

BLUE CROSS BLUE SHIELD FEP DENTAL® 2026 DENTAL OFFICE PROVIDER USER GUIDE



The Blue Cross Blue Shield Association (BCBSA) has partnered with the GRID Dental Corporation (GDC) to administer Blue Cross Blue Shield FEP Dental Program (BCBS FEP Dental). BCBS FEP Dental members are able to utilize the GRID+ network as an in-network provider source. By participating in your local Blue Cross and Blue Shield plan you have access to BCBS FEP Dental members.

Visit bcbsfedental.com

Call **1-855-504-BLUE (2583)**.



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ANNOUNCEMENT



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Here are new benefits for both Changes to the High and Standard option in 2026:

For individuals over age 22, we added:

- D1206 Topical application of fluoride varnish – Limit 2 during the calendar year (Class A)

The addition of a new dental code:

- D6280 Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch – Limit 1 every 36 months (Class C)

Emergency exam services are no longer bundled:

- D0140 Limited oral evaluation - problem focused - Limited to once per year (Class A)
- D0160 Detailed and extensive oral evaluation - problem focused, by report - Limited to once per year (Class A)

An increase in co-insurance for anesthesia/sedation services and medications:

High Option:

- In-Network – From 30% to 50%
- Out-of-Network – From 40% to 60%

Standard Option:

- In-Network – From 45% to 65%
- Out of Network – From 60% to 80%



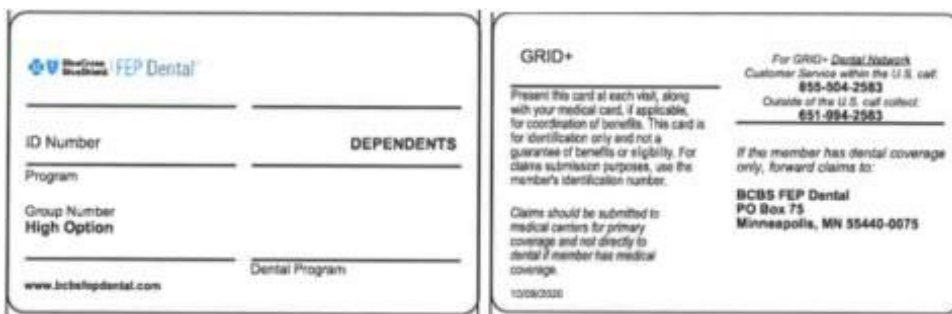
IDENTIFICATION CARDS



Each contract holder receives two BCBS FEP Dental ID cards. The cards only have the contract holder's name on them. The word 'Dependents' appears on the card if the contract includes a spouse and/or dependent.

- The ID card is for identification ONLY. The ID card is not a guarantee of eligibility or benefits. BCBS FEP Dental recommends that you verify member coverage for each appointment. This may be done by calling the BCBS FEP Dental Customer Service Department at 855-504-BLUE (2583) (TTY: Dial 711). Participating providers can also obtain eligibility or benefit information by using the provider portal on the website bcbsfepdental.com.

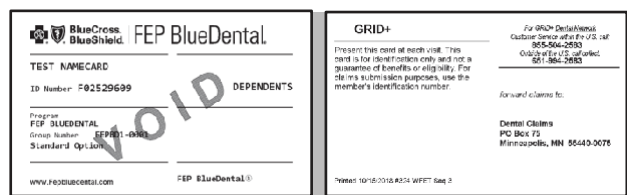
Below is a generic sample of a BCBS FEP Dental ID Card.



When a member provides your office with their BCBS FEP Dental ID Card, you may need to ask for their medical ID card.

- If they are covered under the Federal Employee Health Benefit (FEHB) or Postal Service Health Benefit (PSHB) Program, their medical ID card is important because by **law**, the FEHB/PSHB member's medical plan is the primary carrier and should be billed first if there is dental coverage through their medical plan.
- Uniformed Services members are not under this requirement and should be billed directly to our office. Please see additional details below under coordination of benefits.

**Please note: Existing members may have an ID card with the previous program name, FEP BlueDental. New ID cards were not issued to all existing members.*





CLAIM SUBMISSION TIPS

Accurate claims submission results in faster payment. To ensure timely claim payments, use the following checklist as a tool. Verify the information you provide for completeness and accuracy.

- State-issued treating Dentist License Number and Tax Identification Number (TIN)
- Patient's birth date
- Patient's relationship to the member
- Member's birth date
- Member's social security number (SSN) or identification number
- Member/patient's signature
- Current ADA procedure code(s)
- Fee for treatment
- Treatment date(s)
- Tooth number, surface and/or quadrant when applicable
- Treating dentist's signature
- Up-to-date and complete practice address details
 - Treating address
 - Billing address if different than treating address

Pre-treatment Estimates

Pre-treatment estimates are not mandatory. However, we do recommend that your office submits a pre-treatment estimate if the member is considering major or extensive dental care. Pre-treatment estimates should include a comprehensive treatment plan and necessary supporting documentation such as chart notes, radiographic images, and photos.

If more than one service can be used to treat a dental condition, benefits may be alternated to a less costly procedure that meets broadly accepted national standards of dental practice.

We will provide a non-binding explanation of benefits to both you and the member that will indicate if procedures are covered and an estimate of what we will pay for those specific services. The estimated plan allowance is based on the member's current eligibility and benefits in effect at the time of the pre-treatment estimate. Submission of other claims or changes in eligibility or benefits may alter final payment. A pretreatment estimate is not a guarantee of benefits.

Pre-treatment estimates are valid through the calendar year in which they are processed, or 12 months, subject to eligibility and plan limitations.

Submit pre-treatment estimates to BCBS FEP Dental at the address below. Do not send pre-treatment estimates to the medical plan.

BCBS FEP Dental
P.O. Box 75
Minneapolis, MN 55440-0075



Post-treatment Review and Radiograph Submission

A pre-treatment review program is not used by BCBS FEP Dental; instead, we have implemented a post-treatment program that monitors individual dentist utilization patterns.

BCBS FEP Dental has developed the ability to modernize the process of professional review. This process has greatly improved service to our network dentists and members—because pre-treatment estimates and claims will be processed faster, and radiographs will not be required prior to rendering services. You may find this new process makes it easy to do business with BCBS FEP Dental.

Post-payment review is simple and straightforward: individual dentist utilization is analyzed periodically and compared over time to determine if changes in utilization have occurred. You may be asked to periodically provide post-payment treatment information as part of this review process.

Alternate Benefits

If more than one service or procedure can be used to treat the member's dental condition, BCBS FEP Dental reserves the right to authorize an alternate treatment, less costly covered service as deemed by a dental professional to be appropriate and to meet broadly accepted national standards of dental practice. If you and the member choose the more expensive treatment instead of the alternate benefit, the member is responsible for the additional charges beyond the plan allowance for the alternate service.

Example: If a dental professional determines an implant is not dentally necessary or a less expensive appropriate treatment is available, no benefits will be allowed for the individual implant or implant related procedures, and the allowance for the less expensive treatment may be approved. For additional information on covered dental services, please refer to the Benefit Brochure, which can be found on the website bcbsfedental.com/brochure.

Submissions for Cosmetic Services

Cosmetic dental services are excluded from the plan. If you provide cosmetic services to a member, you do not need to submit a claim to BCBS FEP Dental. Claims for cosmetic services which may require a denial of payment from BCBS FEP Dental may be submitted directly to:

BCBS FEP Dental Claims
P.O. Box 75
Minneapolis, MN 55440-0075

**Do not send cosmetic claims to the medical carrier.*



COORDINATION OF BENEFITS (COB)

Current Process

Under the current approach, BCBS FEP Dental estimates its secondary payer responsibility and issues immediate payment when a dental claim is received prior to the FEHB and PSHB medical plan's adjudication. Once the primary medical plan processes its claim, BCBS FEP Dental conducts a final reconciliation.

What's Changing

To address member and provider feedback, BCBS FEP Dental is eliminating the estimation of payment process. This will enhance transparency, efficiency and member experience while aligning with industry best practices. It is intended to provide a more predictable and positive experience for both members and providers.

New Process

Under the new process, BCBS FEP Dental will defer all secondary payments until after the FEHB and PSHB medical plan has issued its claim determination and payment. For instances where dental claims are received directly and the member is known to have primary insurance, the explanation of benefits (EOB) will instruct the member and provider to submit the claim first to the primary medical plan, then resubmit to BCBS FEP Dental with the required primary plan EOB for accurate secondary processing.

Primary vs. Secondary Coverage

For patients with FEHB or PSHB medical coverage, and certain retired uniformed service members who have dental benefits included in their medical plan, medical is always primary and BCBS FEP Dental is secondary. Submit dental claims to the medical carrier first.

Important Guidelines:

- When BCBS FEP Dental is secondary, dentists should not collect member's cost shares as BCBS FEP Dental will cover the copayment with their secondary payment.
- When the medical plan does not include dental benefits or the member lacks medical coverage, submit claims directly to BCBS FEP Dental with a primary payment amount of \$0.
- Pre-treatment estimates and orthodontic claims should be submitted directly to BCBS FEP Dental.

BCBS Federal Employee Program (FEP) Medical for FEP Blue Standard or FEP Blue Basic Members

Submitting Dental Claims

When a patient has FEP Blue Standard or FEP Blue Basic medical coverage, submit their claims to the local Blue Cross Blue Shield medical plan first. The medical plan will process the claim and forward payment details to BCBS FEP Dental for secondary payment. BCBS FEP Dental then issues secondary payment directly to your office if you are a participating dentist in our network.



Process:

- Always submit the claim to the medical plan. The FEP medical plan will then automatically transfer the claim to BCBS FEP Dental for secondary payment.
- When submitting to BCBS FEP medical, the member ID begins with an “R” followed by eight digits (e.g., R12345678). Incorrect member IDs will result in claim rejection. Ensure member IDs are entered in the correct field by following the claim form instructions.
- The patient cannot be billed beyond allowed amounts.
- If a claim is sent to BCBS FEP Dental prior to submission to the FEP medical plan, BCBS FEP Dental will deny the claim for primary payment.
- BCBS FEP Dental explanation of benefits (EOB) will reflect both the medical (Other Insurance Coverage Paid) and BCBS FEP Dental coordinated benefit payments.

BCBS Federal Employee Program (FEP) Medical for FEP Blue Focus Members

Direct Submission to BCBS FEP Dental

Patients with FEP Blue Focus do not have dental benefits embedded in their medical plan. Submit all dental claims directly to BCBS FEP Dental, which acts as the primary payer. FEP Blue Focus will be printed on the patient's medical ID card.

Non-BCBS FEHB and non-PSHB Medical Members

Claims Processing Steps

For patients covered by other medical plans with dental benefits embedded in them, submit claims to their medical plan first. After you receive primary payment, submit the remittance advice and secondary claim to BCBS FEP Dental for payment. Do not submit claims to BCBS FEP Dental before the medical plan has processed the claim. If a claim is sent to BCBS FEP Dental prior to the patients' medical plan, it will be denied for primary payment.

Retired Uniformed Service Members

Primary Dental Coverage

For retired uniformed service members who do not carry FEHB or PSHB medical coverage, BCBS FEP Dental is the primary payer. Submit their claim directly to BCBS FEP Dental. Their BCBS FEP Dental member ID cards will indicate Uniformed Service High Option or Uniformed Service Standard Option as the group.

Special Circumstances

Retired uniformed service members may have additional coverage if:

- They re-enter the federal workforce and carry active FEP (FEHB or PSHB) medical coverage.
- They are covered under a spouse's active FEHB or PSHB plan with embedded dental benefits.
- They are covered under a spouse's non-FEHB or PSHB plan with no embedded dental benefits, in which case BCBS FEP Dental is primary.
- They are covered under a spouse's non-FEHB or non-PSHB plan with embedded dental benefits, in which case BCBS FEP Dental is secondary.
- They carry a non-federal dental plan, in which case the member's longest-standing plan is primary.
- They are covered under a spouse's active military TRICARE Dental Plan (TDP), in which case BCBS FEP Dental is primary.



Please validate with patients whether any special circumstances may apply to ensure accurate and timely payment of dental claims.

Provider Assistance & Support

For questions and support, please contact Blue Cross Blue Shield FEP Dental provider services at 1-855-504-BLUE (2583), 8 a.m. – 8 p.m. ET Monday – Friday.

Reconsiderations – Claim Dispute

If you and your BCBS FEP Dental patient disagree with the initial decision of how dental services were processed, refer to Section 8, Claims Filing and Disputed Claims Process, of the BCBS FEP Dental Brochure on how to submit a reconsideration. Providers may not appeal without a dated and signed “[Patient Consent Form for Provider Submitted Appeals](#)” completed by the member. This form can be found on the bcbsfepdental.com website under the Tools & Resources tab, Brochures & Resources then Forms.

Reconsiderations or claim disputes must be received within **60 days** from the date the determination was made and should be sent to:

BCBS FEP Dental Claims Appeals
P.O. Box 551
Minneapolis, MN 55440-0551



BENEFIT SUMMARY

BCBS FEP Dental Members have two options while choosing benefits during open enrollment: High Option or the Standard Option. A general breakdown can be seen below.

To access the complete BCBS FEP Dental benefit brochure:

1. Go to the BCBS FEP Dental website bcbsfedental.com and click the 'Tools and Resources' link on the universal navigation bar on the home page.
2. Click on Brochures & Resources, click on the Dental Plan Brochure and select your choice language.
3. The document can either be downloaded and saved or printed for your office use.

While you are not prohibited from providing services that are not covered by the Plan, surprise bills and large out of pocket costs can lead to a negative dental patient and dentist experience. As a Participating Dentist, you must inform the Covered Person in a written treatment plan prior to the provision of such services that the services are not likely to be covered by the Plan and the approximate cost to the Covered Person for such services. Most common non-covered procedures that cause member abrasion when not properly communicated are:

- photographic images (D0350)
- oral hygiene instruction (D1330)
- gingival irrigation (D4921)
- topical application of fluoride (D1208) and varnish (D1206) for members over the age of 22



A general breakdown can be seen below.

Benefit	High Option		Standard Option	
	IN-NETWORK Member Responsibility	OUT-OF-NETWORK Member Responsibility	IN-NETWORK Member Responsibility	OUT-OF-NETWORK Member Responsibility
Class A (Basic) Services e.g., exams, cleanings, X-rays, sealants	Member Pays nothing	Member Pays 10%	Member Pays nothing	Member Pays 40%
	THREE CLEANINGS A YEAR COVERED		THREE CLEANINGS A YEAR COVERED	
Class B (Intermediate) Services e.g., oral surgery, fillings, deep cleanings	Member Pays 30%	Member Pays 40%	Member Pays 45%	Member Pays 60%
Class C (Major) Services e.g., crowns, bridges, implants, root canals, dentures	Member Pays 50%	Member Pays 60%	Member Pays 65%	Member Pays 80%
Class D (Orthodontic) Services Adults & Children	Member Pays 50% . up to \$3,500 lifetime maximum per person	Member Pays 50% . up to \$3,500 lifetime maximum per person	Member Pays 50% . up to \$2,500 lifetime maximum per person	Member Pays 50% . up to \$1,250 lifetime maximum per person
	NO WAITING PERIOD		NO WAITING PERIOD	

*** Orthodontic plan payments are made monthly through the course of treatment***

Annual Deductible for Class A, B and C Services Does not apply to Class D (Orthodontics)	Member Pays No deductible	Member Pays \$50 per person	Member Pays No deductible	Member Pays \$75 per person
Annual Maximum Benefits for Class A, B and C Services Does not apply to Class D (Orthodontics)	No benefit limit	\$3,000 per person	\$1,500 per person	\$750 per person



PROVIDER PORTAL ACCESS

Our goal is to make it as easy as possible for you to do business with us. For this reason, we created our provider portal to give you the information you need when you need it - without having to call our customer service.

The provider portal gives you, as a contracted dentist, access to a wealth of patient information and the ability to view the following:

- Eligibility
- Plan benefits
- Claims
- Coverage details
- BCBS FEP Dental benefit brochure
- Clinical policies
- Provider user guide
- Provider QRGs

To access this helpful information:

1. Go to the BCBS FEP Dental website bcbsfepdental.com and click the 'Provider Login' link on the universal navigation bar on the home page.
2. Complete the information on the BCBS FEP Dental registration screens. When registration is complete, a confirmation letter will be sent in the mail.



CONTACT INFORMATION



Our goal is to make it as easy as possible for you to do business with us. Please feel free to contact us with any questions. Contact Information:

- Participating providers can obtain eligibility or benefit information by using the provider portal on the website bcbsfedental.com.
- Customer Service (in the U.S.) 855-504-BLUE (2583) (TTY: 711).
 - Hours: 8 a.m. to 8 p.m. EST, M-F.
- Submit claims to:

BCBS FEP Dental Claims
P.O. Box 75
Minneapolis, MN 55440-0075
bcbsfedental.com