Δ delta dental°

Dental Office Toolkit (DOT) Quick Guide

How to submit a pre-treatment estimate

- On the DOT home screen, click Change Member.
 Image 1
- 2. Enter the following subscriber information:
 - Delta Dental Member ID or SSN
 - Date of Birth
 - First Name
 - Last Name

All fields are required. Click Search.

Image 2

3. Using the Selected Member ID drop down menu, select the patient for this estimate.

Image 3



2		TAL [®] Dental Office Toolkit	Welcome, Name! LOGOUT		
	SELECTED SERVICE OFFIC First Name Last Name [License	E: HOME OFFICE e No.] Street Address, City, State	CHANGE OFFICE	Selected Member ID:	CANCEL
	Standard Programs Federal Government Programs	Service Office Det	e Details		FIRST NAME
	Q Search	First Last Street Name	License Number: NPI Type 1: XXXX	DATE OF BIRTH mm/dd/yyyy	LAST NAME
	Ø Office	City, State ZIP Code	Tax ID: XXXXXXX	•	SEARCH
	Office Details Foo Schodulor	Service Office NPI Type 2: XXXXXXXX	Business NPI Typ Payment Method:		RESET



4. Click the Member tab on the left navigation bar.

Image 4

5. Once the Member tab is open, click Enter Claim / Pre-treatment Estimate.

Image 5

6. Verify that the Selected Service Office at the top of the screen matches the provider and location associated with the treatment.

If this information is not correct for the pre-treatment estimate you will be submitting, click **Change Office**.

Image 6

7. Choose to submit a claim for the patient or for a family member of the patient.

Image 7

First Last License Number: XXXX		
	XXXX	
Street Name NPI Type 1: XXXXXXX		
City, State ZIP Code Tax ID: XXXXXXX		
Service Office NPI Type 2: Not on file Business NPI Type XXX	xxxxx	
rce Details Payment Method: XXXX	XXXX	
e Schedules THIS IS YOUR HOME OFFICE Par Status:	Par Status:	
ect Deposits Delta Dental Premier©		
To access EFT/ERA information from other Delta Dental companies on the Delta Dental National Portal, click HERE.		



5	SELECTED SERVICE OFFICE:	CHANGE OFFICE	Selected Member ID:	CHANGE MEMBER	
			First Last		
	Standarg Programs Federal Government Programs Enter Claim / Pre-treatment Estimate Control The claim will be submitted for this treating DDS: First Last XXXXXX Street Name, City, State ZIP Code				
	O I'd like to submit this claim for this patient: First Last				
	Office I'd like to submit this claim for a family member not listed.				
	L Member				
	Member Details & Repetits				

7	SELECTED SERVICE OFF		HOME OFFICE	CHANGE OFFICE	Selected Member ID: xxxxx2222 First Last	CHANGE MEMBER
	Standard Programs Programs Programs Programs Programs Provide Programs Programs Provide Provid					
	The claim will be submitted for this treating DDS: First Last XXXXXX Street Name, City, State ZIP Code					
	Office I'd like to submit this claim for this patient: First Last I'd like to submit this claim for a family member not listed.					
	L Member					

- 8. Scroll down to enter Treatment Details. Enter the following:
 - Tooth Number
 - Area of Arch
 - Surface(s)
 - Procedure Code
 - Submit Amount

Check the Pre-Treatment Estimate box.

Fill in other claim details as needed for the pre-treatment estimate.

Image 8

9. If the service(s) require additional documentation, click **Choose** or drop files under Claim Attachments.

Image 9

10. Check the box if Coordination of Benefits (COB) does not apply to this claim. Click **Submit Claim** to generate a pre-treatment estimate.

Image 10

11. View your pre-treatment estimate.

Some CDT codes require additional review and will not process immediately. The claim status will appear as *Routed* and/or *In Process*.

Image 11



9 1000 Anis And Bulkaciji Predmet Ball Predmet Gall Bulkaciji 0 0 0 0 0 0 0 0 0 0 0 0 0 Attract Menter 0 Attract Menter -</td



11 O Office	Pre-treatment Estimate C	aim < CREATE ANOTHER CLAIM
L Member	Patient Information	Claim Information
0	Patient Account Number: XXXXXXXX	Receipt Date: xx/xx/xxxx
Admin	Patient Name: First Last	Process Date: xx/xx/xxxx
	Date of Birth: xx/xx/xxxx	Claim Number: XXXXXXXX
	Relationship Code: XXXXXXXXX	Claim Type: Pre-treatment Estimate
	Subscriber Name:	Claim Status: In Process
		Other Carrier Payment:
	Dentist Information	
	Dentist Name: First Last	PRINT CLAIM DETAIL
	License Number: XXXXXXXX	
	Dentist TIN: XXXXXXXX	SUBMIT FOR PAYMENT
	Specialty:	
	Other Carrier:	CANCEL CLAIM This claim cannot be cancelled.