

# Superior Dental Care Office Quick Reference

## Inquiries

View a summary of benefits by entering the plan number listed on the ID card into the search field in the top right corner at **SuperiorDental.com**.

Participating providers can also access eligibility, benefits and claims using **Superior Direct Connect**.

SDC's Dentist & Member Services team is available Monday-Friday, 7:30am-5:00pm EST at **1-800-801-4915**.

## Claim Submissions

**Superior Dental Care**  
**P.O. Box 6018**  
**Cleveland, OH 44101-1018**

For electronic submissions, use **Payor ID 31117**

Note: Supporting documents accepted using NEA attachments/reference number only.

| Service                                | Claim Requirement  |
|--|--|
| <b>Palliative</b>                      | Narrative  |
| <b>Gingival Scaling or Debridement</b> | Narrative date of last prophylaxis   |
| <b>Scaling and Root Planing</b>        | Pre-op full mouth perio chart including mobility*  |
| <b>Perio Maintenance</b>               | Date of most recent SRP or osseous surgery   |
| <b>Restorations</b>                    | For multiple anterior or 6 or more posterior, diagnostic quality pre-op x-ray*   |
| <b>Crowns on Natural Teeth</b>         | Initial placement or date of prior placement prep date and seat date diagnostic quality pre-op x-ray* for all out of network claims or for in network claims with 2 or more crowns                           |
| <b>Crowns over Implants</b>            | Initial placement or date of prior placement impression date and seat date complete chart of missing teeth* if pre-existing crown or bridge, date of prior placement   |
| <b>Bridges</b>                         | Initial placement or date of prior placement prep date and seat date complete chart of missing teeth* date of prior placement of other bridges in arch condition/ pending treatment of other bridges in arch |
| <b>Partials</b>                        | Initial placement or date of prior placement impression date and delivery date complete chart of missing teeth*  |
| <b>Dentures</b>                        | Initial placement or date of prior placement impression date and delivery date complete chart of missing teeth* if pre-existing partial, date of prior placement   |

\*Patient Name and Date must be visible on all x-ray images and tooth/perio charting. Additional documentation may be requested by SDC's Dental Consultants to complete review of submitted services. Visit **SuperiorDental.com** for additional submission guidelines.