Term	Definition	Attribution
270 Transaction	*See ASC X12/005010X279A1*	
271 Transaction	*See ASC X12/005010X279A2*	
835 transaction segments	A group of like data elements within the Electronic Remittance Transactions beginning with a segment ID which describes the type of data elements that follow. Segments, once prescribed in a sequence, for a complete electronic document or transaction set.	Edibasics.com
ADA CDT	American Dental Associaiton Current Dental Terminology is a dental procedure code set authored and maintained by the American Dental Association, a national Standards Development Organization accredited by ANSI	ada.org
ADA CDT Category of Service	The ADA CDT Manual organizes dental procedures code into groups, for example *Diagnostic* category of service is the code range D0100-D0999. Additional examples are available in Appendix A of the ADA CDT Manual.	ada.org
ADA CDT Manual	Published by the ADA annually, a reference manual that contains CDT codes effective for services provided for the year published (i.e. January 1, 2015-December 31, 2015).	ada.org
ADA Codebook	See *ADA CDT Manual* .	ada.org
ADA Common Dental Codebook	See *ADA CDT Manual.*	ada.org
ADA Glossary	The ADA Glossary is defines "many terms used daily by dentists and their staff in the course of delivering care to patients, maintaining patient records and preparing claims. Many terms are familiar, especially to experienced individuals. New dentists and staff, however, may not be as familiar – and over time new terms come into use and old terms are revised for clarity."	ada.org
Adjunctive Procedures	A category of dental procedures outlined in the ADA CDT Code Book including secondary treatments in addition to the primary therapy. See ADA CDT D9000 series codes).	
Adjustment Amount	The amount that the expected claim payment is changed due to a specific reason determined by the payer.	
Adolescent	The period in human growth and development that occurs after childhood and before adulthood, from ages 10-19, though from a dental benefit plan design perspective, the age range may be different.	WHO.int
Adult	A person older than 19 years of age, though from a dental benefit plan design perspective, the age range may be different.	WHO.int
Age Limitations	The minimum or maximum age at which and insured person can receive benefits.	
Aligners	A clear, custom fabricated device used for straightening teeth; a device that uses incremental, transparent molded trays to adjust teeth as an alternative to braces.	Thefreedictionary.com
Appliance	A device placed in or on a patient by a dentist as part of treatment protocol. Dental appliances include orthodontic, prosthetic, retaining, snoring/airway and habit modification devices.	Thefreedictionary.com
Arch	The curved composite structure of the natural dentition and residual ridge (or the remains thereof) after the loss of some or all natural teeth. Classified as 'upper' or 'lower'.	ada.org

ASC X12	Accredited Standards Committee: established in 1979 by the American National Standards Institute (ANSI) to develop standards for industry electronic exchange of business transactions (Electronic Data Interchange or EDI).	x12.org
ASC X12/005010X279A1	The Type 1 Errata modifications mandate for use with the ASC X12N/005010X2179 270/271 Health Care Eligibility Benefit Inquiry and Response transaction format.	registry.x12.org
Beneficiary	A person who is eligible for benefits under a dental benefit contract. Also known as covered person, or member.	ada.org
Benefit Class	Also known as coverage category: Categories defined by payers / plans containing similar types of procedures which will also have similar benefit coverage, exclusions and limitations. Benefit classes can vary from plan to plan.	deltadental.com
Benefit Inquiry	A request for information from a dental provider or patient to a dental payer regarding the details of benefit information for a beneficiary. Requests can come in via the 270 transaction or via phone call, fax or viewing a website.	
Benefit Period Maximums	The maximum reimbursement level determined by the administrator of a dental benefit plan to be provided for a specified period of time.	
Benefit Plan Description	The plan administrator is legally obligated to provide to participants, free of charge, the SPD. The Summary Plan Description is an important document that tells participants what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits becomes vested, when and in what form benefits are paid, and how to file a claim for benefits. If a plan is changed, participants must be informed, either through a revised summary plan description, or in a separate document, called a summary of material modifications, which also must be given to participants free of charge.	
Best Practices	A set of guidelines, ethics or ideas that represent the most efficient or prudent course of action, set forth by an authority; a recommended course of action.	investopedia.com
Business Rules	Business rules are abstractions of the policies and practices of a business organization. In computer software development, the business rules approach is a development methodology where rules are in a form that is used by, but does not have to be embedded in, business process management systems.	en.wikipedia.org
Business Scenarios	A business scenario describes a business process, application, or set of applications that can support a specific patient situation for a provider use case and the information source being the payer's response.	
Business Use Case	*See Business Scenario*	
CAGC	Claim Adjustment Group Code; claim adjustment group codes assign financial responsibility for the unpaid portion of the claim balance; CAGC codes include CO (Contractual Obligations) OA (Other Adjustments) PI (Payer Initiated Reductions) PR (Patient Responsibility)	Wpc-edi.com
Calendar Year	A period of time from January 1 through December 31.	

CAQH CORE Business Scenarios	CAQH CORE Business Scenarios are: #1: Additional Information Required – Missing/Invalid/Incomplete Documentation #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim #3: Billed Service Not Covered by Health Plan #4: Benefit for Billed Service Not Separately Payable Together, the CAQH CORE Business Scenarios and code combinations make up the CORE-required Code Combinations for CORE-defined Business Scenarios, a companion document to the CAQH CORE 360: Uniform Use of CARCs and RARCs (835) Rule	caqh.org
CAQH CORE Operating Rules	The necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation. The rules clarify existing standards to make electronic transactions more predictable and consistent regardless of the technology. They build of applicable HIPAA requirements and other related standards.	caqh.org
CARC	Claim Adjustment Reason Codes; claim adjustment reason codes are used to communicate an adjustment or denial when a claim or service line is paid differently than it was billed.	Wpc-edi.com
CDT Nomenclature	Developed by the federal government in 2000 as the national terminology for reporting dental services on claims submitted to third-party payers in accordance with the HIPPA Act of 1996. See ADA CDT Manual.	ada.org
Claim Payment Amount	The amount that an benefit plan pays on a claim based on the terms of the insurance policy.	
Contract (provider)	A legally enforceable agreement between 2 or more entities or individuals that confers rights and duties on the parties. i.e. contract between an insurance carrier (benefit organization) and a dentist would define the dentist's duties to both the beneficiaries and the insurance carrier and usually define the way in which the dentist will be reimbursed.	ada.org
Contract Period	Usually a 12 month period of time for which a contract is written and a group's deductibles, maximums and other provisions apply. This may or may not be the same as a calendar year.	ada.org
Contracted Allowance Period	The period of time under which benefits are eligible. See *Eligibility Dates, Frequency Limitation* and *Procedure Frequency* .	
Coverage Category	*See Benefit Class.*	
Covered Person	*See Beneficiary.*	
Current Payment Period	The period of time for which the current remittance advice applies.	
Date of Service	The date on which a dental procedure(s) was performed on a patient.	
Deductible (family)	*See deductible (plan).*	
Deductible (patient)	*See deductible (plan).*	
Deductible (plan)	The amount of dental expense for which the beneficiary is responsible before a dental insurer will assume any liability for payment of benefits. Deductible may be an annual or one-time charge, and may vary in amount from program to program. *See Deductible (patient) and Deductible (family)* .	ada.org
Deferred Payment	Any payment to be made at a later time.	number 45 ok

Dental Payer	An licensed organization offering a dental benefit plan; Also known as insurance carrier, dental plan organization.	ada.org
Dental Plan	Entitles covered individuals to specified dental services in return for a fixed, periodic payment made in advance of treatment. Also known as Dental Insurance Plan.	ada.org
Dental Plan Payers	See "Dental Payer"	
Dental Practice	A health care organization comprised of one or more dental practitioners specializing in the diagnosis, prevention, and treatment of diseases and conditions of the oral cavity.	DDPA.com
Dental Procedure Code	A 5 character alphanumeric code beginning with the letter "D" that identifies a specific dental procedure. A procedure code cannot be changed, extended or abbreviated except through the ADA CDT Code Set change process.	ada.org
Dental Provider	A licensed practicitioner who provides dental treatment(s) to patients. Examples of dental providers are: general dentists, oral surgeons, endodontists, periodontists, pediatric dentists, prosthodontists, orthodontists and dental hygienists.	
Dental Reconciliation Vendors	An entity ensures that claim payments are applied to the proper patients and services.	
Dental Service Type Codes	A code used to identify the classification of services or benefits. This code list is for use in ASC X12 Transaction Sets for 270, 271 and 278. *See NDEDIC Top Dental Eligibility and Benefit Questions Response Guide, Appendix A.*	wpc-edi.com
Dependent	Refers to individuals covered under family-based employer group health plans. Covered "Dependents" are typically defined by terms of the benefit contract.	
Diagnostic Procedures	A category of dental procedures outlined in the ADA CDT Code Book used to identify a particular dental disease or condition. See ADA CDT codes D0100-D0999.	
DSO	Dental Service Organization: individual companies who provide comprehensive administrative and other support services to dentists or groups of dentists. DSO's are typically associated with multiple location practices.	dentistryiq.com
EDI	A method of **electronically transmitting** data using a structured format that is reliant upon a standard or set of standards mutually agreed upon by all trading partners.	
Electronic Remittance Advice (ERA)	*See Health Care Claim Payment/Advice (835).*	
Eligibility	The circumstances or conditions that define who and when a person may qualify to enroll in a plan and/or a specific category of covered services. These circumstances or conditions may include the length of employment, job status, length of time an enrollee has been covered under the plan, dependency, child and student age limits, etc.	deltadentalins.com
Eligibility Dates	The date(s) in which an individual and/or dependents became eligible for benefits under a benefit contract. See also *Contracted Allowance Period, Frequency Limitations* , and *Procedure Frequency* .	ada.org

Endodontics	A category of dental procedures outlined in the ADA CDT Code Book concerned with morphology, physiology, and pathology of the human dental pulp and periradicular tissues (i.e. root canal therapy). See ADA CDT codes D3000-D3999.	
Extraction	The process or act of removing a tooth or tooth parts. This procedure is defined in the oral maxiofacial ADA CDT codes in the D7111-D7251 range.	ada.org
Financial Obligations	Any payments that must be made by one party to another.	
Financial Responsibility: Patient's	The amount of money that a patient is responsible to pay to the provider for services provided based on their plan provisions.	
Financial Responsibility: Plan's	The amount of money that a payer is responsible to pay to the provider for an covered patient for services rendered based on their benefit plan provisions.	
Fiscal Year	A period used for calculating annual ("yearly") financial statements and contract periods beginning and ending dates in healthcare businesses and other organizations all over the world. This varies from organization to organization; an example of a fiscal year for the federal government begins October 1 and ends on September 30.	en.wikipedia.org
Frequency	The rate at which something occurs or is repeated over a particular period of time.	Google
Frequency Limitation	Often times specified in a dental contract, the rate at which something occurs or is repeated over a particular period of time. A limit placed on how much time must elapse before certain procedures can be repeated. For example: on the same tooth, within a calendar period, patient age, etc. See also Contracted Allowance Period, Eligibility Dates, and Procedure Frequency.	
Health Care Claim Payment/Advice (835)	The 835 is an electronic transaction used primarily by healthcare insurance plans to report payments to healthcare providers, to provide Explanations of Benefits (EOBs), or both. When a healthcare service provider submits an 837 Health Care Claim, the insurance plan uses the 835 in response to detail the payment or denial details of that claim.	1edisource.com
Implant	Also known as "Dental Implant". A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement, and referenced by ADA CDT CDT codes D6000-D6199.	ada.org
Individual	See *Patient; Subscriber.*	
Initial Payment	In the instance where a dental provider submits a single orthodontic claim and the payer determines that the treatment is a covered benefit, the payer establishes a payment schedule, reimbursing the provider first for the placement of the orthodontic appliance (initial payment) then generates subsequent payments for the balance of the total covered orthodontic services (deferred payment).	
Intermediary Calculations	During the payer's processing of an orthodontic claim, there are numerous calculations performed, some of which are part of the 835 remittance transaction, while others are internal payer system calculations. See the terms beginning with "*Ortho-xxx*" for related terms.	

Life of the Claim	The period of time beginning when a provider submits a claim to a payer until it is either denied or final payment is made.	
Line Item Charge Amount	The dollar amount supplied by a provider on a claim for a specific procedure code.	
Line Item Control Number	An identifier (a unique number or other format) on the claim's detail for a specific line item.	
Line Item Provider Payment Amount	The dollar amount determined to be reimbursable by the payer to the provider for a specific line item.	
Maxiofacial Prosthetics	A category of dental procedures outlined in the ADA CDT Code Book, a subspecialty of prosthodontics that manages replacement and restoration of lost or missing structures and functions in the head and neck region with artificial substitutes. See ADA CDT codes D5900-D5999.	
Member	*See Beneficiary.*	ada.org
Missing Tooth Limitations	A Dental Plan rule that determines whether or not services will be covered for a tooth removed prior to the patient eligibility in the dental plan.	
NCPDP	NCPDP (National Council for Prescription Drug Programs) is a not-for-profit, multi-stakeholder forum for developing and promoting industry standards in the pharmaceutical benefit industry and business solutions that improve patient safety and health outcomes, while also decreasing costs. The work of the organization is accomplished through its members who bring high-level expertise and diverse perspectives to the forum.	NCPDP.org
Next Available Date	The date at which a procedure will next be covered following a frequency or coverage limitation.	
Oral and Maxillofacial Surgery	A category of dental procedures outlined in the ADA CDT Code Book which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. See ADA CDT Codes D7000-D7999.	
Ortho-1st Payment – Allowed Amount	For the *initial Orthodontic claim payment* , the total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be reimbursable to the provider. The amount is composed of two parts: Ortho-1st Payment - Patient Responsibility Ortho-1st Payment - Plan Paid Amount	
Ortho-1st Payment - Patient Responsibility	For the *initial Orthodontic claim payment* , the dollar amount (of a single orthodontic claim submission) determined by the payer to be reimbursable to the provider from the patient. This is a subset of the "Ortho-1st Payment – Allowed Amount".	
Ortho-1st Payment - Plan Paid Amount	For the *initial Orthodontic claim payment* , the dollar amount (of a single orthodontic claim submission) determined by the payer to be reimbursable to the provider from the payer. This is a subset of the "Ortho-1st Payment – Allowed Amount".	

Ortho-Amount Claim Exceeds Total Contract Allowed Amount (provider write-off)	The total dollar amount (of a single orthodontic claim submission) that is determined by the payer to exceed the provider's contracted reimbursement amount. Providers are required to adjust their receivables when this amount will not be reimbursed by the the patient for services delivered. If they are permitted by their payer contact, they may elect to seek reimbursement from the patient.	
Ortho-Current Period Benefit Paid Amount	For a *scheduled, deferred Orthodontic claim payment,* the dollar amount (of a single orthodontic claim submission) that is determined by the payer to be the plan's responsibility to the provider as part of a periodic, scheduled payment.	
Ortho-Current Period Contract Allowed Amount	For a *scheduled, deferred Orthodontic claim payment,* the total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be reimbursable to the provider from the payer itself and the patient as part of a periodic, scheduled payment.	
Ortho-Current Period Patient Deferred Amount	For a *scheduled, deferred Orthodontic claim payment,* the total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be the balance of what the patient will owe in the future.	
Ortho-Current Period Patient Responsibility	For a *scheduled, deferred Orthodontic claim payment,* the total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be the patient's responsibility as part of this current payment.	
Ortho-Current Period Provider Deferred Amount	For a *scheduled, deferred Orthodontic claim payment,* the total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be the balance of what the payer owes the provider in the future.	
Orthodontic Claim	A transaction submitted by a dental provider to a dental payer seeking reimbursement for orthodontic services.	
Orthodontic Treatment Services	A category of dental procedures outlined in the ADA CDT Code Book associated with the correction of a patient's improper positioning of teeth. See ADA CDT code book codes D8000-D8999	
Orthodontics	A category of dental procedures (including Dento-Facial orthopedics. Orthodontics and Dento-Facial orthopedics) outlined in the ADA CDT Code Book that includes diagnosis, prevention, interception, and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures. See ADA CDT codes D8000-D8999.	
Ortho-Initial Provider Responsibility (write off)	For the *initial Orthodontic claim payment* , the dollar amount (of a single orthodontic claim submission) that is determined by the payer as part of the first claim payment to exceed the provider's contracted reimbursement amount.	
Ortho-Patient Deferred Amount	The total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be the amount the patient [their share] owes the provider to be paid in future payments.	
Ortho-Previous Period (s) Patient Responsibility	For a *scheduled, deferred Orthodontic claim payment* , this represents total dollar amount (of a single orthodontic claim submission) that is determined by the payer as the patient [their share] had been responsible for from previous payment periods.	

Ortho-Provider Deferred Amount	For a *scheduled, deferred Orthodontic claim payment,* this represents the total dollar amount (of a single orthodontic claim submission) that is determined by the payer as their responsible to be paid in future periodic payments.	
Ortho-Total Contract Allowed Amount	The total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be reimbursable under the patient's plan and provider contract rules.	
Ortho-Total Deferred Amount	The total dollar amount (of a single orthodontic claim submission) that is determined by the payer to be paid to the provider from both the payer and the patient in future periodic payments.	
Ortho-Total Initial Submitted Charges	The total dollar amount of a single orthodontic claim submission.	
Ortho-Total Patient Responsibility	The total dollar amount (of a single orthodontic claim submission) that is determined by the payer as the patient [their share] responsibility.	
Ortho-Total Previously Paid Amount	For a *scheduled, deferred Orthodontic claim payment* this represents the total dollar amount (of a single orthodontic claim submission) that has been paid to the provider from both the payer and patient.	
Patient	An individual who has established a professional relationship with a dentist for the delivery of dental health care.	ada.org
Patient Control Number	A unique number assigned by the provider to refer to a patient, term is also known as a *Patient Number, Account Number, Patient Account Number* and/or *Patient ID.*	
Patient Representative	The patient's parent, caretaker, guardian, or other individual as appropriate under state law who is legally authorized to speak on behalf of the patient when communicating with a dental provider or dental payer.	
Patient Responsibility Amount	See *Financial Responsibility: Patient's* .	
Payer	See *Dental Payer* .	ada.org
Payer Claim Control Number	A unique number assigned by the payer to identify and track a claim.	
Payer's Payment Cycle	The periodicity by which a payer sends payments to a provider, e.g. monthly, bi-weekly, weekly, or daily.	
Payment Schedule	A defined set of dates or periods with associated amounts by which a series of payments will be made.	
Periodic Examinations	An examination performed on a patient to determine any change in the patient's dental and medical health status since a previous comprehensive evaluation.	ada.org
Periodic Maintenance Treatments	Treatments received over time to supplement and maintain the success of the initial treatment.	
Periodontic Procedures	A category of dental procedures outlined in the ADA CDT Code Book which includes the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues. See ADA CDT codes D4000-D4999.	
Plan	*See Dental Plan.*	
Plan Deductible	*See Deductible.*	
Plan Maximums	The maximum amount a health plan will pay for specified procedures for a covered patient over the lifetime of the plan or a contracted duration of time.	

Plan Specific Web Sites	A web site for dental plan that provides dental health care information, health plan sales, services and support to brokers, providers and patients.	
Plan-Level	The contracted benefit design rules that govern all covered individuals in a dental plan.	
Predetermination of Benefits	A process where a dentist submits a treatment plan to the payer before treatment begins. The payer reviews the treatment plan and notifies the dentist and patient of one or more of the following: patient's eligibility, covered services, amounts payable, co-payment and deductibles and plan maximums. This process includes a clinical documentation review and the covered services include the amounts the payer will pay for them.	ada.org
Pre-treatment Estimate	A process where a dentist submits a treatment plan to the payer before treatment begins. The payer reviews the treatment plan and notifies the dentist and patient of one or more of the following: patient's eligibility, covered services, amounts payable, co-payment and deductibles and plan maximums.	
Preventative Dentistry	Aspects of dentistry concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.	ada.org
Preventative Procedures	A category of dental procedures outlined in the ADA CDT Code Book including prophylaxis and fluoride application. See ADA CDT codes D1000-D1999.	
Prior Authorizations	A process where a dental provider submits a treatment plan to the payer before treatment begins. The payer reviews the treatment plan and clinical documentation and notifies the provider and patient of the reimbursement amount based on contracted benefits, eligibility, maximums, deductibles and guarantees payment if exact treatment is provided within a payer-specified time period, typically 60 to 90 days.	
Prior Contractual Reductions	A reduction in reimbursable payment amount that had been previously reported.	
Procedure Class	For the purpose of this document, Procedure Class will align with the ADA CDT Category of Service. Refer to Section 1 of the ADA CDT Manual for more information	
Procedure Frequency	The number of times a procedure is or may be performed in a given time period. See also *Contracted Allowance Period, Eligibility Dates* , and *Frequency Limitation* .	
Procedure Qualifier	An indicator to note that the benefit information sent is specific to the procedure code(s) level.	
Prosthodontic Procedures	A category of dental procedures outlined in the ADA CDT Code Book and associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes. See ADA CDT codes D5000-D5999	
Prosthodontics	See Prosthodontics Procedures (fixed) and Prosthodontics Procedures(removable).	

Prosthodontics Procedures (fixed)	A category of dental procedures outlined in the ADA CDT Code Book including the preparation and installation of dental prostheses designed to be permanent and not be removable by the patient. Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes. See ADACDT codes D6200-D6999	
Prosthodontics Procedures(removable)	A category of dental procedures outlined in the ADA CDT Code Book including the preparation and installation of dental prostheses designed to be removable by the patient. Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes. See ADA CDT codes D5000-D5899.	
Provider Adjustments	The amount that the expected claim payment is changed due to a specific reason determined by the payer.	
Provider Write-off	The amount of a claim in excess of the amount allowed by the contract between the payer and the provider. This amount may or may not be collectable by the provider from any source, depending on the contract.	
Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. (I.e. upper right, lower right, upper left and lower left.)	ada.org
RARC	Remittance Advice Remark Codes (RARCs) are used to provide additional explanation for an adjustment as defined by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing.	Wpc-edi.com
Remittance Transactions	An electronic communication from a payer to a provider concerning payment, e.g. ASC X12 835 transactions.	
Restorative Procedures	A category of dental procedures outlined in the ADA CDT Code Book to repair, strengthen, stabilize, and/or limit the progression of lesions for teeth damaged by decay, breakage or fissures. See ADA CDT codes D2000-D2999.	
Reversal Process	The process whereby a payer reverses a previous claim payment.	
Seat Date	The date on which a crown, bridge, implant or other restorative appliance is actually placed (installed) in the patient's mouth. Also known as a Placement Date.	
Service Type Code	A code maintained by ASC X12 Codes Committee that is used to classify medical, dental or other health care service types or benefit classifications.	wpc-edi.com
Services	A collection of dental-related procedures for the evaluation, diagnosis, treatment planning, and treatment of a dental patient.	
Subscriber	A person that pays the premiums or a person whose employment makes him or her eligible for membership in the plan in an individual or group-based health care plan.	online-health-insurance.com

Technical Report 3 (ASC X12 TR3)	ASC X12 standards are developed to identify the broadest data requirements for a transaction set. Type 3 Technical Reports (TR3) defines explicit data requirements for a specific business purpose. Trading partners who implement according to the instructions in this TR3 can exchange data with multiple trading partners in a consistent manner. Trading partners define their specific transport requirements separately. Neither ASC X12 standards nor TR3s define transport requirements.	wpc-edi.com
Total Claim Charge Amount	The total amount charged to the payer by the provider for the services listed on the claim.	
Total Reimbursable Charges	The total dollar amount (of a single claim submission) that is determined by the payer to be reimbursable under the patient's plan and provider contract rules. *See Ortho-Total Contract Allowed Amount.*	
Treatment Category	*See Procedure Class.*	
Treatment Plan	The sequential guide for the patient's care as determined by the dentist's diagnosis and is used by the dentist for the restoration to and/or maintenance of optimal oral health.	Ada.org
Uniting the Industry Forum	An annual meeting held by NDEDIC which assembles dental industry stakeholders to discuss the advancement of Electronic Data Interchange (EDI) in the dental industry	
Waiting Period	The period between employment or enrollment in a dental program and the date when a covered person becomes eligible for a given benefit.	ada.org