointment time.

If a patient shows up to the office without a full breakdown being complete use all of your ressources to get the necessary information and bring them back to the operatory. You do not need a full breakdown to start x-rays and an exam.

## H. Verbals

***"Good morning/afternoon Mrs./Mr. Smith this is _____ from Thrive Dental.***
***I am calling to confirm your appointment for 11 am on Tuesday in (Office location) for your new patient exam. Please call our office as soon as you get this to confirm your appointment as we require a verbal confirmation to keep your appointment on the schedule.***
***Thank you and we look forward to hearing from you."***

Notate in the CommLog that you attempted to contact the patient, what number you called, and your initials.

**Removal from Schedule Call**

- If the patient does not confirm their appointment by 12 pm for the next day we must break the appointment and move it down off the schedule.

- It is now your responsibility to contact our unscheduled treatment list, broken appointment list, or recall list to fill that broken appointment with an MVP patient. ( **See MVP Scripts**)

***"Good afternoon Mrs. Smith, this is _____ from Thrive Dental. We have not been able to contact you regarding your appointment for tomorrow therefore we will be taking you off the schedule to give your appointment to someone on our waiting list.***
***Please call us back to schedule a new time that works better for you.***
***Thank you and have a great day!"***

Always notate any communication with patients in the CommLog and initial your note.

Once the patient is moved immediately start contacting patients on the unscheduled treatment list and broken appointment list and try to get them in as our MVP patients.

**The flow of confirmations:**

1. The patient makes an appointment and lighthouse immediately emails them the appointment time. The patients cannot confirm at this point, they are only notified of the appointment.

2. 2 days before their appointment, lighthouse will text or email the patients to confirm their appointment. If an office does not have lighthouse chair 1 will call/text for appointments that are the day after tomorrow.
    a. If the patient does not confirm by 5 pm for the appointments 2 days from today they will be moved to the ghost column.
3. 1 day before the patient's appointment chair 1 calls/texts before 10 am.
    a. If the patient does not respond by 12 pm the appointment is broken and moved off the schedule.
        i. Chair 1 will call/text the patient by 1 pm to let them know their appointment has been removed.
4. Immediately contact the available patient lists to search for an MVP patient.

**<u>Cancellation Verbiage</u>**

> **When a patient calls to cancel you must first, place them on hold to read through all commlog notes and see how many times they have cancelled in the past (if any).**

**First Cancellation:**

***"Mr. / Mrs. Patient, is there any way I can help you keep your appointment for today? We did have (amount of time) reserved on our schedule just for you. We can see you a little bit later / earlier to help accommodate for your situation"***

- If the patient keeps their appointment let them know that we appreciate them. "Mr Patient, thanks so much for keeping your appointment today. We look forward to seeing you shortly!"
- If the patient still cancels: **DO NOT** give them another prime time spot (prime time = first thing in the morning, in the late afternoon or a Saturday). Schedule them wherever you need spots filled (TODAY OR TOMORROW) and **ALWAYS** notate their cancellations and their reasons for cancelling in the commlogs. Ie:

**Second Cancellation:**

Ask them to hold and read through their commlogs
***"I see this is your second time that you haven't been able to make your appointment. We do try our best to try and schedule Dr Fazal's time very strategically because we do have a lot of patients wanting to get in to see her. Is there no way that you can make it to this appointment?" they say no, you say "okay well we understand" schedule them three weeks out.***

**Third Cancellation:**

Place them on hold, read through history, bring them back on the line and say:
***"Gosh I hate to hear that you won't be able to make your appointment today, Mrs Patient. I do see here that this has happened a few times in the past and I understand how busy your schedule must be. How about we go ahead and place you on our VIP priority list which is that any pt that has to make a last minute schedule change like you have this morning, we put them on our VIP list and if we have any last minute openings we can reach out to you and call you and see if you'd be available that same day if it would work with your schedule! How does that sound to you?"***

VIP list = ASAP list.
ASAP list: In order for the pt to show up on the ASAP list, they MUST have an appointment on the schedule (the broken appt we leave on the schedule is fine just check that little ASAP box on the appointment)

**In Network vs Out of Network Questions:**
• We accept **ONLY** PPO plans
• We are In Network with most PPO plans

## Billing Questions:

Most patients do not understand their EOB (explanation of benefits). It is very complicated and usually arrives at the patient's house 2 weeks before the office gets it. The EOB may not match up to what we have offered the patient and many times they will be paying a lot less than what their EOB states so the patient is confused.

Make sure to reference the treatment plan that was scanned into the patient's chart for all billing questions as they should be clearly marked there.

If it is a question you cannot easily answer, have them direct the question to the manager.

**If you do not know the answer do not make it up**. Nothing is worse than you telling them something that is incorrect and the manager having to reconcile any mistakes that were said.