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1 A bill to be entitled  
2 An act relating to dental insurance claims; amending  
3 s. 627.6131, F.S.; prohibiting a contract between a  
4 health insurer and a dentist from containing certain  
5 restrictions on payment methods; requiring a health  
6 insurer to make certain notifications and obtain a  
7 dentist's consent before paying a claim to the dentist  
8 through electronic funds transfer; providing that the  
9 dentist's consent applies to the dentist's entire  
10 practice; requiring the dentist's consent to bear the  
11 signature of the dentist; specifying the form of such  
12 signature; prohibiting the insurer and dentist from  
13 requiring consent on a patient-by-patient basis;  
14 specifying the requirements of a certain notification;  
15 prohibiting a health insurer from charging a fee to  
16 transmit a payment to a dentist through Automated  
17 Clearing House (ACH) transfer unless the dentist has  
18 consented to such fee; providing applicability;  
19 authorizing the Office of Insurance Regulation of the  
20 Financial Services Commission to enforce certain  
21 provisions; authorizing the commission to adopt rules;  
22 prohibiting a health insurer from denying claims for  
23 procedures included in a prior authorization;  
24 providing exceptions; providing applicability;  
25 authorizing the office to enforce certain provisions;  
26 authorizing the commission to adopt rules; amending s.  
27 636.032, F.S.; prohibiting a contract between a  
28 prepaid limited health service organization and a  
29 dentist from containing certain restrictions on

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30 payment methods; requiring the prepaid limited health  
31 service organization to make certain notifications and  
32 obtain a dentist's consent before paying a claim to  
33 the dentist through electronic funds transfer;  
34 providing that a dentist's consent applies to the  
35 dentist's entire practice; requiring the dentist's  
36 consent to bear the signature of the dentist;  
37 specifying the form of such signature; prohibiting the  
38 limited health service organization and dentist from  
39 requiring consent on a patient-by-patient basis;  
40 specifying the requirements of a certain notification;  
41 prohibiting a prepaid limited health service  
42 organization from charging a fee to transmit a payment  
43 to a dentist through ACH transfer unless the dentist  
44 has consented to such fee; providing applicability;  
45 authorizing the office to enforce certain provisions;  
46 authorizing the commission to adopt rules; amending s.  
47 636.035, F.S.; prohibiting a prepaid limited health  
48 service organization from denying claims for  
49 procedures included in a prior authorization;  
50 providing exceptions; providing applicability;  
51 authorizing the office to enforce certain provisions;  
52 authorizing the commission to adopt rules; amending s.  
53 641.315, F.S.; prohibiting a contract between a health  
54 maintenance organization and a dentist from containing  
55 certain restrictions on payment methods; requiring the  
56 health maintenance organization to make certain  
57 notifications and obtain a dentist's consent before  
58 paying a claim to the dentist through electronic funds

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59 transfer; providing that the dentist's consent applies  
60 to the dentist's entire practice; requiring the  
61 dentist's consent to bear the signature of the  
62 dentist; specifying the form of such signature;  
63 prohibiting the health maintenance organization and  
64 dentist from requiring consent on a patient-by-patient  
65 basis; specifying the requirements of a certain  
66 notification; prohibiting a health maintenance  
67 organization from charging a fee to transmit a payment  
68 to a dentist through ACH transfer unless the dentist  
69 has consented to such fee; providing applicability;  
70 authorizing the office to enforce certain provisions;  
71 authorizing the commission to adopt rules; prohibiting  
72 a health maintenance organization from denying claims  
73 for procedures included in a prior authorization;  
74 providing exceptions; providing applicability;  
75 authorizing the office to enforce certain provisions;  
76 authorizing the commission to adopt rules; providing  
77 an effective date.

78  
79 Be It Enacted by the Legislature of the State of Florida:

80  
81 Section 1. Subsections (20) and (21) are added to section  
82 627.6131, Florida Statutes, to read:

83 627.6131 Payment of claims.—

84 (20) (a) A contract between a health insurer and a dentist  
85 licensed under chapter 466 for the provision of services to an  
86 insured may not specify credit card payment as the only  
87 acceptable method for payments from the health insurer to the

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88 dentist.

89 (b) When a health insurer employs the method of claims  
90 payment to a dentist through electronic funds transfer,  
91 including, but not limited to, virtual credit card payment, the  
92 health insurer shall notify the dentist as provided in this  
93 paragraph and obtain the dentist's consent in writing before  
94 employing the electronic funds transfer. The dentist's written  
95 consent described in this paragraph applies to the dentist's  
96 entire practice. For purposes of this paragraph, the dentist's  
97 written consent, which may be given through e-mail, must bear  
98 the signature of the dentist. Such signature includes an  
99 electronic or digital signature if the form of signature is  
100 recognized as a valid signature under applicable federal law or  
101 state contract law or an act that demonstrates express consent,  
102 including, but not limited to, checking a box indicating  
103 consent. The insurer or dentist may not require that a dentist's  
104 consent as described in this paragraph be made on a patient-by-  
105 patient basis. The notification provided by the health insurer  
106 to the dentist must include all of the following:

107 1. The fees, if any, associated with the electronic funds  
108 transfer.

109 2. The available methods of payment of claims by the health  
110 insurer, with clear instructions to the dentist on how to select  
111 an alternative payment method.

112 (c) A health insurer that pays a claim to a dentist through  
113 Automated Clearing House transfer may not charge a fee solely to  
114 transmit the payment to the dentist unless the dentist has  
115 consented to the fee.

116 (d) This subsection applies to contracts delivered, issued,

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117 or renewed on or after January 1, 2025.

118 (e) The office has all rights and powers to enforce this  
119 subsection as provided by s. 624.307.

120 (f) The commission may adopt rules to implement this  
121 subsection.

122 (21) (a) A health insurer may not deny any claim  
123 subsequently submitted by a dentist licensed under chapter 466  
124 for procedures specifically included in a prior authorization  
125 unless at least one of the following circumstances applies for  
126 each procedure denied:

127 1. Benefit limitations, such as annual maximums and  
128 frequency limitations not applicable at the time of the prior  
129 authorization, are reached subsequent to issuance of the prior  
130 authorization.

131 2. The documentation provided by the person submitting the  
132 claim fails to support the claim as originally authorized.

133 3. Subsequent to the issuance of the prior authorization,  
134 new procedures are provided to the patient or a change in the  
135 condition of the patient occurs such that the prior authorized  
136 procedure would no longer be considered medically necessary,  
137 based on the prevailing standard of care.

138 4. Subsequent to the issuance of the prior authorization,  
139 new procedures are provided to the patient or a change in the  
140 patient's condition occurs such that the prior authorized  
141 procedure would at that time have required disapproval pursuant  
142 to the terms and conditions for coverage under the patient's  
143 plan in effect at the time the prior authorization was issued.

144 5. The denial of the claim was due to one of the following:  
145 a. Another payor is responsible for payment.

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146 b. The dentist has already been paid for the procedures  
147 identified in the claim.

148 c. The claim was submitted fraudulently, or the prior  
149 authorization was based in whole or material part on erroneous  
150 information provided to the health insurer by the dentist,  
151 patient, or other person not related to the insurer.

152 d. The person receiving the procedure was not eligible to  
153 receive the procedure on the date of service.

154 e. The services were provided during the grace period  
155 established under s. 627.608 or applicable federal regulations,  
156 and the dental insurer notified the provider that the patient  
157 was in the grace period when the provider requested eligibility  
158 or enrollment verification from the dental insurer, if such  
159 request was made.

160 (b) This subsection applies to all contracts delivered,  
161 issued, or renewed on or after January 1, 2025.

162 (c) The office has all rights and powers to enforce this  
163 subsection as provided by s. 624.307.

164 (d) The commission may adopt rules to implement this  
165 subsection.

166 Section 2. Section 636.032, Florida Statutes, is amended to  
167 read:

168 636.032 Acceptable payments.—

169 (1) Each prepaid limited health service organization may  
170 accept from government agencies, corporations, groups, or  
171 individuals payments covering all or part of the cost of  
172 contracts entered into between the prepaid limited health  
173 service organization and its subscribers.

174 (2) (a) A contract between a prepaid limited health service

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175 organization and a dentist licensed under chapter 466 for the  
176 provision of services to a subscriber may not specify credit  
177 card payment as the only acceptable method for payments from the  
178 prepaid limited health service organization to the dentist.

179 (b) When a prepaid limited health service organization  
180 employs the method of claims payment to a dentist through  
181 electronic funds transfer, including, but not limited to,  
182 virtual credit card payment, the prepaid limited health service  
183 organization shall notify the dentist as provided in this  
184 paragraph and obtain the dentist's consent in writing before  
185 employing the electronic funds transfer. The dentist's written  
186 consent described in this paragraph applies to the dentist's  
187 entire practice. For purposes of this paragraph, the dentist's  
188 written consent, which may be given through e-mail, must bear  
189 the signature of the dentist. Such signature includes an  
190 electronic or digital signature if the form of signature is  
191 recognized as a valid signature under applicable federal law or  
192 state contract law or an act that demonstrates express consent,  
193 including, but not limited to, checking a box indicating  
194 consent. The prepaid limited health service organization or  
195 dentist may not require that the dentist's consent as described  
196 in this paragraph be made on a patient-by-patient basis. The  
197 notification provided by the prepaid limited health service  
198 organization to the dentist must include all of the following:

199 1. The fees, if any, that are associated with the  
200 electronic funds transfer.

201 2. The available methods of payment of claims by the  
202 prepaid limited health service organization, with clear  
203 instructions to the dentist on how to select an alternative

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204 payment method.

205 (c) A prepaid limited health service organization that pays  
206 a claim to a dentist through Automatic Clearing House transfer  
207 may not charge a fee solely to transmit the payment to the  
208 dentist unless the dentist has consented to the fee.

209 (d) This subsection applies to contracts delivered, issued,  
210 or renewed on or after January 1, 2025.

211 (e) The office has all rights and powers to enforce this  
212 subsection as provided by s. 624.307.

213 (f) The commission may adopt rules to implement this  
214 subsection.

215 Section 3. Subsection (15) is added to section 636.035,  
216 Florida Statutes, to read:

217 636.035 Provider arrangements.—

218 (15) (a) A prepaid limited health service organization may  
219 not deny any claim subsequently submitted by a dentist licensed  
220 under chapter 466 for procedures specifically included in a  
221 prior authorization unless at least one of the following  
222 circumstances applies for each procedure denied:

223 1. Benefit limitations, such as annual maximums and  
224 frequency limitations not applicable at the time of the prior  
225 authorization, are reached subsequent to issuance of the prior  
226 authorization.

227 2. The documentation provided by the person submitting the  
228 claim fails to support the claim as originally authorized.

229 3. Subsequent to the issuance of the prior authorization,  
230 new procedures are provided to the patient or a change in the  
231 condition of the patient occurs such that the prior authorized  
232 procedure would no longer be considered medically necessary,



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233 based on the prevailing standard of care.

234 4. Subsequent to the issuance of the prior authorization,  
235 new procedures are provided to the patient or a change in the  
236 patient's condition occurs such that the prior authorized  
237 procedure would at that time have required disapproval pursuant  
238 to the terms and conditions for coverage under the patient's  
239 plan in effect at the time the prior authorization was issued.

240 5. The denial of the dental service claim was due to one of  
241 the following:

242 a. Another payor is responsible for payment.

243 b. The dentist has already been paid for the procedures  
244 identified in the claim.

245 c. The claim was submitted fraudulently, or the prior  
246 authorization was based in whole or material part on erroneous  
247 information provided to the prepaid limited health service  
248 organization by the dentist, patient, or other person not  
249 related to the organization.

250 d. The person receiving the procedure was not eligible to  
251 receive the procedure on the date of service.

252 e. The services were provided during the grace period  
253 established under s. 627.608 or applicable federal regulations,  
254 and the dental insurer notified the provider that the patient  
255 was in the grace period when the provider requested eligibility  
256 or enrollment verification from the dental insurer, if such  
257 request was made.

258 (b) This subsection applies to all contracts delivered,  
259 issued, or renewed on or after January 1, 2025.

260 (c) The office has all rights and powers to enforce this  
261 subsection as provided by s. 624.307.

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262 (d) The commission may adopt rules to implement this  
263 subsection.

264 Section 4. Subsections (13) and (14) are added to section  
265 641.315, Florida Statutes, to read:

266 641.315 Provider contracts.—

267 (13) (a) A contract between a health maintenance  
268 organization and a dentist licensed under chapter 466 for the  
269 provision of services to a subscriber of the health maintenance  
270 organization may not specify credit card payment as the only  
271 acceptable method for payments from the health maintenance  
272 organization to the dentist.

273 (b) When a health maintenance organization employs the  
274 method of claims payment to a dentist through electronic funds  
275 transfer, including, but not limited to, virtual credit card  
276 payment, the health maintenance organization shall notify the  
277 dentist as provided in this paragraph and obtain the dentist's  
278 consent in writing before employing the electronic funds  
279 transfer. The dentist's written consent described in this  
280 paragraph applies to the dentist's entire practice. For purposes  
281 of this paragraph, the dentist's written consent, which may be  
282 given through e-mail, must bear the signature of the dentist.  
283 Such signature includes an electronic or digital signature if  
284 the form of signature is recognized as a valid signature under  
285 applicable federal law or state contract law or an act that  
286 demonstrates express consent, including, but not limited to,  
287 checking a box indicating consent. The health maintenance  
288 organization or dentist may not require a dentist's consent as  
289 described in this paragraph be made on a patient-by-patient  
290 basis. The notification provided by the health maintenance

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291 organization to the dentist must include all of the following:

292 1. The fees, if any, that are associated with the  
293 electronic funds transfer.

294 2. The available methods of payment of claims by the health  
295 maintenance organization, with clear instructions to the dentist  
296 on how to select an alternative payment method.

297 (c) A health maintenance organization that pays a claim to  
298 a dentist through Automated Clearing House transfer may not  
299 charge a fee solely to transmit the payment to the dentist  
300 unless the dentist has consented to the fee.

301 (d) This subsection applies to contracts delivered, issued,  
302 or renewed on or after January 1, 2025.

303 (e) The office has all rights and powers to enforce this  
304 subsection as provided by s. 624.307.

305 (f) The commission may adopt rules to implement this  
306 subsection.

307 (14) (a) A health maintenance organization may not deny any  
308 claim subsequently submitted by a dentist licensed under chapter  
309 466 for procedures specifically included in a prior  
310 authorization unless at least one of the following circumstances  
311 applies for each procedure denied:

312 1. Benefit limitations, such as annual maximums and  
313 frequency limitations not applicable at the time of the prior  
314 authorization, are reached subsequent to issuance of the prior  
315 authorization.

316 2. The documentation provided by the person submitting the  
317 claim fails to support the claim as originally authorized.

318 3. Subsequent to the issuance of the prior authorization,  
319 new procedures are provided to the patient or a change in the

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320 condition of the patient occurs such that the prior authorized  
321 procedure would no longer be considered medically necessary,  
322 based on the prevailing standard of care.

323 4. Subsequent to the issuance of the prior authorization,  
324 new procedures are provided to the patient or a change in the  
325 patient's condition occurs such that the prior authorized  
326 procedure would at that time have required disapproval pursuant  
327 to the terms and conditions for coverage under the patient's  
328 plan in effect at the time the prior authorization was issued.

329 5. The denial of the claim was due to one of the following:

330 a. Another payor is responsible for payment.

331 b. The dentist has already been paid for the procedures  
332 identified in the claim.

333 c. The claim was submitted fraudulently, or the prior  
334 authorization was based in whole or material part on erroneous  
335 information provided to the health maintenance organization by  
336 the dentist, patient, or other person not related to the  
337 organization.

338 d. The person receiving the procedure was not eligible to  
339 receive the procedure on the date of service.

340 e. The services were provided during the grace period  
341 established under s. 627.608 or applicable federal regulations,  
342 and the dental insurer notified the provider that the patient  
343 was in the grace period when the provider requested eligibility  
344 or enrollment verification from the dental insurer, if such  
345 request was made.

346 (b) This subsection applies to all contracts delivered,  
347 issued, or renewed on or after January 1, 2025.

348 (c) The office has all rights and powers to enforce this

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349 subsection as provided by s. 624.307.

350 (d) The commission may adopt rules to implement this  
351 subsection.

352 Section 5. This act shall take effect January 1, 2025.