Insurance Manager Guide

To open the Insurance Manager:

Click on the DXWeb Toolbar from any module in Dentrix then the E in the red circle which is your Insurance Manager Icon on the DXWeb toolbar.

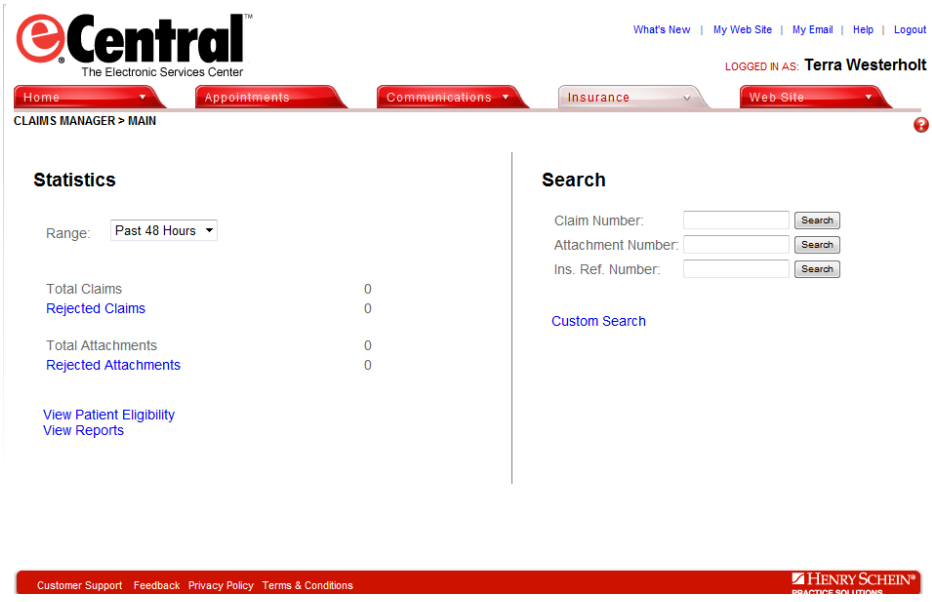
There are 3 main areas of the Insurance Manager.

Claims Manager

Reports Manager

Patient Eligibility

When the Insurance Manager opens it will open to the Claims Manager. The Claims Manager looks at the statistics of your practice and always defaults to the last 48 hours. You can see how many claims you have submitted in the last 48 hours as well as any rejections that may have come through. You can change the date range by clicking on the down arrow and selecting a new range.



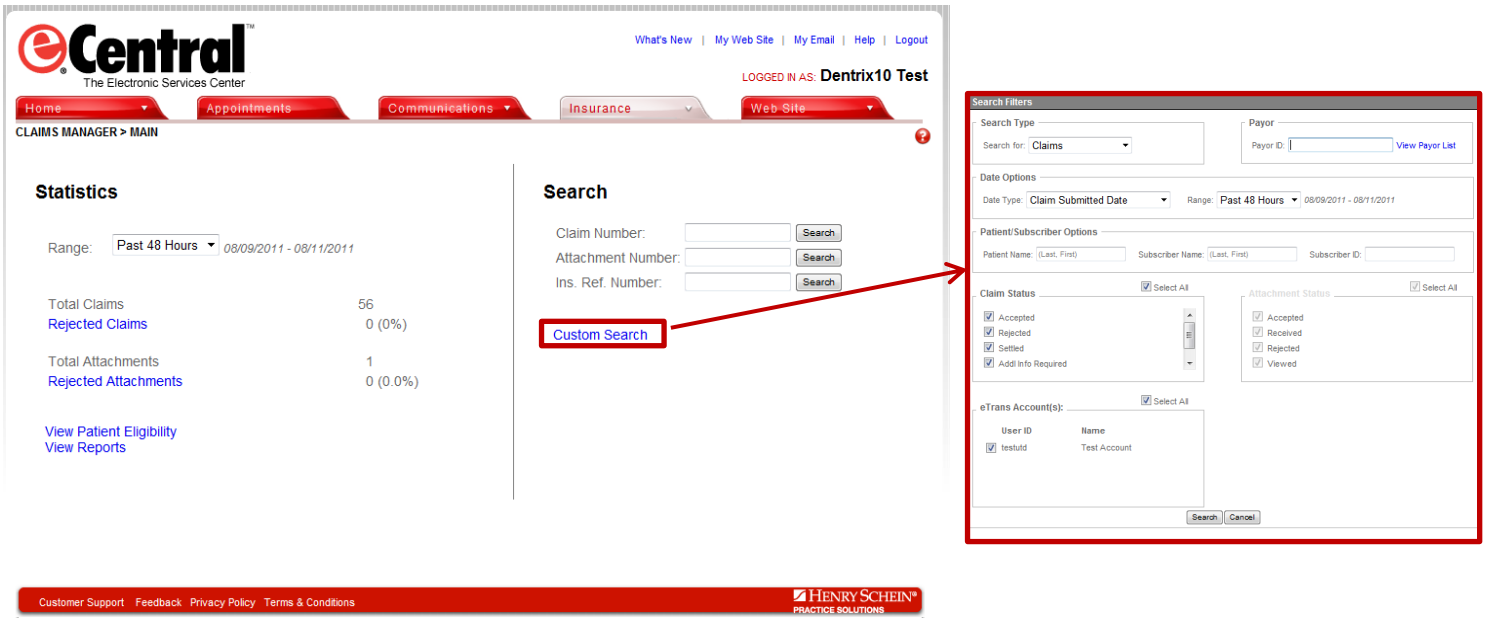
Anything that is in blue in the Insurance Manager is a link that you can click on to get more information about what you are looking at.

Rejected Claims:

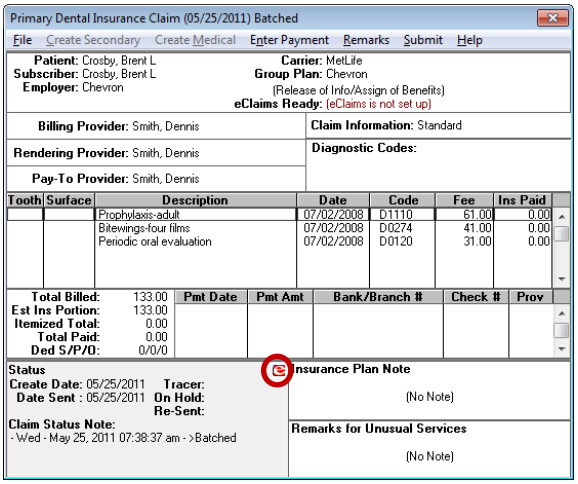
By clicking on “Rejected Claims” in blue it will open a new window that will show you which patients had rejected claims, the subscriber name, Insurance company, date the claim was submitted and the date of service. It will also list the claim number in blue which you can then click on to give you the reason the claim was rejected. (If you see “TesiaRT and no other explanation, this means that this claim was sent to a payor in real time. You have already received a report in your Transmission Report called a Pass Through Report giving you the explanation of the rejection. You can look it up again in the Reports Manager by selecting the date of submission and then looking at each Pass Through Report until you find the one for this patient. The Pass Through Reports are patient specific).

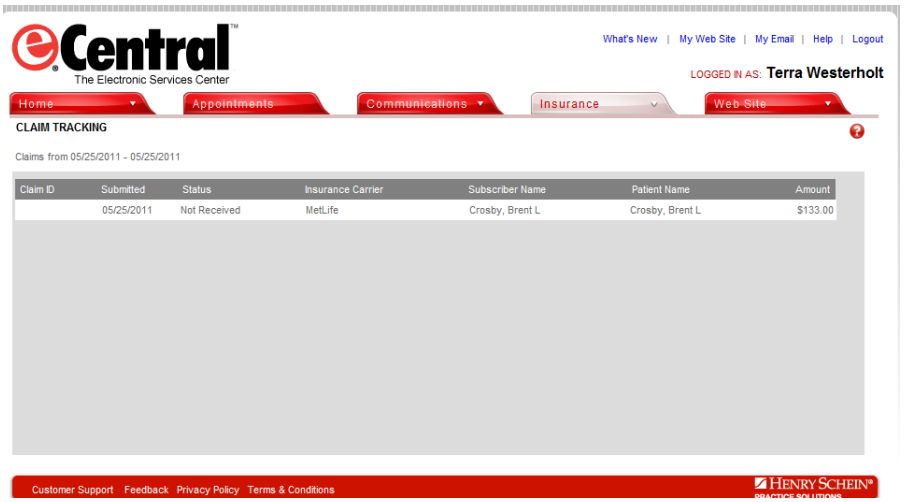
Claim Tracking:

You can do claim tracking two different ways. You can click on the “Custom Search” link in the Claims Manager and enter the Patient name, Subscriber name, Subscriber ID and change the date range to include the submission date. This will pull up a list of claims for that patient in that date range and give the status of the claims.



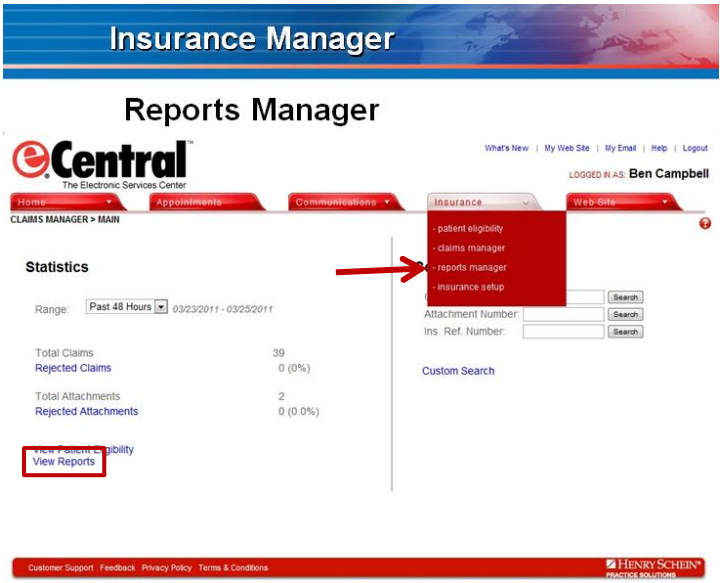
You can also go to the Patient Ledger and double click on the claim to open it up. Once it’s open you can double click on the “E” in the red box in the lower left hand corner of the claim. By doing this you have started a claim tracking for this claim. *Watch for the window to open where you have the internet open.





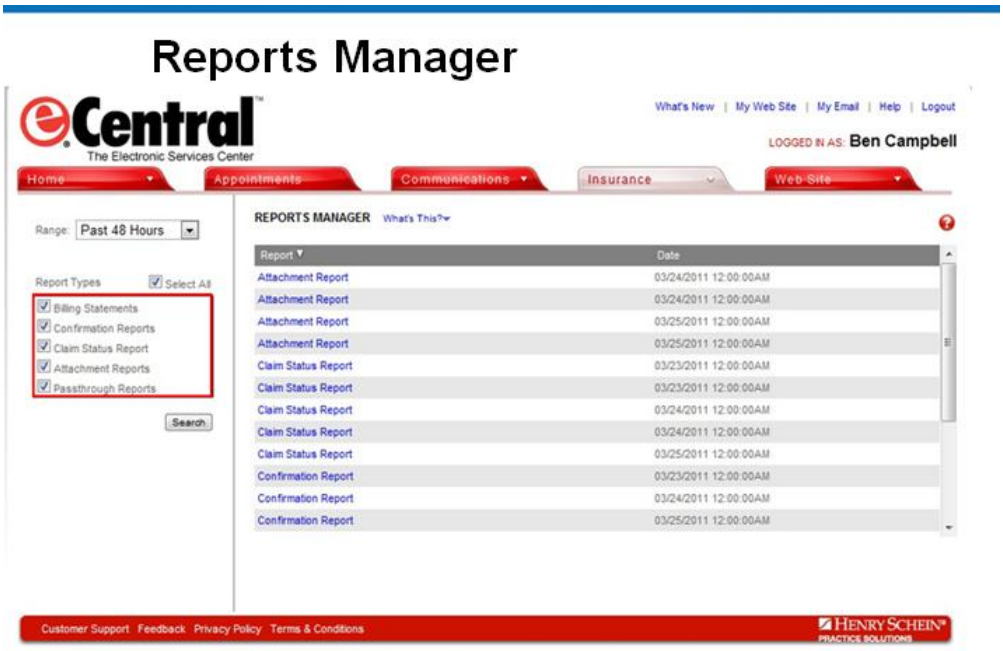
Reports Manager:

You can open the Reports Manager by going back to the main page of the Insurance Manger and hovering over the Insurance tab at the top and then clicking on Reports Manager or by clicking on “View Reports” in the lower left hand area of the page.



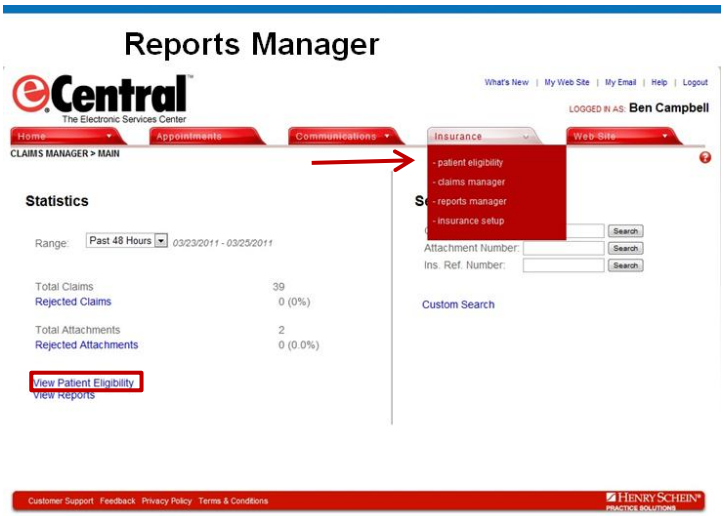
The Reports Manager will store the entire history of Eclaim reports that the practice has received. These reports are what make up the Transmission Report that you view after submitting your Eclaims.

Any report can be viewed from this screen by choosing the desired report and clicking on the blue title of the report.



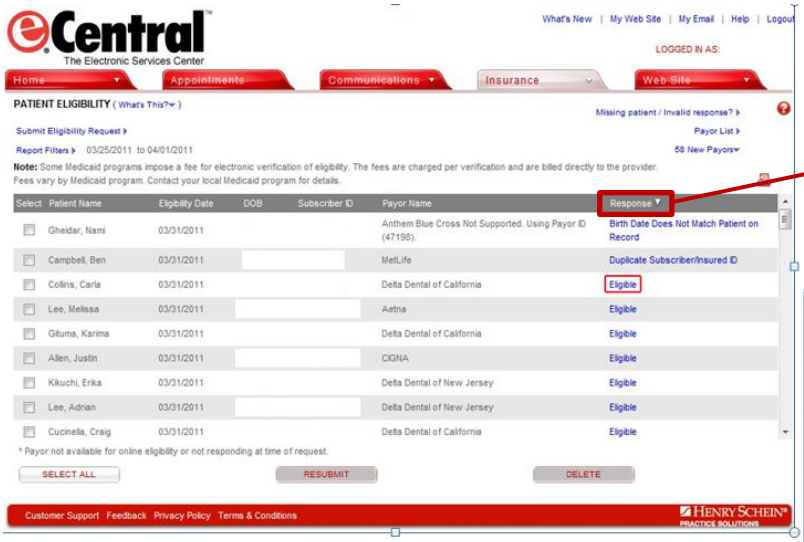
Patient Eligibility:

You can open the Patient Eligibility by going back to the main page of the Insurance Manger and hovering over the Insurance tab at the top and then clicking on Patient Eligibility or by clicking on “View Patient Eligibility” in the lower left hand area of the page.



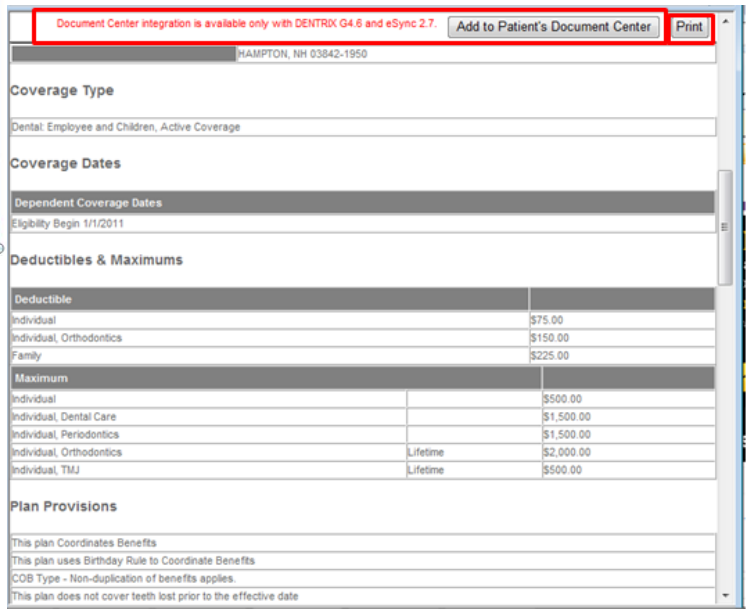
Patient Eligibility is a feature that provides real-time information about whether a patient is eligible for insurance. Ecentral looks at the patients you have scheduled on your appointment book for two weeks out and based on the information you have entered in the Insurance Data area of the Family File it checks with the Insurance Companies that are participating with Ecentral for patient Eligibility. This looks at all of your patients scheduled that have insurance. You will only be able to get the Eligible status however if that insurance company is participating with Ecentral. *You may narrow your responses by clicking on “Report Filters” in the upper left hand area of the screen and unselect All Responses and then select only the “Eligible” response.

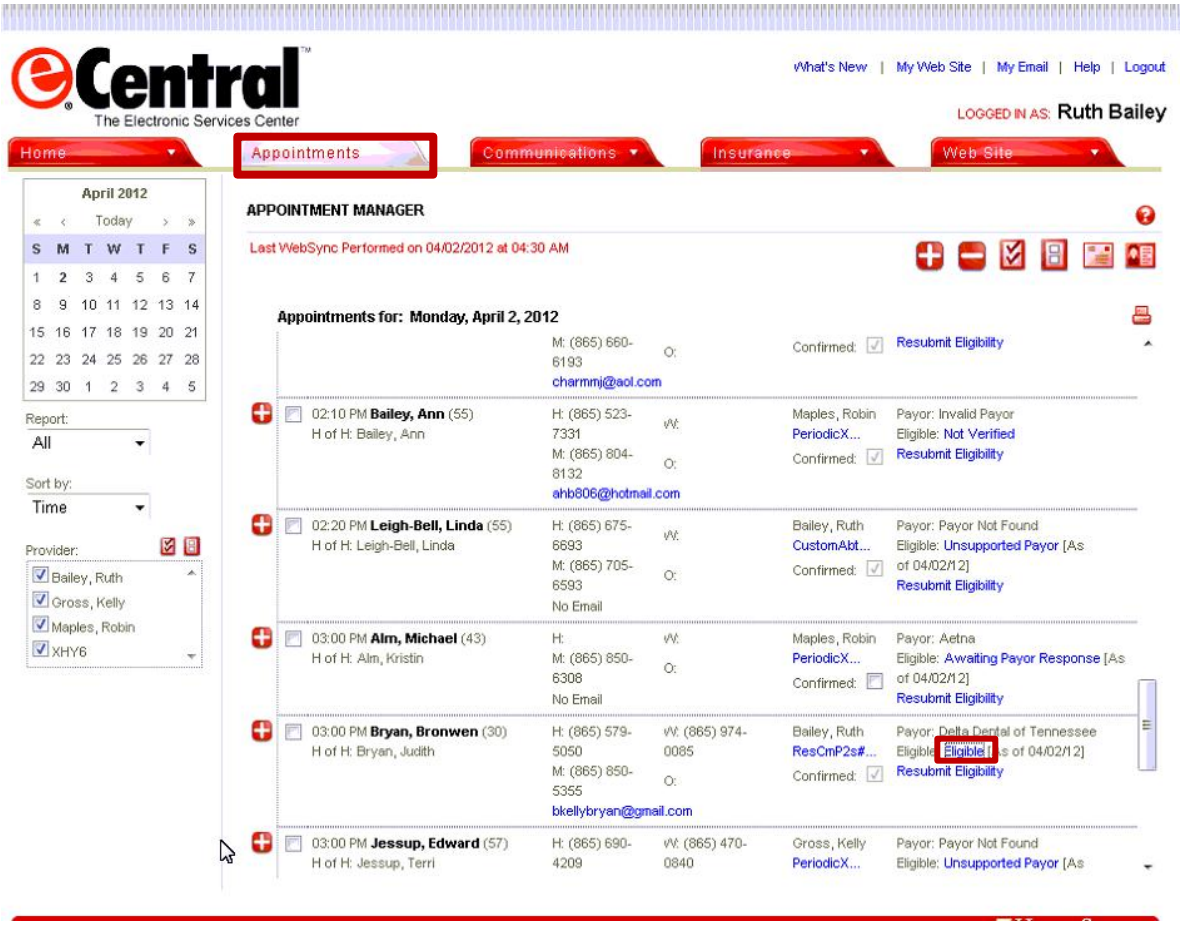
If a patient is eligible, a breakdown of benefits may be found by clicking on the blue ‘eligible’ link.



By clicking directly on the word Response the page will alphabetize the responses and bring the Eligible ones to the top of the list.

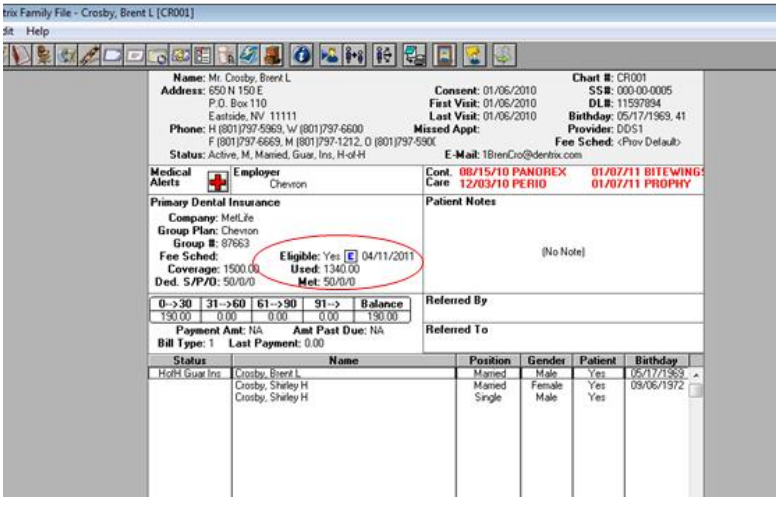
The breakdown of the Patients benefits will open in a new window.
You can Print the Detail Document or Add to Patient's Document Center. **The information that is downloaded depends on the insurance company. Some insurance companies send more benefit information than others do.



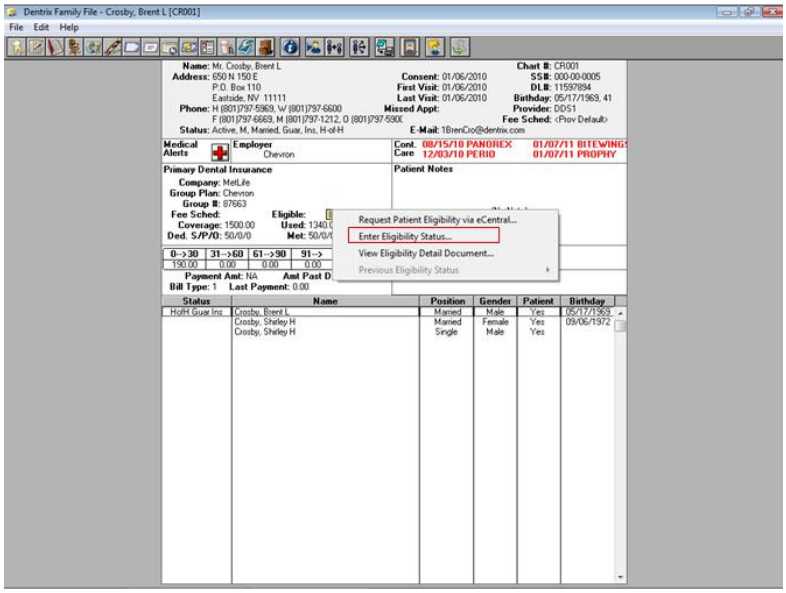


By clicking on the "Appointments" tab at the top it will allow you to look at the patients you have scheduled per day. You can get to the eligibility on the right hand side and click on the word "Eligible". This will load the breakdown of benefits for that patient. You will have an option at the top of the page to "Save to Patients Document Center". Click in the blank box and type in the name of the insurance company for that patient. This will save it in this patients Doc Center under the Eligibility folder and then the name of the Insurance.

The little "E" in the primary insurance window of the Family File or on the appointment in the Appointment Book will turn blue once the eligibility has been verified and loaded by Ecentral.



By right clicking directly on the "E" you will see more options available to you.



*Request Patient Eligibility via eCentral
Does the same as double clicking on the “E”

*Enter Eligibility Status
You can manually change the status. You can use this for companies that do not participate with Ecentral yet and enter any notes you want.

*View Eligibility Detail Document
If you have saved the breakdown of benefits to the patient Doc Center you can now view it from either the Family File or the Appointment Book and don’t have to go to the Doc Center to open it.