eServices

eTrans 5.0/5.1 for Dentrix

USER'S GUIDE

For customers in Puerto Rico

HENRY SCHEIN®

PUBLICATION DATE

October 2011

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LICENSES AND TRADEMARKS

Contents

Introduction

Welcome to eTrans for Dentrix. eTrans simplifies the complex and time consuming task of sending insurance claims by allowing you to send claims electronically through the Office Manager. Using eTrans will lead to faster resolution of your claims and give you the time you need to interact with your patients.

With eTrans, the cost of sending claims electronically is significantly lower than the cost of sending paper claims. eTrans saves time, materials, and postage. (If your primary claim cannot be sent to the payor electronically because the insurance company is not found on the Electronic Payor List, you can use "PR000." If Inmediata has the insurance company listed as a valid payor, they will send it electronically; otherwise, you will need to print and mail the claim.)

When you send e-claims through eTrans, your claims arrive at the insurance company faster and go directly into the insurance company's computer. So, your office receives payment in about half the time it would take you to receive payment if you had mailed the claims.

This guide includes all the information you need to use eTrans quickly and easily.

Minimum System Requirements

- Dentrix 11 or higher
- Modem or Internet connection capabilities

Note:

- Software modems (also called "winmodems" or "softmodems") are not recommended for use with this program.
- If you will be sending your existing paper documents electronically, you must have a 32-bit TWAIN-compliant scanner.

Enrolling and enabling eTrans

To enroll in eTrans, you must do the following:

- Obtain a registration form from eServices Sales (1-800-734-5561, option 2) and complete the registration form.
- Print the Practice Organization List (for more information, see "Practice Organization List" on page 25).
- Send both documents to eServices Sales (for details, call 1-800-734-5561, option 2).

Special Enrollment

Some insurance payors require notification before they will accept claims electronically from your office. These payors are identified on the Electronic Payor List, which is included in your Welcome Kit and can be found online at www.dentrix.com/eservices (click **Payer Search Tool**).

Until the insurance payors have received e-claims notification from your office, you must print these claims and mail them to the payor. When you receive confirmation from the payor that the notification has been received, you can enter the proper Payor ID and begin sending claims to that payor electronically.

Note: Until confirmation is received from the insurance company, claims submitted electronically to that insurance company will be rejected.

Special Enrollment Forms

Special Enrollment Forms and instructions for completion and processing of these enrollment forms are outlined on the front page of each special enrollment packet. Contact the eServices Enrollment department (see "How to Get Help" below) for more information about these forms or to receive additional Special Enrollment forms.

How to Get Help

Should you have questions about eClaims, the eServices department of Henry Schein Practice Solutions is available to provide you with exceptional customer service and support. You can reach the eServices department by calling 1-800-734-5561. When you call the eServices department of Henry Schein Practice Solutions, you have the option to speak with technical support, sales, finance, or enrollment. Use the following guidelines to decide which resource will be able to best help you:

- **Technical Support** – Option 1
    - Installation, setup and use of eClaims
    - Reading or printing reports
    - Claim tracking
- **Sales** – Option 2
    - New sales of eTrans
- **Billing** – Option 3
    - Billing questions
    - Changing pre-authorized payment selection
    - Reconciling invoices to statements or reports
- **Enrollment** – Option 4
    - Registration
    - Special Enrollment
    - Change in Federal Tax ID numbers
    - Adding new providers to your practice

eClaims Tracking

To track the status of your claims, contact Inmediata at (787)-783-3233, send e-mail to

infopr@inmediata.com, or visit their website at www.inmediata.com/hipaa/

eServices Customer Support

Toll-free telephone support is available only to registered eTrans users. Support is limited to the current version of the software and one prior release. When calling Support, be near a computer running the Dentrix and eTrans software programs, and have a copy of the *eTrans User's Guide* available. Be prepared to give the following information:

- Your name and the name of the practice
- The Dentrix customer number assigned to the practice
- The version number of the product(s) being used

- The type of network being used, if any
- The version of Windows installed on the computer
- The exact wording of any messages that have appeared on the screen
- The circumstances surrounding the question or problem
- Steps that have been taken to reach a solution

The eServices Support department has training and experience in supporting the Dentrix software but are not authorized to answer questions or solve problems relating to your hardware, network, or operating system. Operating system questions can sometimes be answered by reading the Windows documentation. For help with computer or network maintenance, please contact a qualified integration specialist who offers help with installation and ongoing service and support.

Setting up eTrans

Before you can use eTrans to send insurance claims electronically, you must set up eTrans in Dentrix and test the connection to the eTrans server.

To set up eTrans

In the Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Electronic Claims Setup**.

The **eTrans Setup** dialog box appears.

The **eTrans Setup** dialog box is divided into these sections:

- User Settings
- File Transfer

- Post Submission
- Advanced Options

These are explained in the sections that follow.

Note: All the setup options are workstation-specific (you must perform the setup on all computers from which you plan to submit e-claims using eTrans).

Setting Up the User Account Settings

As part of the set up, you can enter your user ID and password, and you can register to use eTrans (if you have not already done so).

To set up the user account settings

1. In the **User ID** field, enter your user ID that was e-mailed to you with your eTrans Welcome Kit (for example, 019036PRE).
2. Click **Change Password**.
3. In the **New Password** field, type the password that was e-mailed to you with your eTrans Welcome Kit.
4. Type the password again in the **Confirm Password** field.
5. Click **OK**.
6. If you have not already registered using the registration form from eServices (see "Enrolling and enabling eTrans" on page 4), you can click **Register** to open the eServices Registration Wizard from which you can register eTrans.

Important: Do not use the Registration Wizard to register eTrans if you have already sent the registration form.

Note: You must complete the eTrans Registration process before you can begin using eTrans.

Setting the Connection Method

You can specify the type of connection you are using to submit e-claims: dial-up or Internet.

To specify the connection method

1. Under **Connection Method**, select the connection method that applies to your office:
   - **Internet –** Select this connection method if you have any type of Internet connection in your office.
   - **Dial-up –** Select this connection method if you do not have any type of Internet connection in your office, and you are going to connect through an eServices department server.
2. If you selected **Dial-up** as your connection method, click **Dial-up Settings** to open the **eTrans Dial-up Settings** dialog box.
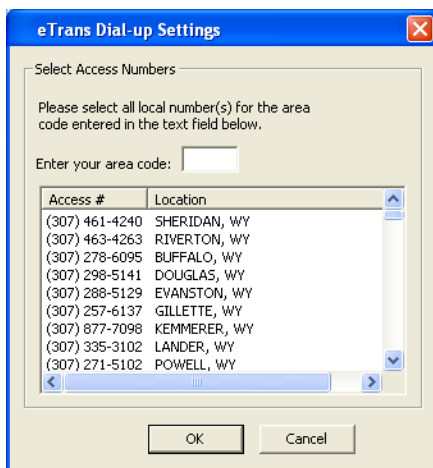
3. Enter your area code in the field provided, and then select the local phone number(s) for your area code. The number(s) you select will be used to connect to the eTrans Server when you send your e-claims.

4. Click **OK**.

Setting the Post Submission Option

When you submit an electronic claim, the Error Report is automatically displayed when there are claims that have errors or need attention. You can specify if you do not want this report to be displayed when there no are claims that need attention.

To specify whether the Error Report will appear if there no are claims that need attention

Under **Post Submission**, clear the **If no claims need attention, do not display Error Report** check box.

Setting Advanced Options

To set the Advanced setup options

Click **Show Advanced** to display and change any of the following advanced eTrans transmission options:

- **Server -** This field displays the name of the eTrans server to which you are connecting to send your e-claims. Do not change this information.

- **Port -** This field displays the number through which you are connecting to the eTrans server to send your e-claims. Do not change this information.

- **eClaims Path -** This is the path where your eTrans program files are saved on your computer.

- **Suppress warning messages on validation reports -** When selected, this option suppresses warning messages on Validation Reports so that you are not notified if there are problems with your e-claims.

Click **Hide Advanced** to hide the advanced options.

Saving Changes

Click **OK** to save your changes. Or, click **Apply** to save your changes but not exit the **eTrans Setup** dialog box.

Testing Your eTrans Server Connection

It is important for you to test your eTrans connection to ensure that you are connecting to the eTrans server properly so that you can send your claims electronically.

Note: If you are sending electronic claims over the Internet with a dial-up connection, you will usually need to connect to your ISP before testing your connection or sending claims.

You can test your eTrans connection two different ways:

To test your eTrans connection using the Test Connection button

1. In the Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Electronic Claims Setup**.
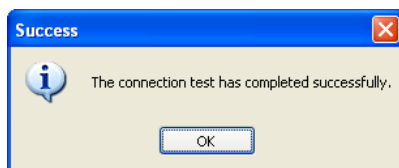
    The **eTrans Setup** dialog box appears.

2. Click **Test Connection** to test your eTrans Server connection.

    The **Test eTrans Connection** dialog box appears with the status of the connection test.
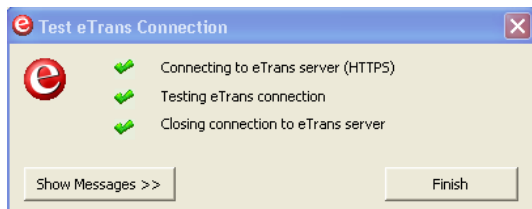
    When the process has been completed successfully, a message appears and states that your reports have been retrieved successfully.

3. Click **OK** to close the message and return to the **Test eTrans Connection** dialog box.

4. If you want to view a detailed log of the transmission, click **Show Messages >>**.
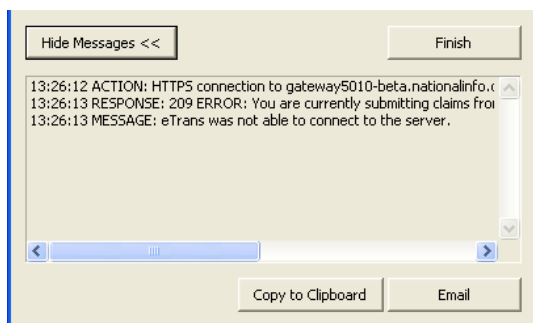
    The expanded dialog box, provides the following options for the log:

    •   **Copy to Clipboard** – If you want to copy the output log to the Windows clipboard to be pasted into another program, click **Copy to Clipboard**.

    •   **Email** – If you want to send a message containing the output log, click **Email**.

5. Click **Finish** to close the **Test eTrans Connection** dialog box.

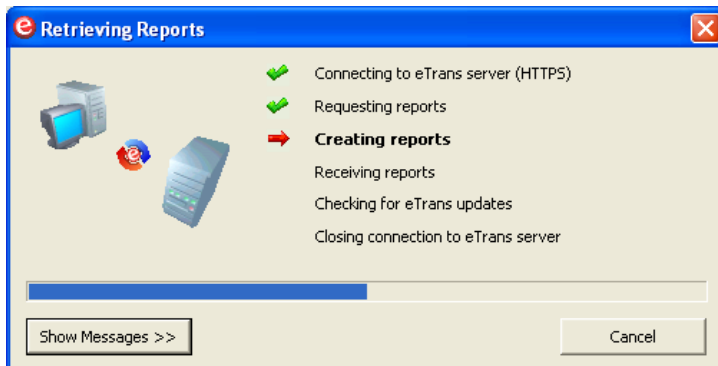**To test your eTrans connection using the Retrieve Reports option**

1. From the Dentrix Office Manager toolbar, click the **Electronic Claim Submission** button.

    The **Electronic Claims Submission** dialog box appears.
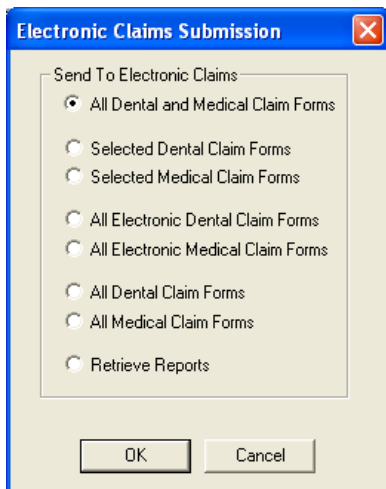
2. Select **Retrieve Reports**, then click **OK**.

    The **Retrieving Reports** dialog box appears, detailing the status of the transmission.

    Note: This option is normally used to retrieve new reports on claims you have already sent, but you can also use it to test your connection.

    When the process has been completed successfully, a message appears, stating that your reports have been retrieved successfully.

3. Click **OK** to close the message.

4. Click **Finish** to close the **Retrieving Reports** dialog box.

Specifying Direct Print Options

You can have your insurance claims directly printed or sent to the Batch Processor when they are created. If you are sending claims electronically, you should send claims to the Batch Processor so that you can send them electronically from the Office Manager.

To set up direct print options

1. Open the Ledger.

2. From the **File** menu, click **Direct Processing Options Setup**.

   The **Direct Processing Options Setup** dialog box appears.
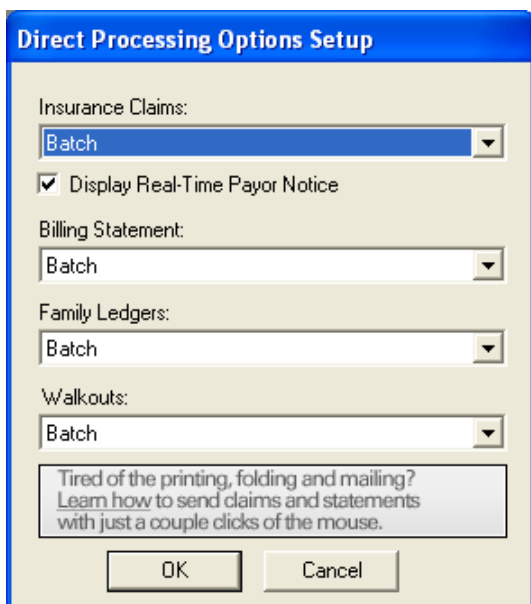
3. Under **Insurance Claims**, select **Batch**. When you create insurance claims, they will be sent directly to the Batch Processor, so you can send the claims electronically from the Batch Processor at any time.

Downloading eTrans Updates

Occasionally, updates become available for you to download from the eTrans server. When an update is available, the **New eTrans Client Available** dialog box will appear after you submit electronic claims.
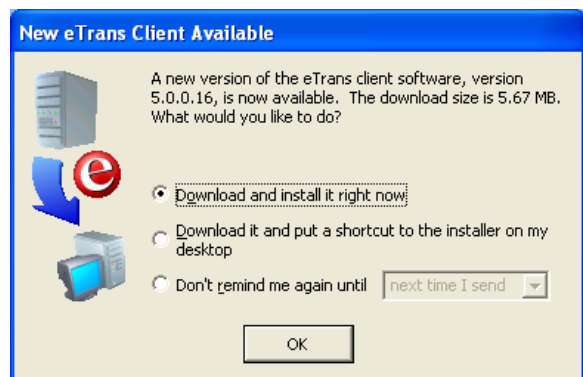
To upgrade the eTrans software

1. When the **New eTrans Client Available** dialog box appears, select one of the three options:
   - **Download and install it right now**
   - **Download it and put a shortcut to the installer on my desktop**
   - **Don't remind me again until**...(If you select this option, select the desired option from the menu.)

2. After you have selected the desired option, click **OK**.

   If you selected the **Download and install it right now option**, a progress indicator appears.

Updating Payor ID Numbers

The eServices department assigns electronic payor numbers to the insurance providers that will receive electronic claims from your office. These numbers, called Payor ID numbers, act like an address that directs the electronic claims to the correct insurance company.

You can find a complete list of Payor ID numbers in the **Insurance Data** dialog box. If you have not used eClaims before, this field may be blank. In order to send electronic claims, you must set up Payor ID numbers for the insurance carriers to whom you will be sending electronic claims.

It is recommended that you update your payor ID numbers after each installation. So, if you already have payor ID numbers that were assigned during a previous eTrans installation, update your payor ID numbers for each subsequent eTrans update. The eServices department maintains a list of payor ID numbers for most available insurance companies. The information is available at www.dentrix.com/products/eservices/eclaims (click **Payer Search Tool**).
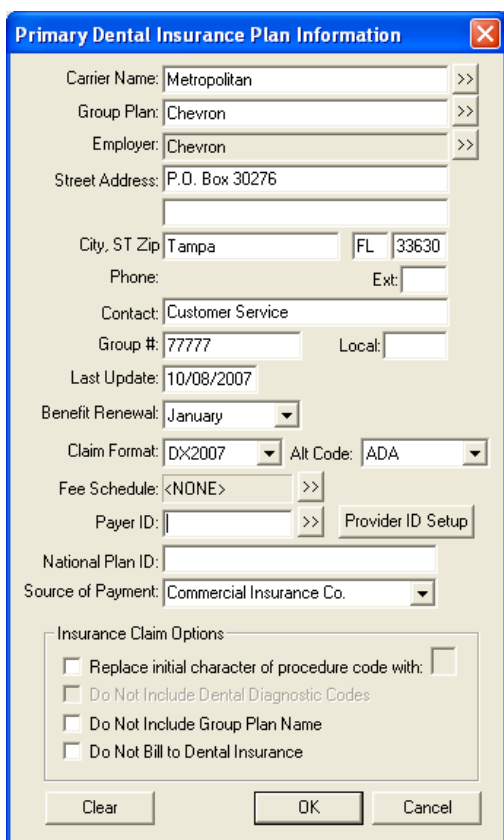
To update Payor IDs

1. Double-click the **Insurance Information** block in the Family File.

    The **Insurance Information** dialog box appears.

2. With the appropriate Carrier selected, click **Insurance Data**.

    The **Primary Dental Insurance Plan Information** dialog box appears.

Primary Dental Insurance Plan Information

Carrier Name: Metropolitan

Group Plan: Chevron

Employer: Chevron

Street Address: P.O. Box 30276

City, ST Zip: Tampa   FL   33630

Phone: Ext:

Contact: Customer Service

Group #: 77777   Local:

Last Update: 10/08/2007

Benefit Renewal: January

Claim Format: DX2007   Alt Code: ADA

Fee Schedule: <NONE>

Payer ID: Provider ID Setup

National Plan ID:

Source of Payment: Commercial Insurance Co.

Insurance Claim Options
- Replace initial character of procedure code with:
- Do Not Include Dental Diagnostic Codes
- Do Not Include Group Plan Name
- Do Not Bill to Dental Insurance

Clear   OK   Cancel

3. Click the Payer ID search button to display a list of available Payor IDs. Select the appropriate payor ID from the list.

Note:

- If you cannot find the payor ID, enter 06126.

- If there is a Payor ID on the eServices Electronic Payor List that is not listed in the **Select Payor ID** dialog box, you can enter that number directly into the **Payor ID** field.

- Do not contact the insurance company for a Payor ID number; these are assigned by the clearinghouse.

Sending Electronic Claims

Using eTrans, you can transmit insurance claims electronically from your Dentrix practice management software to the insurance carriers. Electronic claims can only be sent from a computer with an Internet connection and/or a modem.
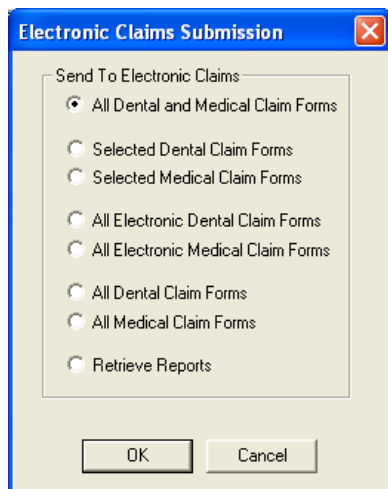
To send electronic claims

1. In Dentrix, create an insurance claim and send it to the electronic claims batch.

    Note: For information about creating insurance claims, refer to the Dentrix Help or user's guide.

2. When you are ready to submit your claims, select the claims you want to send (if you want to send specific claims), and then click the Electronic Claim Submission button [⚡] on the Office Manager toolbar.

The **Electronic Claims Submission** dialog box appears.

Under **Send To Electronic Claims**, select one of the following options:

All Dental and Medical Claim Forms – To submit all dental and medical claims (electronic and non-electronic).

- **Selected Dental Claim Forms** – To submit only the dental claims you have selected in the Batch Processor.

- **Selected Medical Claim Forms** – To submit only the medical claims you have selected in the Batch Processor.

All Electronic Dental Claim Forms – To submit all the electronic dental claims.

- **All Electronic Medical Claim Forms** – To submit all the electronic medical claims.

All Dental Claim Forms – To submit all the dental claims (electronic and non-electronic).

- **All Medical Claim Forms** – To submit all the medical claims (electronic and non-electronic).

Retrieve Reports – To get reports regarding the claims currently listed in the Batch Processor.

3. Click **OK**.

   The **eClaims Pre-submission Summary** dialog box appears.

   Note: You can specify selected claims to send by selecting those claims in the Batch Processor and selecting the **Selected Dental Claim Forms** or **Selected Medical Claim Forms** option.

4. eTrans performs a check on all of the claims you are sending, and each claim is given one of three statuses:

   - **Validated –** This status is assigned to claims that contain all the required information and are ready to be sent electronically.

   - **Warning –** This status is assigned to claims that are missing information (such as payor ID numbers, insurance plan numbers, and so forth). This status is also assigned to claims that require attachments (such as X-rays, panoramic films, periodontal charting information, and so forth). You can send claims with a Warning status to the insurance company/payor, but it is recommended that you correct the information on the claim before you send it.

   - **Rejected** – This status is assigned to claims that have an error that would cause the insurance company to reject the claim. If the error is caused by information included on the claim, delete the claim from both the Batch Processor and the Ledger, correct the error(s), recreate the claim, and re-send it to the Batch Processor for processing with your next batch of claims.

   Check the eClaims Pre-submission Summary for claims with a Warning or Rejected status. If there are any claims with a status of Warning or Rejected, click the **Edit** link in the **Status** column to display the **Edit Missing Claim Information** dialog box. For more information, see "Editing Electronic Claims" on page 22.

   Note: You can click **Print Report** in the **eClaims Pre-submission Summary** dialog box to produce a working copy of the Pre-submission Summary. You can use this report to see which errors need to be corrected on the claims before they can be sent. If you click **Print**, the claims will not be sent.

5. If you want to provide additional claims data that conforms to the new HIPAA 5010 standards (in effect as of January 1, 2012), click the **Add'l Data** link to display the **Add'l Claim Data for [patient]** dialog box.

Notes:

- To conform to the new HIPAA 5010 standards, your provider address information must include your 9-digit ZIP Code. You can look up your 9-digit ZIP Code on the U.S. Postal Service Web site. Go to zip4.usps.com, enter the address in the Required Fields, and click Submit.

- If you don't need to provide additional claims data, skip to step 6.

- For medical claims, the **Treatment Dates** and **Diagnostic Codes** tabs will not appear.

Review the claim information in the five tabs in the **Add'l Claim Data for [patient]** dialog box, and make any needed corrections. (Changes you make in this dialog box are not saved in the Dentrix database.

a. If you need to include treatment date information to successfully process the claim, on the **Treatment Dates** tab, enter the treatment **Start Date** and **End Date** (if known) for the procedures listed.

b. Depending on the procedure, you may need to provide a diagnosis code for the claim. On the **Diagnostic Codes** tab, you can provide up to four diagnosis codes to associate with the claim procedures.

Tip: If the listed procedures require more than four diagnosis codes, you should cancel the claim, divide it into multiple claims with fewer procedures per claim, and then resubmit them.

Note: Each time you successfully enter a **Dx Code** in one of the four fields, the next field becomes available. You can enter up to four diagnosis codes.

If more than one diagnosis code is entered, for each listed procedure, under **Diagnosis Code(s)**, select the diagnosis codes in descending order of importance.

c. On the **Provider** tab, in the **UPIN** field, specify the Unique Physician Identification Number for the billing provider and rendering provider. These will often be the same, but may be different if, for example, the rendering provider is the hygienist and all insurance billing is done under the dentist's UPIN. (If the UPINs were previously entered for the provider(s), the UPINs will automatically appear.)

d. If you need to include referring provider information, click the **Referring** tab.

On the **Referring** tab, specify the following information:

- **First Name, MI, Last Name** – Type the first name, middle initial, and last name of the referring provider in the respective fields.
- **NPI** – Type a valid National Provider Identifier number for the referring provider.
- **UPIN** – Type a valid Unique Physician Identification Number for the referring provider.
- **State License #** – Type the state license number for the referring provider.
- **Commercial #** – Type the commercial number for the referring provider.
- **Specialty** – Select the referring provider's specialty from the list.

e. When a patient or family has multiple insurance coverage, additional claim information may be required for other insurance subscribers (such as when a claim has been submitted to a primary payor and you are now submitting a claim to the secondary payor for the remaining amount). If this is the case, click the **Other** tab.

Under **Other Subscriber Information**, enter the balances for the **Remaining Patient Liability** and the **Total Non-Coverage Charges**. If applicable, under **Other Payor Information**, enter the **Claim Control Number** or Document Control Number assigned by the insurance company.

f. If you submit claims to Health Safety Network (payer ID MCMA1), the **HSN Info** tab appears, and additional information may be needed.

- Under **Plan Information**, specify the **Plan Type**: either **Full** or **Partial**. If you choose **Partial**, you will also need to specify a **Partial Coverage Start Date**, the date when partial coverage began.

- Select a **Deductible Status**: (**None**, **Open**, or **Met**).

- Specify the **Patient Amount Paid** and the **HSN Estimated Amount Due**.

- If the claim needs to be voided with the insurance company, select **This is a Voided Claim**.

g. If you are submitting secondary claims, you may need to use the **Claim Adjustment** tab.

- Under **Primary Claim Adjustments**, select a **Group Code**.

- Enter the **Reason Code** and the **Amount** and then click **Add**.

Note: You can add up to five claim adjustment reasons; when you reach this amount, the **Add** button is no longer available.

h. When finished, click **OK** to return to the **eClaims Pre-submission Summary** dialog box.

6. Once you have corrected the errors, click the **Electronic Claim Submission** button on the Office Manager toolbar to regenerate the eClaims Pre-submission Summary. Review the warnings and rejection errors, and make sure the claims you want to send electronically are selected (have a check mark next to them). By default, claims with the status of Validated or Warning are automatically selected, but claims with a status of Rejected are not.

Note: Make sure you complete this step and carefully review your claims before submitting them.

7. Click **Send Selected Claims** to send all the selected claims.

The **Sending Claims** dialog box appears.
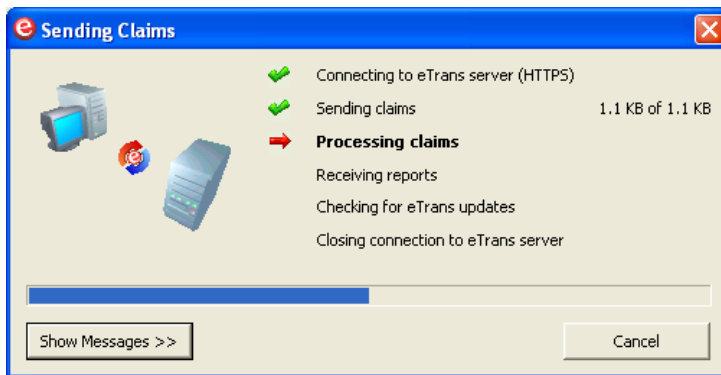
8. If you want to view a detailed log of the transmission, click **Show Messages**.
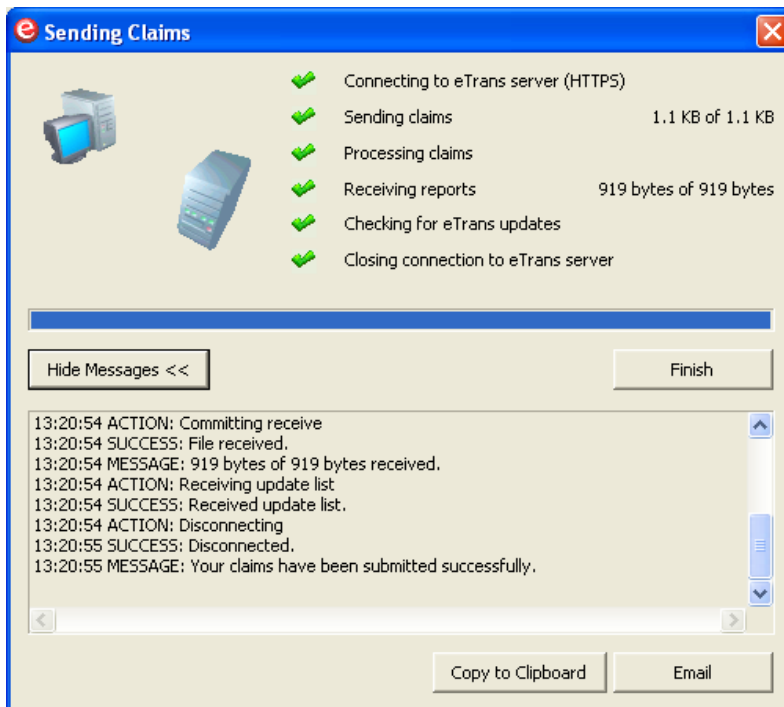
The expanded dialog box provides the following options for the log:

- **Copy to Clipboard** – If you want to copy the output log to the Windows Clipboard so you can paste it into another program, click **Copy to Clipboard**. (This is only necessary if there is a problem and a support representative needs the information for troubleshooting.)

- **Email** – If you want to send a message containing the output log, click **Email**.

9. After you send electronic claims, eTrans sends reports to the Batch Processor that you can view. These reports include the eClaims Pre-submission Summary Report and the Transmission Report. If any of the claims you sent were rejected, the Error Report will open on your screen after you send electronic claims. Review these reports to ensure that your claims are being processed and view important information about the electronic claims you have sent and your eTrans account.

10. Once the claims have been successfully transmitted, delete the claims from the Batch Processor.

Note: Deleting a claim in the Batch Processor does not delete the claim in the Ledger. The claim will still be available for access in the Ledger.

Editing Electronic Claims

You can add missing information on claims submitted electronically through eTrans.

Note: If the Place of Service code or Service Facility TIN is missing on a medical insurance claim, you must fix the error from the Ledger.

To add missing information on an electronic claim

1. For each rejected claim in the **eClaims Pre-submission Summary** dialog box, there is an **Edit** link. Click the **Edit** link to edit patient, subscriber, provider, and insurance plan information.

The **Edit Missing Claim Information** dialog box appears.

2. Add the necessary information on each tabbed page (all fields that are not disabled are required except for the second **Street** fields).

   Note: Changes you make in this dialog box are saved in the Dentrix database and reflected in the Family File and other areas of Dentrix the next time you open those modules.

   • **Patient tab** – The patient's **Date of Birth** and **Address**.

     If you want to use the subscriber's address, select the **Use Subscriber Address** check box to populate the fields with the claim subscriber's address. This check box is unavailable if all the required fields of the **Address** are filled in, if **Use Patient Address** is selected on the **Claim Subscriber** or **Other Subscriber** tab, or if there is no address for the claim subscriber.

   • **Claim Subscriber tab** – The **Date of Birth**, **Address**, and **Subscriber ID #** for the subscriber on the claim (primary or secondary, whichever applies).

     If you want to use the patient's address, select the **Use Patient Address** check box to populate the fields with the patient's address. This check box is unavailable if all the required fields of the **Address** are filled in, if **Use Subscriber Address** is selected on the **Patient** tab, or if there is no address for the patient.

- **Providers tab** – The **NPI** and **TIN#** or **SS#** for the **Billing Provider**, **Pay-To Provider**, and **Claim Rendering Provider**. (You do not need to type the dashes (-) when putting in the numbers.)

- **Insurance Plan tab** – The **Address** where claims are sent for the insurance plan.

- **Other Subscriber tab** – The other subscriber is the secondary subscriber if this is a primary claim or the primary subscriber if this is a secondary claim. The **Date of Birth**, **Address**, and **Subscriber ID #** for the subscriber on the claim (primary or secondary, whichever applies).

  If you want to use the patient's address, select the **Use Patient Address** check box to populate the fields with the patient's address. This check box is unavailable if all the required fields of the **Address** are filled in, if **Use Subscriber Address** is selected on the **Patient** tab, or if there is no address for the patient.

3. Click **OK** to apply the changes to the Dentrix database, update the claim, and return to the **eClaims Pre-submission Summary** dialog box.

   Note: There will be more claims listed when you return to the **eClaims Pre-submission Summary** dialog box than previously if additional electronic claims were sent to the Batch processor from another workstation while you were editing a claim.

4. Repeat steps 1 – 3 for any other rejected claim(s).

eTrans reports

When you send claims electronically, you receive reports containing important information about your claims and your eTrans account. Reading and understanding your eTrans reports will help you ensure that you receive payment in a timely manner. For steps on how to retrieve your eTrans reports, see "Testing Your eTrans Server Connection" on page 9.

There are two reports that will appear in your Batch Processor when you send e-claims: the eClaims Pre-submission Summary Report and the eTrans Transmission report. These reports are discussed in detail in the sections that follow.

Practice Organization List

When you enroll and enable eTrans (or any time changes are made in your practice organization), you must print and send a copy of the Practice Organization List to eServices Sales so that a representative can use your practice's information to create (or update) an eTrans account.

To print the Practice Organization List

1. In the Office Manager, from the **Reports** menu, point to **Reference**, and then click **Practice Organization List**.

2. Click **OK** to send it to the Batch Processor.

3. From the Batch Processor, select the report you want to print.

4. Click the Print Reports button.

5. Please review the Tax Identification Number (TIN), 4-digit site ID, and provider name for any of the *primary* providers before you send the report.

eClaims Pre-submission Summary Report

Before claims are transmitted, the eTrans software performs over 250 checks to assure that the information in the claims is complete and that the claims are ready to be sent to the insurance company/payor. The eClaims Pre-submission Summary Report shows you if your claims are Validated, Warning, or Rejected.

- **Validated** – Claims with a Validated status contain all the necessary information and are ready to be sent to the insurance company/payor.
- **Warning** – Claims with a Warning status are missing information that should be included with the claim. You can send claims with a Warning status to the insurance company/payor, but you should correct the information in the claim before you send it.
- **Rejected** – Claims with a Rejected status are missing information that will cause the claim to be rejected by the insurance company/payor. If the error is caused by information included on the claim, delete the claim from both the Batch Processor and the Ledger. Correct the error(s), recreate the claim, and re-send it to the Batch Processor for processing with your next batch of claims. You can send rejected claims by placing a check mark in the box under the status column, but this is not recommended.

A copy of the eClaims Pre-submission Summary Report will be placed in the Batch Processor after you send your electronic claims.

Note: The eClaims Pre-submission Summary Report is not a transmission report and is not an indication that you have successfully submitted your claims.

Transmission Report

The Transmission Report is a compilation of reports from Henry Schein Practice Solutions that is delivered after you send electronic claims. This report may contain any the following reports: the Confirmation Report and the Billing Statement. You can view each of these reports by previewing or printing the eTrans Transmission Report.

Confirmation Report

The Confirmation Report shows all the claims Henry Schein Practice Solutions received in a given transmission. Henry Schein Practice Solutions assigns a unique number to each claim on this report so that you can distinguish between the claims submitted for the same patient. The Confirmation Report also indicates whether each claim was accepted for electronic processing or was rejected before being submitted to the insurance company/payor. If a claim is rejected, the report will include information about the reason for the rejection. You should receive this report immediately after you submit claims. If you do not receive this report at the time of submission, resubmit the claims or contact eServices Support at 1-800- 734-5561 for further assistance.

Billing Statement

The Billing Statement is sent to you at the beginning of each month. This report contains a complete list of the claims processed by Henry Schein Practice Solutions during the previous month, some basic statistical data about the number of claims you have submitted, and the total charges to be remitted to Henry Schein Practice Solutions.

Depending on the payment method you selected when you registered for eTrans, the charge may be deducted automatically from a checking account or charged to a credit card.

Error Report

The Error Report appears after you send your claims electronically. This report only appears if one or more of the claims that you sent were rejected by the eServices department.

The top section of the Error Report displays claims and the statuses of those claims. The bottom section displays totals, such as the total number of claims rejected and dollar amount of those claims. The important information area serves as a reminder that any claim listed on this report needs your attention.

You can access the most recent Error Report that you received by right-clicking the eSync Reminder Icon and selecting **eClaims Error Report**.

Frequently Asked Questions about eTrans

This section answers frequently asked question about eTrans. Read these questions and answers before contacting eServices Support.

Sending eClaims

Q: When can I send claims?

A: Claims can be sent 24 hours a day, seven days a week. However, the high-peak transmission time is from 2:00 P.M. to 6:00 P.M. Mountain Time, Tuesday through Thursday. To avoid busy signals and connection difficulties, you may want to schedule your claims submission for the early morning hours.

Note: Occasionally, enhancements and maintenance are performed on our computers and other systems that may cause you to be unable to send claims. You will be notified in advance when this will occur. Maintenance will be done during non-peak hours.

Q: How many claims can/should I send at any given time?

A: You can submit up to 100 claims per batch. The eServices department suggests that you submit all of your claims for any given day in one large batch, either at the end of your work day or at the beginning of the following work day. Offices who submit one claim at a time frequently experience duplicate claim problems and confusion trying to match up reports. Submitting one large batch per day keeps your reports consolidated and easy to manage.

Q: How do I know if a claim was submitted successfully?

A: The status of each claim you send is listed on the Confirmation Report (part of the eTrans Transmission Report) that is delivered to the Batch Processor immediately following your transmission. If you do not receive this report, please contact eServices Customer Support at 1-800-734-5561, option 1.

Q: How do I resubmit a claim?

A: To resubmit a claim, you need to correct any erroneous information, delete and recreate the claim in the Ledger, and re-send it to the Batch Processor to go with your daily batch of electronic claims. The eServices department does not have the ability to resubmit claims for your office.

Q: How do I cancel or delete a claim once it has been transmitted?

A: Claims are processed in "real-time." That means as soon as your claim is received by the eServices department, processing begins. Therefore, we are unable to delete claims. Review your eClaims Pre-Submission Summary carefully before transmitting your claims to eliminate the possibility of sending claims you did not intend to send.

Q: Can I still submit a claim electronically if the insurance company is not found on the Electronic Payor List?

A: Yes. If the payor is not listed, use PR000. No active carrier needs to send paper claims.

Q: Now that I send claims electronically, does that mean I don't have to follow up with insurance companies?

A: We recommend that you follow up with insurance companies after 30-45 days about outstanding claims that have been submitted but not settled. eTrans claim submission is a service that provides you with faster claim submission and tracking information. The insurance companies are still responsible for processing and paying your claims.

Changing Account Information

Q: Do I need to notify anyone if I add a new dentist to my practice?

A: Yes! It is extremely important that you notify the eServices Enrollment department prior to submitting claims for a new dentist. Otherwise, all claims for this provider will be automatically rejected. eServices Enrollment can be reached at 1-800-734-5561, option 4.

Q: Do I need to notify anyone if I have a new address, telephone number, or tax identification number?

A: Yes! It is extremely important that our records be as accurate as possible. So, it is important that you relay any changes made to your account to the eServices Enrollment department at 1-800-734-5561, option 4. Changes to your tax identification number must also be communicated directly to all insurance companies to whom you submit claims through eTrans. Changes made to your eTrans enrollment are not necessarily picked up by the insurance companies. Therefore, they must be notified directly. Any changes not properly communicated to the eServices Enrollment department and/or the insurance companies can result in claim delays and/or rejections.

Q: What does the asterisk next to an insurance company found on the Electronic Payor List mean?

A: Those insurance companies that are marked with an asterisk require notification that you are going to be submitting claims to them electronically. Therefore, it is vital that you contact eServices Enrollment at 1-800-734-5561, option 4 and complete the proper paperwork before submitting claims to these companies. For more information, see "Special Enrollment" on page 4.

Billing

Q: Why did I receive a billing statement with a $0 balance?

A: Billing statements are generated and sent automatically, even for customers who regularly have a $0 balance.

Support

Q: What if an insurance company says they never received my claim?

A: Verify the claim information (name, Social Security number, date of birth, group ID, and so forth) with the insurance company. If the correct information was submitted and the claim was submitted through eTrans, contact eServices Customer Support at 1-800-734-5561, option 1.

Note: The eServices department is unable to research any claim that is older than six months from the submission date. Please run an Insurance Aging Report from Dentrix on a regular basis to ensure that claims are not aging more than 45-60 days.

Q: Who do I call if I have questions or concerns?

A: Depending on the type of question you have, you can contact one of the Support teams listed below:

- For claim tracking issues, contact Inmediata at (787) 783-3233.
- eServices Customer Support is available at 1-800-734-5561, option 1 to help you with installation and setup problems and software-related troubleshooting.
- If you have claims which are rejected because the "provider is not registered for ECS or is invalid," or if you know you are going to need to request special enrollment with an insurance company, contact the eServices Enrollment department at 1-800-734-5561, option 4.

Henry Schein Practice Solutions hours of operation are Monday through Thursday from 6:00 A.M. to 6:00 P.M. Mountain Standard/Daylight Time, and Friday from 6:00 A.M. to 5:00 P.M. Mountain Standard/Daylight Time.

Technical Troubleshooting

Q: When running the eTrans installation, I get the message, "Setup could not detect an installed TCP/IP protocol. Your computer does not appear to be set up to connect to the Internet. Please make sure to get an Internet connection before trying to send claims."

A: When you tell the installation program that you want to send claims over the Internet, it tries to determine whether or not your computer can connect to the Internet. If it can't verify the connection, you get this warning. If you know that you have an Internet connection, you can safely ignore this message.

Q: When I select a Dial-up install, the installation program displays a message asking me to insert my Windows CD. What should I do?

A: If you have your Windows CD, insert it into the CD-ROM drive. The eTrans install is trying to install Dial-up Networking, and it requires some files on the Windows CD. If your computer did not come with a Windows CD, the files are probably on your computer. If you do not feel comfortable installing operating system components, have your technician help you with this part of the installation.

Q: I installed eTrans to send claims over a dial-up connection, and now I want to send them over the Internet. What do I do?

A: In the Office Manager, from the **Practice Setup** menu, click **Electronic Claims Setup**. Change the **Connection Method** to **Internet**, and click **OK**.

Q: Why is my dial-up networking or Internet connection suddenly unable to connect to the eTrans server to transmit my claims?

A: If you are trying to submit claims during a high-peak time (between 2:00 P.M. and 6:00 P.M. Mountain Time, Tuesdays through Thursdays) and receive an "unable to connect" message, you may be calling during an extremely busy time. Early morning is the best time to transmit easily and quickly.

Q: What does the message "No Dial tone" mean?

A: Your modem is not able to get a dial tone. Check all connections between your computer and the telephone jack. Also, check the telephone line for a dial tone. If you still have no dial tone, contact your telephone company.

Q: What does the message "Could not initialize modem" mean?

A: For an unknown reason, your modem is not responding. You will need to reset your modem:

- **Internal modems** (inside your computer) – Exit all running software programs, turn your computer off, count to five, turn your computer back on, and try submitting claims again.
- **External modems** (outside your computer) – Turn your modem off, count to three, turn your modem back on, and try submitting claims again.

Note: Any problems with your modem or incorrect communication settings in your software or hardware setups will cause this message. If resetting the modem does not work, have it checked out or replaced by a professional technician.