VYNE DENTAL

Your Guide to Dental Claims Processing

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Guide to Claims Processing

Office managers organize the nuts and bolts of a practice – they keep the wheels turning. Your day is demanding, between organizing schedules, overseeing staff, advocating for your patients, and navigating insurance claim processing.

To help tackle your insurance battles we created this guide to dental claims processing.

Even if you are a master at working with insurance payers and keeping the books, these articles, code guides, and insider knowledge can guide you exactly to what you need to process claims faster and focus on what matters – your patients and practice.

This information guide covers the nitty-gritty of claims submissions:

- How to help keep claims from being rejected
- EOBs
- An insider look into clearinghouses

We hope that this can serve as a reference point for you to tackle common issues with your claims.

SECTION 1

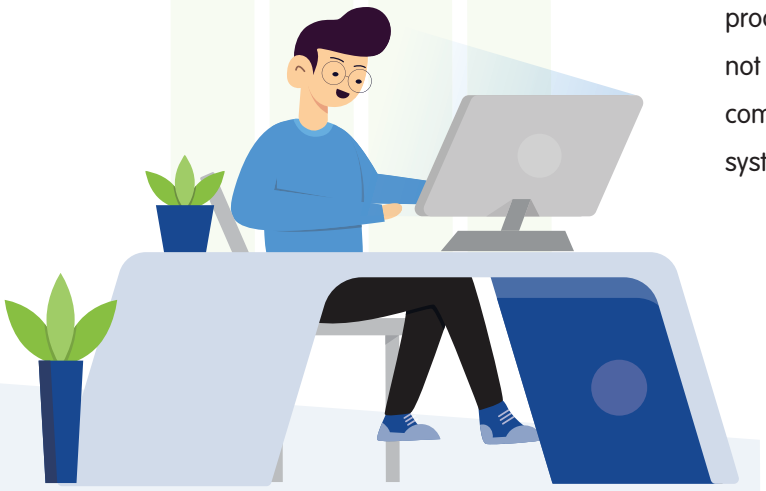
Submitting Claims

How a Dental Claim is Processed

Processing claims are not only one of the most important parts of your daily routine, it can also be the most mysterious. We spoke with some of our Vyne Dental claims geniuses at Tesia Clearinghouse, LLC, ("Tesia") Vyne Dental's industry-leading clearinghouse, to break down exactly what happens from the time a dental claim leaves your practice to when the check clears.

First and foremost, there are many ways that a claim can be filed. The most frequent methods are:

- **Paper**
- **Payer Web Portal**
- **Practice Management Systems**
- **Partnering with a Clearinghouse**



Let's look at the path a claim typically takes in each scenario.

Paper Submission

When a claim is submitted via a paper form, it's the provider's responsibility to mail it to the insurance company. There are a few things that can go wrong here. If the dental claim isn't filled out properly you could receive a rejection. Also, there is a possibility of claims being lost or damaged in the mail. It's also the slowest of the four processing options in terms of approval time, though it is considered the traditional way to process claims.

Payer Web Portal

While this is one of the cheaper options, it's by far the most demanding in terms of time. Every claim requires you to navigate each insurance company's website and enter each one by hand. In terms of your busy day and labor costs, this is one of the least efficient methods of processing for a high-volume office. It also does not increase your chances of getting paid faster compared to using a practice management system or partnering with a clearinghouse.

Practice Management Systems Submission

Practice management systems are likely one of your most trusted tools. They are great for keeping track of patients and your practice's schedule, and you can even submit your claims directly through most of them.

There is a caveat. Using only a practice management system costs roughly 50 cents per claim in addition to an attachment processing fee; which means the average dental practice spends up to $160 per month on processing claims and attachments. This is where a third party, easy to use, system like Remote Lite can save you thousands. Remote Lite works alongside your practice management system, allows for easy drag and drop attachments, lets you track your claims through the submission and approval journey, identifies why a claim might be rejected, and offers solutions to remedy those rejected claims. It also replaces the per-claim fee with a flat rate per month.

Clearinghouse Partnership

Once the claim is sent from one of the three methods above, it goes either to a clearinghouse or directly to the insurance payer to be processed. Clearinghouses act as a connector; think of them as a Venmo or PayPal, bridging the transaction gap between two parties. With the symbiotic relationship between Tesia and Vyne Dental, the process can take mere seconds.

It's a common misconception that submitting the same claim using a combination of the previously mentioned methods will help get the claim approved faster; our industry experts confirm that's simply not the case. In fact, it will likely slow down the process and may cost you more money as a dental care provider. More to come on that topic later.

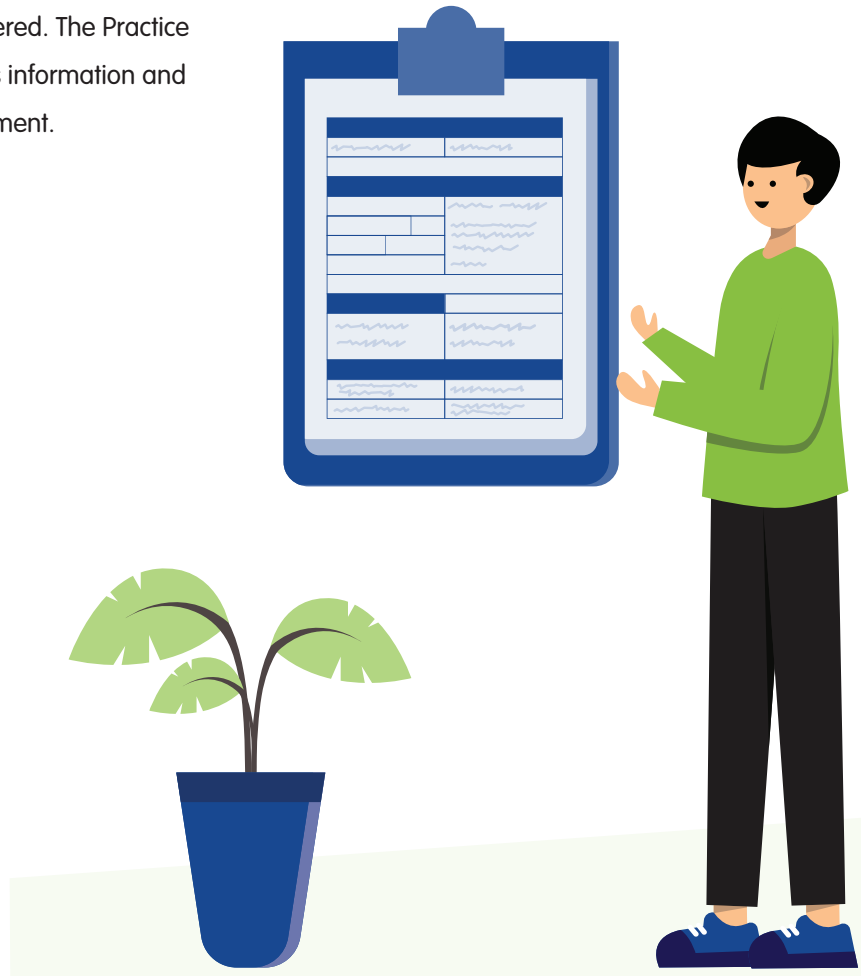
How to Read a Dental Claim

If you're new to handling dental claims, reading an ADA Dental Claim Form can feel a bit like filing your taxes for the first time. Luckily you can break down a claim form into three main sections that are easy to tackle: Policy, Patient, and Practice.

The Policy section applies to the insurance policy that will cover the procedure, the policyholder, and the insurance company. The Patient section applies to the patient's information and what procedures are being covered. The Practice section covers your office's information and the dentist providing treatment.

As you work through the ADA Dental Claim Form, keep in mind that most of this information will be imported from your practice management system if you are submitting claims electronically.

[1]For more information, please visit:
https://www.ada.org/en/publications/cdt/ada-dental-claim-form



Header Information			Policyholder/Subscriber Information		
1. Type of Transaction			12. Policyholder Name		
2. Predetermination/Preauthorization Number					
Insurance Company/Dental Benefit Plan Information			13. D.O.B.	14. Gender	15. Policyholder ID
3. Company/Plan Name			16. Plan/Group#	17. Employer Name	
Other Coverage					
4. Dental? Medical?					
5. Name of Policyholder					
6. D.O.B.	7. Gender	8. Policyholder ID			
9. Plan/Group#	10. Patient's Relationship				
11. Other Insurance Company/Dental Benefit Plan Name					

Policy Information

Box 1 The Type of Transaction field indicates to the insurance company if the procedure(s) are completed or if this is a predetermination of the patient's benefits. Some insurance companies may require you to send a predetermination to evaluate the cost of the procedure.

Box 2 If a predetermination has been sent, use this box to reference the previous claim number.

Box 3 This is the address of the insurance company (payer) that you're submitting the claim to.

Box 4-11 Secondary/Other Coverage: To be used if the patient's treatment is covered by more than one insurance policy. Most frequently, this will be a child covered by both parents' employer benefits. Note: Medicaid is entered as secondary coverage.

Box 4 Indicates if the secondary coverage is through dental or medical insurance.

Box 5 Name of policyholder/subscriber for secondary policy.

Box 6 Date of birth for policyholder/subscriber for secondary policy.

Box 7 Gender of policyholder/subscriber for secondary policy.

Box 8 Social Security or Identification Number of policyholders/subscribers for secondary policy.

Box 9 Plan or Group Number for secondary policy.

Box 10 Patient's Relationship to policyholder/subscriber (spouse, child, etc.).

Box 11 Address of the insurance company the secondary policy is affiliated with.

Box 12-17 Policyholder/Subscriber Information is where the patient's primary coverage information will go. The policyholder information may differ from the patient information, likely due to a parent or spouse's insurance covering the patient's treatment.

Box 12 Name and address of policyholder/subscriber.

Box 13 Date of birth of policyholder/subscriber.

Box 14 Gender of policyholder/subscriber.

Box 15 Social Security or Identification Number of policyholders/subscribers.

Box 16 Plan or Group Number for policy.

Box 17 Name of policyholder's employer.

Patient Information

Box 18-23 Patient Information: If the policyholder and patient are not the same people, you'll use this space to provide the patient's information. If the policyholder is the patient you can indicate this in Box 18 and leave 19-23 blank, as this information will be redundant to the policyholder.

Box 18 Indicates the patient's relationship to the policyholder/subscriber (self, spouse, child, other).

Box 19 No longer in use. This space was previously used to indicate student status.

Box 20 Name and address of the patient.

Box 21 Date of birth of the patient.

Box 22 Gender of the patient.

Box 23 For your own use if your practice has internal patient ID numbers, will not be referenced by the insurance company.

Box 24 Procedure Date indicates when the treatment performed (date of patient visit). If the claim is being submitted as a predetermination, you'll leave Box 24 blank.

Patient Information		
18. Relationship to Policyholder		
20. Name		
21. D.O.B.	22. Gender	23. Patient ID

Record of Service Provided										
	24. Procedure Date	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
30. Missing Teeth Info						34. Diagnosis Code List Qualifier			31.a Other Fee(s)	
						35. Diagnosis Code A__B__C__D__				
35. Remarks									32. Total Fee	

Box 25 Area of Oral Cavity: Indicates the area of the mouth that received treatment as a two-digit number (see right).

Box 26 Tooth System should have the initials "JP" in it. This indicates that you are using the ADA's Tooth Designation System (1-32 for permanent teeth and A-T for primary or "baby" teeth).

Box 27 Tooth Number or Letter indicates what teeth are being worked on. If the procedure involves three or fewer teeth, you'll use the tooth number or letter (1-32 or A-T). If the procedure involves more than three teeth, you'll use the Cavity Code associated with Box 25.

Box 28 This indicates what surface of the tooth is being worked on (see left).

Box 29 Procedure Code.

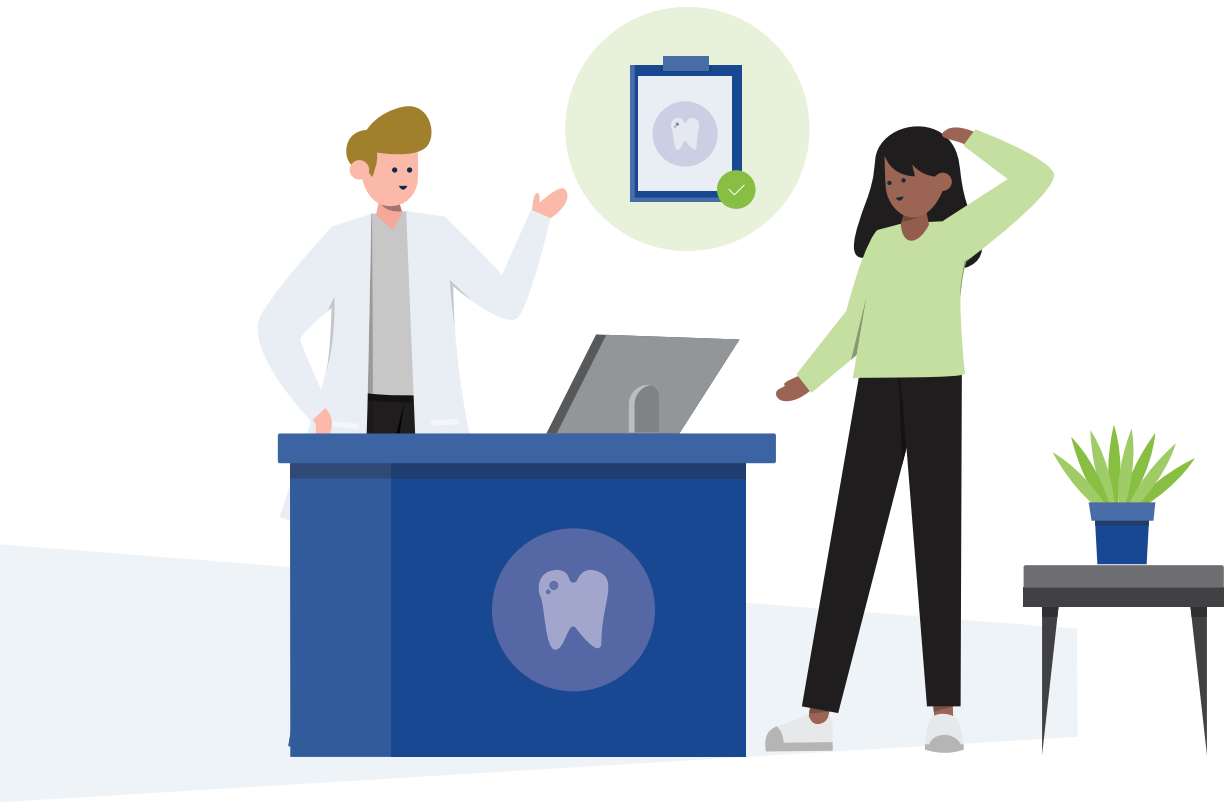
Box 30 Description of the procedure. Typically automated by the software used to submit claims.

Box 31 Itemized fees for each procedure that are determined by the practice.

Box 33 Used to indicate any missing teeth. This is typically automated by your practice management software.

Box 34 Currently not used by most insurance companies. The Diagnosis Code List Qualifier tells the insurance company which type of procedure code the office is sending.

Box 35 This is used to make any notes regarding the procedure. The remarks are not typically used by insurance companies unless you want to indicate that information may be missing from the attachments.



Practice Information

Box 36-37 Authorizations are where the patient and subscriber will provide a signature to accept treatment and the associated fees. If you submit claims electronically, your software will write "Signature on File" in this field.

Box 38 Place of Treatment indicates where the patient received care. As a dental practice, you will almost always use "11" to indicate that treatment was provided in an office.

Box 39 Enclosures indicate if you are sending any attachments with the claim. This is not required if you submit your claims electronically and the attachments are sent with the claim.

Box 40-42 Box 40 identifies if the procedure was an orthodontic treatment. If this is a yes, Box 41 indicates when the appliance was placed, and Box 42 is how long the patient will receive orthodontic treatment.

Box 43-44 Box 43 will indicate if the treatment replaced any fixed or removable prosthesis (typically applied to crowns). If yes, Box 44 will indicate the date of the prior placement of the prosthesis.

Box 45-47 Box 45 will indicate if the patient is receiving treatment due to an accident. If so, Box 46 provides the date of the accident. If it is an auto accident, you'll indicate the state of the accident in Box 47.

<table>
<tr><th colspan="3">Authorization</th><th colspan="2">Ancillary Claim/Treatment Information</th></tr>
<tr><td colspan="3">36.

X_____
Patient/Guardian Signature Date</td><td>38. Place of Treatement</td><td>39. Enclosures</td></tr>
<tr><td colspan="3" rowspan="2"></td><td>40. Is Treatment for Orthodontics?</td><td>41. Date of Appliance Placed</td></tr>
<tr><td colspan="3">37.

X_____
Patient/Guardian Signature Date</td><td>42. Months of Treatment Remaining</td><td>43. Replacement of Prosthesis</td></tr>
<tr><td colspan="3" rowspan="2"></td><td>46. Date of Accident</td><td>47. Auto Accident Site</td></tr>
<tr><th colspan="3">Billing Dentist or Dentaly Entity</th><th colspan="2">Treating Dentist and Treatment Location Information</th></tr>
<tr><td colspan="3">48. Name, Address, City, State, Zip Code</td><td colspan="2" rowspan="2">53.

X_____
Patient/Guardian Signature Date</td></tr>
<tr><td>49. NPI</td><td>50. License #</td><td>51. SSN or Tin</td></tr>
<tr><td colspan="3" rowspan="2"></td><td>54. NPI</td><td>55. License #</td></tr>
<tr><td>52. Phone #</td><td colspan="2">52a. Additional Provider ID</td><td>56. Address, City, State, Zip Code</td><td>56a. Provider Specialty Code</td></tr>
<tr><td colspan="3" rowspan="2"></td><td>57. Phone #</td><td>58. Additional Provider ID</td></tr>
</table>

Box 48 Billing Dentist or Dental Entity is essentially your practice's information and address, either reference the individual dentist's name or the name of the group/corporation.

Box 49 Group or Organizational NPI (National Provider Identifier) is a unique number assigned by the Federal Government to your practice.

Box 50 If the billing dentist is an individual, enter the dentist's license number. If a billing entity (group) is submitting the claim, leave blank.

Box 51 If a billing dentist is an individual you can provide either their TIN (Tax Identification Number) or SSN (Social Security Number). If a billing entity is submitting the claim, use the group TIN.

Box 52 Phone number of practice.

Box 52a Additional Provider IDs were more common before NPI (Box 49). Some insurers, like Medicaid, will require the Additional Provider ID.

Box 53-58 Treating Dentist and Treatment Location Information indicates the dentist that provided treatment to the patient. If you're not part of a group practice, this information will repeat Box 48-52.

Box 53 Signature of treating dentist and date of signature.

Box 54 Individual NPI (National Provider Identifier) for the treating dentist.

Box 55 Treating the dentist's license number.

Box 56 Treating the dentist's address.

Box 56a Provider Specialty Code indicates the type of dental professional that delivered treatment to the patient.

Box 57 Treating the dentist's phone number.

Box 58 Treating dentist's Additional Provider ID (see Box 52a description).

SECTION 2

Knowing Your Clearinghouse

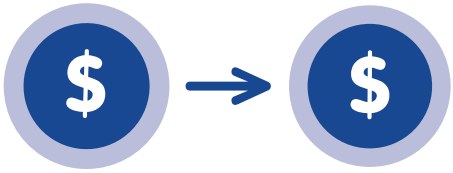
What is a Clearinghouse?

If you're of a certain age, you most likely associate the word clearinghouse with an image of Ed McMahon carrying around a comically oversized check. If this is all that comes to mind, you might be a little confused about why we are discussing our relationship with Tesia Clearinghouse so much. The reality is that clearinghouses play an integral role in daily financial and medical transactions.

A clearinghouse is a service processor between providers and payers that submits patient claims through EDI processes.

It's All About Clearing Checks

In the banking world, clearinghouses serve as an intermediary (or "middleman") between financial institutions. The act of clearing turns the promise of payment, such as a check or electronic request, into the movement of money from one account to another. Clearinghouses facilitate these transactions between separate banks.



How Insurance Payers Use Clearinghouses

Medical and dental clearinghouses fulfill a similar role for patients and insurance payers. In this setting, the promise of payment is the insurance claim submission on behalf of the patient to their financial institution, which is an insurance company. However, unlike a check from a bank, the criteria for clearing an insurance claim to pay for the medical provider is much more complicated.

For an insurance claim to clear, the insurance payer needs valid procedure codes and patient information. Additionally, the patient's insurance benefits must cover the treatment.

An added value of insurance clearinghouses is that they scrub this information to help ensure the claim isn't rejected due to minor clerical errors. Clearinghouses like Tesia will return information to the provider on why a claim was rejected and recommended next steps to resolve the issue.

Am I Able To Choose My Clearinghouse?

It's likely that you process claims through whatever clearinghouse your practice management system uses. The downside to these default clearinghouses will often charge an average of $0.50 for each claim you process, unlike Tesia.

When you process claims through Vyne Dental's Remote Lite® eClaims software, you partner with Tesia clearinghouse. Not only does your practice have the ability to save thousands on dental claims annually with the two, but you also receive helpful information on why your claims are rejected and how to fix them.

14 Things Insurance Companies Want Dental Offices to Know

Tesia clearinghouse is known throughout the industry for bridging the gap between insurance payers and dental care providers. In the spirit of that relationship, we decided to ask the masterminds behind Tesia what payers wish providers knew about claims processing.

Many of these examples not only make the job of insurance payers easier, they also help your claims move through the processing pipeline faster.

Claim Submission

ADA CLAIM BILLING GUIDELINES — Making sure that your claims adhere to the American Dental Association outline for claim submission might sound simple but running through that checklist can help claims get approved.

BENEFITS OF EDI — It's no secret that the future of dental is electronic claims processing. Submitting claims and attachments electronically allows insurance companies to track them and pay your office faster.

KNOW WHAT ATTACHMENTS ARE NECESSARY — Not all attachments are created equal. Depending on the type of claim you are sending, adding one that doesn't need to be there can slow down processing and subsequent payment.

SUBMIT A REAL-TIME CLAIM — Remote Lite allows for claims to be sent while a patient is still in the office. The benefit of real-time claims is you can see whether they are accepted or rejected right away.

Benefits

COORDINATION OF BENEFITS (COB) IS BEST RECEIVED ELECTRONICALLY — A COB is a claim where there are two policies at play, which could be with the same insurance company. Payers prefer to deliver benefit information electronically to your dental office. It helps to track the communication and get it in your hands faster.

Contacting

EMAIL VS. PHONE — The best way to communicate with an insurance company might not be over the phone. Reaching out over email allows a support ticket to be created and tracked, helping your issue get resolved efficiently.

CONSULT THE WEBSITE — Check the payer websites for any changes or notices. It might answer your question and save you time contacting them.

CHECK REMOTE LITE — Make sure you check your claim submission system for any notifications that might let you know a claim is rejected. It also offers solutions to help change the status from rejected to accepted.

Updating

DIRECT DEPOSIT IS THE MOVE — The dental industry is a bit behind in this process. However, it is the fastest way to track and ensure you are being paid exactly what your office is owed.

UP-TO-DATE PRACTICE MANAGEMENT SYSTEM — Making sure your practice management system is updated with the newest member IDs can spare you a world of headaches. If that claim gets submitted under the old number it will get rejected by the insurance payer.

KEEPING PATIENT INFO UP-TO-DATE — Make sure to review the patient's insurance information on a regular basis to ensure all changes are updated in your practice management system.

MAKE SURE YOU ARE USING THE CURRENT INSURANCE PAYER MAILING ADDRESS — Checking the Insured ID card for updates can ensure your claims are processed expeditiously.

Policy Information

MAKING THE BEST USE OF A PATIENT'S POLICY — The dental insurance policy is a vehicle to discuss treatment plans with patients and what coverages are available through their plan.

DIFFERENT TREATMENT PLANS — Individuals with dental insurance are much more likely to visit the dentist on a regular basis and be more compliant with treatment plans. If a patient gets regular preventative care, typically that helps avoid costly major services. Also, regular oral checkups can unveil other medical conditions that the patient may not know they have.

SECTION 3

Resolving Claims

Top 6 Reasons Claims are Rejected

Every year, the American Dental Association releases its updated Current Dental Terminology (CDT) codes. Practices that forget to update their codes in the new year can lead to one of the more common reasons why dental claims get rejected. Here are a few other common reasons why your claims might be getting rejected and what steps you can take to fix them.

ADA Code Validation Failure

This can be as simple as using an invalid procedure code. It could also be the case that you have the correct code, but the insurance company requires a different code to process the claim (Ex. D4342 was submitted with a tooth number, but the insurance company wants an oral cavity code). Make sure that your practice is staying current with annual code revisions.

Subscriber Not Found

This issue indicates that the subscriber isn't on file or that the submitted ID doesn't match the insurance company's records. If you find that you're receiving this error even though you have verified the subscriber ID, make sure the information is matched with the correct insurance company.

Missing or Invalid Subscriber ID

This is the policy holder's subscriber ID number. If you are having issues with the subscriber's ID, try inserting their SSN (social security number) in the subscriber ID field and type the subscriber ID in the SSN field. If this doesn't solve the problem, you will want to contact their insurance company.

Missing or Invalid Patient Information

Covering any information regarding the patient. If the patient is not available to verify their details, you can get this information by reaching out to their insurance company or by checking their EOB (Explanation of Benefits).

Incorrect Entity Address

Including the address for the patient or the subscriber. Always confirm the address your patient provides matches what their insurance company has on file for them. The error could be as simple as your patient moving and forgetting to update their records. If you think you have the correct information but are still having issues, you can verify the address on USPS.com to confirm the zip code and the formatting.

Duplicate Claims

These are caused if you submit the same claim multiple ways (Remote Lite, mail, practice management system, etc.). Typically, this means that the insurance company accepted the original claim and is only rejecting the duplicate. However, this can potentially lead to interrupted payment for the claim. It is best that your practice sticks to a single method for submitting claims.

Outside of the abovementioned, many rejections come from specific requirements that the insurance company might have regarding the patient's coverage. Your practice can get in front of rejections by using a claim processing service that works with an insurance clearinghouse.

Having a direct connection to payer information will provide more detail on your rejections and the best course of action to resolve any issues. For example, Vyne Dental partnership with Tesia provides RPractice users solutions for most of the most common claims rejections. Knowing exactly why your claims are getting rejected and what to do next will help your practice spend less time on the phone resolving issues for patients.

Multiple Claims Can Mean Multiple Issues

The world of dental claims processing can seem daunting and mysterious once it leaves the hands of your practice. There are many routes a claim can take before it's adjudicated. At the end of the day, we know your priorities are to care for your patients the best way possible and ensure that your practice succeeds. We have a few suggestions and industry secrets to help.

When filing claims, it's a common misconception that submitting a single claim via multiple channels will help get it approved faster. According to our clearinghouse professionals at Tesia, filing through several points of entry can slow down your claim when it's in the processing pipeline.

For example, imagine you just mailed a claim and submitted it through your practice management system. The payer must halt the electronic process to have someone manually review your paper claim. This results in two records of the same claim which slows down your claims process.

Many providers think that mailing claims while sending them through either their practice management system or a third party like Remote Lite will ensure that the claim is approved faster. Resubmitting through multiple channels essentially means that you are paying for the claim(s) two-to-three times: (1) the flat rate for Remote Lite, (2) the practice management system per claim fee, and (3) a fee for postage.

We say all this knowing there are several ways that you can send your claims, but one of the most efficient and cost-effective ways is through Remote Lite's software bundle — Practice Core.

The Practice Core platform includes three software solutions that work cohesively. Together they allow you to save and send attachments and insurance claims, for one flat-rate price. You can track your claims to see if they are accepted or rejected right away. You can also communicate via encrypted email with patients, providers, payers, and anyone else your office needs to reach. Practice Core helps your office stay in control of your claims, resulting in faster claim processing.

SECTION 4

How to Use EOBs and ERAs

Understanding EOBs vs ERAs

What is an Explanation of Benefits?

Every time your practice submits a claim, your patient's insurance payer will provide an Explanation of Benefits (EOB) to disclose how insurance will be applied to the patient's treatment. EOBs are sent to both your practice and the patient to inform what portion is covered by the insurance payer.

Unlike the ADA Dental Claim Form, every insurer's EOBs are different. Though the information contained within an EOB is standard, the layout and verbiage will likely be different if you deal with multiple insurance companies.

While primarily used by the patient to keep track of their coverage, an EOB can be a useful tool for your practice. For example, if you submit a claim for the predetermination of benefits, the EOB will allow you to provide the patient an estimate for their care plan.

What does a typical EOB look like?

1. The patient's dental insurer or payer.
2. The policyholder or subscriber whose insurance is covering treatment.
3. The patient receiving treatment.
4. The name of the billing dentist or dental entity.
5. Depending on the insurance company, your practice may be provided with a unique identification number.
6. The number that was assigned to the dental claim.
7. The date that the EOB was issued.
8. Description of treatments performed along with their procedure codes.
9. The dates when each treatment was performed.
10. The amount your practice billed for each treatment.
11. The amount allowed by the insurance company for coverage of each type of treatment.
12. The amount paid by the insurance company.
13. The remaining amount for treatment not covered by the insurance company.

14. The remarks section will include any additional information needed to explain what was covered.
15. The policyholder's name and mailing address.
16. A summary of the patient's benefit for the year, including what amount has been applied to the patient's maximum.

What is Electronic Remittance Advice?

Electronic Remittance Advice (ERA) provides the same information that you receive within an EOB. Unlike a digital EOB, which will typically be an image of the unprinted document, an ERA is just the information contained within the EOB (ex. coinsurance, allowance, deductible, etc) in data form.

One major benefit of ERAs over a mailed EOB is speed. Instead of waiting on an EOB to be mailed and delivered, your practice can use services like Remote Lite to receive remittance within a day of the claim being processed.

Another benefit of ERAs is your practice will save on storage. As they replace printed EOBs, you won't have to dedicate a physical space to house years of patient documentation.

What is 835?

Depending on the source, ERAs may be referred to as an 835. The EDI 835 (electronic data interchange) refers to the file format that contains the ERA that conforms to a set of HIPAA 5010 requirements. Unlike an EOB that can differ in format between insurance companies, EDI 835 is a standard format that is used globally for the dental and medical industries.

How can my practice receive digital remittance?

Some insurance companies offer digital copies of EOBs and ERAs through provider portals on their respective websites. However, for many practices, having to go through multiple websites can be time-consuming and cumbersome.

Digital EOBs: Saving, Storing, And Sending

Explanation of benefits is a key element of your practice's client tracking. Not only do you have to keep them for a minimum of seven years under Federal law after the last date of service to a patient (for Medicaid and veterans it is longer), you also have to find your own way to keep them organized.

There are a few options when it comes to digital vs. paper EOBs that all depend on how your office works internally.

While EOBs aren't technically required to be saved, they are often part of a patient's file and fall under the timeline mentioned above. Digital EOBs and ERAs are easier to house because they don't take up a lot of space in your office. (ERAs are a HIPAA compliant digital file that can replace EOBs.) Both are easily searchable, with the correct software, allowing you to filter through them quickly. For high-volume offices, digital EOBs can be extremely helpful when advocating for a client, efficiently communicating with insurance companies, and organizing.

Whether you use paper or digital claims there is a risk in keeping your records too long. Security breaches physically or digitally can put you at risk for HIPAA violations. Staying organized with your EOBs is crucial to running a strong practice.

Paper claims also hold a far larger risk of being damaged, stolen, or accidentally destroyed without a fail-safe measure. Physical copies can lead to data breaches as well. According to the Journal of the American Medical Association (JAMA), paper records account for up to 31% of security breaches.

Remote Lite has built-in measures to give you the best possible security for your claims. It also supports EOBs and ERAs included in the cost. Schedule a time to speak with our specialist today about how your office's EOBs and ERAs can fit with Remote Lite.

About Us

Vyne Dental is Confidence

We're focused on building value in the dental industry by helping our customers reach their goals. **Our business started because we saw a missing link in the dental industry.**

Connecting a Gap

We saw that dental practices needed a seamless way to connect electronic attachments to insurance claims. So we got to work and developed the FastAttach® solution to streamline this process for our customers. With FastAttach, we became one of the most connected and trusted sources for attachments in the industry.

Protecting Dental Practices

As we grew and expanded our work in connecting disconnected data we found another problem that dental offices were facing — how to make sure their patient data was protected while communicating with insurance companies and patients. There was not an encrypted email solution for these types of exchanges, so we expanded our portfolio with Vyne Connect™ email exchange. We're now one of the leading providers of encrypted email services in dentistry.

Helping Practices Flourish

We saw another opportunity to serve our customers, a way to streamline their revenue cycle through claims processing. We joined forces with Renaissance Electronic Services, LLC and Tesia Clearinghouse, LLC to offer our clients Remote Lite®, a claims processing software that removes the per-claim processing fee and tracks insurance claim submission. The integration allows our customers to have the best in claims processing, the best in attachments and cutting-edge email encryption. **Vyne Dental is continuously growing and always striving to advance the dental industry by serving it better.**

Our Company

Vyne Dental is part of the Vyne family of industry-leading information exchange and communication management solutions for medical and dental healthcare. Vyne solutions give health systems, dental practices, and insurance plans and payers the ability to exchange health information in a compliant manner to improve their revenue cycle management processes. The company's Trace® platform for health systems and its FastAttach® service for dental practices remain recognized leaders in their respective software categories and have helped Vyne maintain its 12-year presence on the Inc. 5000 list. Our team is made up of diverse individuals passionate about technology and client service.

VYNE DENTAL