Provider Quick Reference Guide

For information about…	Contact…
Appeals, Complaints, Grievances mailing address	Cypress Dental Appeals & Grievances PO Box 102 Milwaukee WI 53201
Pre-Determination (Estimate) mailing address	Cypress Dental: Pre-Determination PO Box 762 Milwaukee WI 53201
Claim Form mailing address	Cypress Dental: Claims PO Box 1998 Milwaukee WI 53201
Corrected Claims mailing address	Cypress Dental: Corrected Claims PO Box 557 Milwaukee WI 53201
Pay Member Claims mailing address	Cypress Dental: Pay Members PO Box 119 Milwaukee WI 53201
Orthodontic Continuation of Care	Cypress Dental: Continuation of Care PO Box 1998 Milwaukee WI 53201
Contracting	www.cypressadmin.com 800-350-3989 - Press Option #3
Client Member Services	800-350-3989- Press option #1, Dental, Press #1 Member
Client Provider Services	800-350-3989, Option #1, Dental, Press #2 Provider
Provider Web Portal (Registration)	www.cypressadmin.com 844-275-8757
Ortho Claims Payments	Will be paid out Monthly instead of Quarterly

Quick Reference to Common Questions	
Member Eligibility	To verify member eligibility: • Log on to Provider Web Portal: www.cypressadmin.com • Call 800-350-3989
Claims Submission	The timely filing requirement is 365 calendar days. Submit claims in one of the following formats: • Provider Web Portal: www.cypressadmin.com • Electronic submission via clearinghouse, Payer ID: **TLZ04** • Paper ADA Dental Claim Form, sent via postal mail: Cypress Dental Administrators: Claims PO Box 1998 Milwaukee WI 53201
Complaints and Grievances	To make a complaint or grievance: • Write to: Cypress Dental Administrators: Appeals & Grievances PO Box 102 Milwaukee WI 53201
Provider Web Portal	For training or help registering for or using the Provider Web Portal, email the SKYGEN USA Dental Electronic Outreach Team: • CommercialProviderPortal@skygenusa.com • 844-275-8757

Orthodontic Continuation of Care
Request Form

Date: _____

Member Name (Patient): _____

Member ID (Patient): _____ Date of Birth: _____

Prior Carrier(s) Lifetime Ortho Maximum: _____ Total Monthly Visits: _____

Banding Date: _____

Total Dollars Paid to Date by Prior Carrier(s): _____ Remaining Monthly Visits: _____

Continuation of Care (COC) Request Procedure

1. Complete this form (**Orthodontic Continuation of Care Request Form**) to transition the above listed member's benefits to the **Cypress Dental** program.
2. Complete **ADA Claim Form (2012 or newer)** in full, being sure to complete the following required fields for COC
    - **Service Line 1**
        - **Field 24: Date of Service** (date should be on or after the effective date with the plan)
        - **Field 29: Service Code** (D8999)
        - **Field 31: Fee** (monthly adjustment fee)
    - **Field 42**: **Months of Treatment Remaining**
3. Mail completed **Orthodontic Continuation of Care Request Form** and **ADA Claim Form** to the following address:

Cypress Dental: Continuation of Care
PO Box 1998
Milwaukee, WI 53201

Please Note:

- *Primary Carrier EOB is not required*
- *D8999 is a non-payable COC indicator code. The request for adjustment payment (D8670) should be submitted after each service is rendered.*

Notes:_____

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