Dental Provider Manual

UnitedHealthcare Community Plan of Ohio

CFC and ABD - Children Ages 0-20

CFC and ABD - Adults Ages 21 and Over

Provider Services: 1-855-642-5483

Integrated Voice Response (IVR): 1-855-642-5483

Revised 12/1/2026

UnitedHealthcare® | Dental Benefit Providers®

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Section 1: Introduction — who we are

Welcome to UnitedHealthcare Community Plan

UnitedHealthcare welcomes you as a participating Dental Provider in providing dental services to our members.

We are committed to providing accessible, quality, comprehensive dental services in the most cost-effective and efficient manner possible. We realize that to do so, strong partnerships with our providers are critical, and we value you as an important part of our program.

We offer a portfolio of products including, but not limited to, Medicaid and Medicare Special Needs plans, as well as Commercial products such as Preferred Provider Organization (PPO) plans.

This Provider Manual (the "Manual") is designed as a comprehensive reference guide for the UnitedHealthcare Community Plan Medicaid plan. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, it will be uploaded on the portal at **UHCdental.com/medicaid** under State specific alerts and resources.

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353**.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at **1-855-642-5483**.

Unless otherwise specified herein, this Manual is effective the date found on the cover for dental providers currently participating in the UnitedHealthcare Community Plan's network, and effective immediately for newly contracted dental providers.

Please note: "Member" is used in this Manual to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this Manual.

The codes and code ranges listed in this Manual were current at the time this Manual was published. Codes and coding requirements, as established by the organizations that create the codes, may periodically change. Please refer to the applicable coding guide for appropriate codes.

Thank you for your continued support as we serve the Medicaid and Medicare beneficiaries in your community.

Provider Online Academy

Provider Online Academy is a resource for 24/7, on-demand, interactive, and self-paced courses for providers that cover the following topics:

- Dental provider portal training guide and digital solutions
- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy, visit **UHCdental.com/provideracademy**.

Required trainings

To remain compliant with the Ohio Department of Medicaid requirement, participating providers with the United Healthcare Community Plan of Ohio - Medicaid program are required to complete the Dental Hub trainings.

To complete the trainings:

- Click **HERE** to go to the state-specific training page
- Choose Ohio and select “Dental Hub Registration and Overview Training - REQUIRED TRAINING”
- Click on Start Course and complete the Attestation
- After submitting the completed Attestation, click the forward arrow in the bottom right corner to advance to the next page

Follow the same steps to complete the “Dental Hub Portal Training - REQUIRED TRAINING”.

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

Member eligibility or dental benefits may be verified online or via phone.

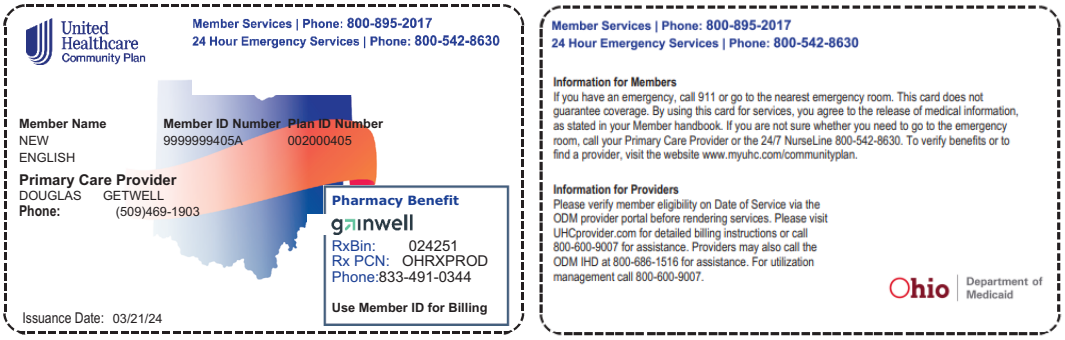
We receive daily updates on member eligibility and can provide the most up-to-date information available.

Important Note: Eligibility should be verified on the date of service. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions. **Additional rules may apply to some benefit plans.**

2.2 Identification card

Members are issued an identification (ID) card by UnitedHealthcare Community Plan. There will not be separate dental cards for UnitedHealthcare Community Plan members. The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the health plan.

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service. To verify a member's dental coverage, go to **UHCdental.com/medicaid** or contact the dental Provider Services line at the telephone number listed on the cover of this document. A sample ID card is provided below. The member's actual ID card may look slightly different.



2.3 Eligibility verification

Eligibility can be verified on our website at **UHCdental.com/medicaid** 24 hours a day, 7 days a week. In addition to current eligibility verification, our website offers other functionality for your convenience, such as claim status. Once you have registered on our provider website, you can verify your patients' eligibility online with just a few clicks.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification. The IVR is available 24 hours a day, 7 days a week.

2.4 Quick reference guide

UnitedHealthcare Community Plan is committed to providing your office accurate and timely information about our programs, products and policies.

Our Provider Services Line (noted on the cover of this manual) and Provider Services teams are available to assist you with any questions you may have. Our toll-free provider services number is available during normal business hours and is staffed with knowledgeable specialists. They are trained to handle specific dentist issues such as eligibility, claims, benefits information and contractual questions.

The following is a quick reference table to guide you to the best resource(s) available to meet your needs when questions arise:

You want to:	Provider Services Line—1-855-642-5483 Dedicated Service Representatives Hours: 8 a.m.-6 p.m. (EST) Monday-Friday	Online UHCdental.com/medicaid	Interactive Voice Response (IVR) System and Voicemail Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

2.5 Provider Portal / Dental Hub

The UnitedHealthcare Community Plan website—**UHCdental.com/medicaid**—provides access to provider manuals, reference guides, educational materials, forms and other resources to help support your dental practice.

You can also register or sign in to the Dental Hub directly from **UHCdental.com/medicaid**. The Dental Hub is the provider portal for participating dentists serving our Medicaid members. It offers digital tools such as eligibility verification, benefit information, claim submission and status, remittance details, and more. After selecting Dental Hub sign in, click More sign in options and select Sign in with UnitedHealthcare. Then create or enter your One Healthcare ID to access both UnitedHealthcare and the Dental Hub provider portals.

To register for the Dental Hub, you will need a W-9 and either a recently paid claim or the registration code included in your UnitedHealthcare Welcome Letter. You can also **join a free webinar or review the Quick Start Guide** to learn how to register and navigate the Dental Hub.

Tip: Create your One Healthcare ID (OHID) by signing in to UnitedHealthcare first, then set up your Dental Hub account. Once both accounts are created, use your OHID as a single login for both UnitedHealthcare and the Dental Hub.

2.6 Integrated Voice Response (IVR) system — 1-855-642-5483

We have a toll-free Integrated Voice Response (IVR) system that enables you to access information 24 hours a day, 7 days a week, by responding to the system's voice prompts.

Through this system, network dental offices can obtain immediate eligibility information, validate practitioner participation status and perform member claim history search (by procedure code and tooth number).

Section 3: Office administration

3.1 Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of services (QOS) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance.
- Available handicapped parking and handicapped accessible facilities.
- Available adequate waiting room space and dental operatories for providing member care.
- Privacy in the operatory.
- Clearly marked exits.
- Accessible fire extinguishers.

3.2 Office conditions

Your dental office must meet applicable Occupational Safety & Health Administration (OSHA), CDC infection control guidelines and American Dental Association (ADA) standards.

An attestation is required for each dental office location that the physical office meets ADA standards or describes how accommodation for ADA standards is made, and that medical recordkeeping practices conform with our standards.

3.3 Sterilization and infection control fees

Dental office infection control programs must meet the minimum requirements based on the Centers for Disease Control & Prevention's (CDC) guiding principles of infection control. All instruments should be sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA and state guidelines.

Sterilization and infection control fees are to be included within office procedure charges and should not be billed to members or the plan as a separate fee.

3.4 Recall system

It is expected that offices will have an active and definable recall system to make sure that the practice maintains preventive services, including patient education and appropriate access. Examples of an active recall system include, but are not limited to: postcards, letters, phone calls, emails and advance appointment scheduling.

3.5 Transfer of dental records

Your office shall copy all requested member dental records for Medicaid eligible individuals available for transfer to new providers at no cost to the individual.

Additionally, your office shall maintain adequate medical, financial and administrative records related to Covered Services in a manner consistent with the standards in the community and in accordance with all applicable State and Federal Law. Any such records shall be maintained for a period of at least ten (10) years or such longer period as is required by applicable law. Upon request, the Practice shall provide to UnitedHealthcare, at the Practice's expense, copies of such information and records. Your office must obtain any member consent required to authorize your office to provide access to such information and records.

3.6 Office hours

Provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

3.7 Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

3.8 Provide access to your records

You shall provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 30 calendar days of receiving the request. However, if the medical records are needed for ongoing medical care, the provider must provide them within a reasonable time, generally no more than 5 business days. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal or a regulatory or accreditation agency requirement. Maintain these records for ten (10) years or longer if required by applicable statutes or regulations.

3.9 Inform members of advance directives

Members have the right to make their own health care decisions. This includes accepting or refusing treatment. They may execute an advance directive at any time. An advance directive is a document in which the member makes rules around their health care decisions if they later cannot make those decisions.

Several types of advance directives are available. You must comply with all applicable state law requirements about advance directives.

Members are not required to have an advance directive. You cannot provide care or otherwise discriminate against a member based on whether they have executed one. Document in a member's medical record whether they have executed or refused to have an advance directive.

If a member has one, keep a copy in their medical record. Or provide a copy to the member's PCP. Do not send a copy of a member's advance directive to UnitedHealthcare Community Plan.

If a member has a complaint about non-compliance with an advance directive requirement, they may file a complaint with the UnitedHealthcare Community Plan medical director, the physician reviewer, and/or the state survey and certification agency.

3.10 Participate in quality initiatives

You shall help our quality assessment and improvement activities. You shall also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by United States government agencies and professional specialty societies.

3.11 New associates

As your practice expands and new associates are added, you must contact us within 10 calendar days to request an application.

It is important to remember that associates may not see members as a participating provider until they've been fully credentialed and approved by the Ohio Department of Medicaid (ODM). Refer to Section 6.2 for additional information regarding Credentialing.

To request a provider application packet, visit **Join our network** or contact Provider Services at **1-855-642-5483.**

3.12 Change of address, phone number, email address, fax or tax identification number

When there are demographic changes within your office, you must notify the Ohio Department of Medicaid (ODM) and UnitedHealthcare at least 10 calendar days prior to the effective date of the change. This supports accurate claims processing as well as helps to make sure that member directories are up-to-date.

Changes should be submitted to ODM in the Provider Network Management (PNM) module. Click on the following links for step-by-step instructions on how to complete these actions:

- **Updating or Adding Owner Information**
- **Updating or Adding Practice Locations**
- **Updating or Adding Specialty in PNM**

Changes should also be submitted to UnitedHealthcare at the address, fax, or email below:

UnitedHealthcare – RMO
ATTN: 400-Provider Services
PO BOX 30567
SALT LAKE CITY, UT 84130

Fax: 1-855-363-9691
Email: **dbpprvfx@uhc.com**

Requests must be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W9, versus an office closing notice where we'd need the notice submitted in writing on office letterhead.

When changes need to be made to your practice, we will need an outline of the old information as well as the changes that are being requested. This should include the name(s), TIN(s) and/or Practitioner ID(s) for all associates to whom that the changes apply.

UnitedHealthcare reserves the right to conduct an onsite inspection of any new facilities and will do so based on state and plan requirements.

If you have any questions, don't hesitate to contact Provider Services at the telephone number listed on the cover of this document for guidance.

Section 4: Patient access

4.1 Appointment scheduling standards

We are committed to ensuring that providers are accessible and available to members for the full range of services specified in the UnitedHealthcare Community Plan provider agreement and this manual. Participating providers must meet or exceed the following state mandated or plan requirements:

- **Urgent care appointments** Within 48 hours
- **Routine care appointments** Offered within six (6) weeks of the request

We may monitor compliance with these access and availability standards through a variety of methods including member feedback, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. If necessary, the findings may be presented to UnitedHealthcare Community Plan's Quality Committee for further discussion and development of a corrective action plan.

Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain, lost tooth, trauma or other dental injury.

Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

4.2 Emergency coverage

All network dental providers must be available to members during normal business hours. Practitioners will provide members access to emergency care 24 hours a day, 7 days a week through their practice or through other resources (such as another practice or a local emergency care facility). The out-of-office greeting must instruct callers what to do to obtain services after business hours and on weekends, particularly in the case of an emergency.

UnitedHealthcare Community Plan conducts periodic surveys to make sure our network providers' emergency coverage practices meet these standards.

4.3 Specialist referral process

If a member needs specialty care, a general dentist may recommend a network specialty dentist, or the member can self-select a participating network specialist. Referrals must be made to qualified specialists who are participating within the provider network. No written referrals are needed for specialty dental care.

To obtain a list of participating dental network specialists, go to our website at **UHCdental.com/medicaid**. Click "Find a Dentist" on the top right and then choose "Medicaid". There you will follow the prompts to search for a participating network specialist in your area. You may also contact Provider services at the telephone number listed on the cover of this document.

4.4 Missed appointments

Enrolled Participating Providers are not allowed to charge Members for missed appointments.

If your office mails letters to Members who miss appointments, the following language may be helpful to include:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Contacting the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment may help to decrease the number of missed appointments.

State law and Medicaid Addendum to your contract with UHG Dental prohibit a Provider from billing Medicaid members for missed appointments. In addition, your missed appointment policy for UnitedHealthcare members cannot be stricter than that of your private or commercial patients.

4.5 Nondiscrimination

The Practice shall accept members as new patients and provide Covered Services in the same manner as such services are provided to other patients of your practice. The Practice shall not discriminate against any member on the basis of source of payment or in any manner in regards to access to, and the provision of, Covered Services. The Practice shall not unlawfully discriminate against any member on the basis of race, color, ethnicity, religion, national origin, veteran status, military status, ancestry, disability, medical status, claims experience, evidence of insurability, source of payment, genetic information, marital status, age, sexual orientation, gender identity or gender.

The Practice shall not unlawfully discriminate against any employee, or applicant for employment, on the basis of race, color, ethnicity, religion, national origin, veteran status, military status, ancestry, health status, disability, genetic information, marital status, age, sexual orientation, gender identity or gender.

Section 5: Utilization Management program

5.1 Utilization Management

Through Utilization Management practices, UnitedHealthcare aims to provide members with cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including provider analytics, utilization review, prior authorization, claims data and audits, UnitedHealthcare can evaluate group and individual practice patterns and identify those patterns that demonstrate significant variation from norms.

By identifying and remediating providers who demonstrate unwarranted variation, we can reduce the overall impact of such variation on cost of care, and improve the quality of dental care delivered.

5.2 Community practice patterns

Utilization analysis is completed using data from a variety of sources. The process compares group performance across a variety of procedure categories and subcategories including diagnostic, preventive, minor restorative (fillings), major restorative (crowns), endodontics, periodontics, fixed prosthetics (bridges), removable prosthetics (dentures), oral surgery and adjunctive procedures. The quantity and distribution of procedures performed in each category are compared with benchmarks such as similarly designed UnitedHealthcare plans and peers to determine if utilization for each category and overall are within expected levels.

Significant variation might suggest either overutilization or underutilization. Variables which might influence utilization, such as plan design and/or population demographics, are taken into account. Additional analysis can determine whether the results are common throughout the group or caused by outliers.

5.3 Evaluation of utilization management data

Once the initial Utilization Management data is analyzed, if a dentist is identified as having practice patterns demonstrating significant variation, his or her utilization may be reviewed further. For each specific dentist, a Peer Comparison Report may be generated and analysis may be performed that identifies all procedures performed on all patients for a specified time period. Potential causes of significant variation include upcoding, unbundling, miscoding, excessive treatment, under-treatment, duplicate billing, or duplicate payments. Providers demonstrating significant variation may be selected for counseling or other corrective actions.

5.4 Utilization Management analysis results

Utilization analysis findings may be shared with individual providers in order to present feedback about their performance relative to their peers.

Feedback and recommended follow-up may also be communicated to the provider network as a whole. This is done by using a variety of currently available communication tools including:

- Provider Manual/Standards of Care
- Provider Training

- Continuing Education
- Provider News Bulletins

5.5 Utilization review

UnitedHealthcare may perform utilization review on all submitted claims. Utilization review (UR) is a clinical analysis performed to confirm that the services in question are or were necessary dental services as defined in the member's certificate of coverage. UR may occur after the dental services have been rendered and a claim has been submitted (retrospective review).

Utilization review may also occur prior to dental services being rendered. This is known as a request for a pre-treatment estimate. UnitedHealthcare does not require pre-treatment estimates (although we encourage these before costly procedures are undertaken).

Retrospective reviews and prior authorization reviews are performed by licensed dentists.

Utilization review is completed based on the following:

- To ascertain that the procedure meets our clinical criteria for necessary dental services, which is approved by the Dental Clinical Policy and Technology Committee, and state regulatory agencies where required.
- To determine whether the documentation supports the submitted procedure.
- To appropriately apply the benefits according to the member's specific plan design.

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

UnitedHealthcare Community Plan has established and continues to maintain an ongoing program of quality management and quality improvement to facilitate, enhance and improve member care and services while meeting or exceeding customer needs, expectations, accreditation and regulatory standards.

The objective of the QIP is to make sure that quality of care is being assessed; that problems are being identified; and that follow up is completed where indicated. The QIP is directed by all state, federal and client requirements. The QIP addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to make sure they meet professionally recognized standards of care.

The QIP description is reviewed and updated annually:

- To measure, monitor, trend and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks.
- To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement.
- To evaluate the effectiveness of implemented changes to the QIP.
- To reduce or minimize opportunity for adverse impact to members.
- To improve efficiency, cost effectiveness, value and productivity in the delivery of oral health services.
- To promote effective communications, awareness and cooperation between members, participating providers and the Plan.
- To comply with all pertinent legal, professional and regulatory standards.
- To foster the provision of appropriate dental care according to professionally recognized standards.
- To make sure that written policies and procedures are established and maintained by the Plan to make sure that quality dental care is provided to the members.

As a participating practitioner, any requests from the QIP or any of its committee members must be responded to as outlined in the request.

6.2 Credentialing

To become a participating provider in UnitedHealthcare's network, all applicants must be fully credentialed and approved by the Ohio Department of Medicaid (ODM). In addition, to remain a participating provider, all practitioners must go through periodic recredentialing approval. Any failure to comply with the recredentialing process constitutes termination for cause under the provider agreement.

The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management (PNM) system. This process adheres to National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process. Practitioners are not able to render services to Medicaid members until they are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. It is recommended that you begin the contracting process with UnitedHealthcare Community Plan while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with UnitedHealthcare Community Plan. Refer to Section 3.11 for additional information on how to add a new associate.

Any questions regarding contracting or credentialing can be directed to Provider Services.

6.3 Site visits

With appropriate notice, provider locations may receive an in-office site visit as part of our quality management oversight processes. All surveyed offices are expected to perform quality dental work and maintain appropriate dental records.

The site visit focuses primarily on: dental record keeping, patient accessibility, infection control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the Peer Review Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

UnitedHealthcare Dental, Dental Benefit Providers, reserves the right to conduct an on-site inspection prior to and any time during the effectuation of the contract of any Mobile Dental Facility or Portable Dental Operation bound by the "Mobile Dental Facilities Standard of Care Addendum."

6.4 Preventive health guideline

The UnitedHealthcare Community Plan approach to preventive health is a multi-focused strategy which includes several integrated areas. The following guidelines are for informational purposes for the dental provider, and will be referred to in a general way, in judging clinical appropriateness and competence.

UnitedHealthcare Community Plan's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including, but not limited to, current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as the Surgeon General's Report on Oral Health in America. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

Caries Management – Begins with a complete evaluation including an assessment for risk.

- X-ray periodicity – X-ray examination should be tailored to the individual patient and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.

- Recall periodicity – Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions – Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient and based on age, results of a clinical assessment and risk, including application of prophylaxis, fluoride application, placement of sealants and adjunctive therapies where appropriate.
- Consideration should be given to conservative nonsurgical approaches to early caries, such as Caries Management by Risk Assessment (CAMBRA), where the lesion is non-cavitating, slowing progressing or restricted to the enamel or just the dentin; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

Periodontal management – Screening, and as appropriate, complete evaluation for periodontal diseases should be performed on all adults, and children in late adolescence and younger, if that patient exhibits signs and symptoms or a history of periodontal disease.

- A periodontal evaluation should be conducted at the initial examination and periodically thereafter, as appropriate, based on American Academy of Periodontology guidelines.
- Periodontal evaluation and measures to maintain periodontal health after active periodontal treatment should be performed as appropriate.
- Special consideration should be given to those patients with periodontal disease, a previous history of periodontal disease and/or those at risk for future periodontal disease if they concurrently have systemic conditions reported to be linked to periodontal disease such as diabetes, cardiovascular disease and/or pregnancy complications.

Oral cancer screening should be performed for all adults and children in late adolescence or younger if there is a personal or family history, if the patient uses tobacco products, or if there are additional factors in the patient history, which in the judgment of the practitioner elevate their risk. Screening should be done at the initial evaluation and again at each recall. Screening should include, at a minimum, a manual/visual exam, but may include newer screening procedures, such as light contrast or brush biopsy, for the appropriate patient.

Additional areas for prevention evaluation and intervention include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition. UnitedHealthcare Community Plan may perform clinical studies and conduct interventions in the following target areas:

- Access
- Preventive services, including topical fluoride and sealant application
- Procedure utilization patterns

Multiple channels of communication will be used to share information with providers and members via manuals, websites, newsletters, training sessions, individual contact, health fairs, in-service programs and educational materials. It is the mission of UnitedHealthcare Community Plan to educate providers and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease and oral cancer screening.

6.5 Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community relationships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

Prevention: Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.

Treatment: Access and reduce barriers to evidence-based and integrated treatment.

Recovery: Support care management and referral to person-centered recovery resources.

Harm Reduction: Access to Naloxone and facilitating safe use, storage, and disposal of opioids.

Strategic community relationships and approaches: Tailor solutions to local needs.

Enhanced solutions for pregnant mom and child: Prevent neonatal abstinence syndrome and supporting moms in recovery.

Enhanced data infrastructure and analytics: Identify needs early and measure progress.

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com** > Tools and resources > Resource library > Pharmacy resources > Drug lists and pharmacy > Opioid Programs and Resources - Community Plan (Medicaid).

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC’s recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines for opioid prevention and overdose can be found at **Preventing Opioid Overdose | Overdose Prevention | CDC**.

Section 7: Fraud, waste, and abuse training

Providers are required to establish written policies for their employees, contractors or agents and to provide training to their staff on the following policies and procedures:

- Provide detailed information about the Federal False Claims Act,
- Cite administrative remedies for false claims and statements,
- Reference state laws pertaining to civil or criminal penalties for false claims and statements, and
- With respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, include as part of such written policies, detailed provisions regarding care providers policies and procedures for detecting and preventing fraud, waste and abuse.

The required training materials can be found at the website listed below. The website provides information on the following topics:

- FWA in the Medicare Program
- The major laws and regulations pertaining to FWA
- Potential consequences and penalties associated with violations
- Methods of preventing FWA
- How to report FWA
- How to correct FWA

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN4649244

Section 8: Governance

8.1 Provider rights bulletin

If you elect to participate/continue to participate with the plan, please complete the application in its entirety; sign and date the Attestation Form and provide current copies of the requested documents. You also have the following rights:

To review your information

You may review any information the plan has utilized to evaluate your application, including information received from any outside source (e.g., malpractice insurance carriers; state license boards), with the exception of references or other peer-review protected information.

To correct erroneous information

If the information you provided varies substantially from information obtained from other sources, we will notify you in writing within 15 business days of receipt of the information. You will have an additional 15 business days to submit your reply in writing. Within two business days, the plan will send a written notification acknowledging receipt of the information.

To be informed of status of your application

You may submit your application status questions in writing or telephonically.

To appeal adverse committee decisions

In the event you are denied participation or continued participation, you have the right to appeal the decision in writing within 30 days of the date of receipt of the rejection/denial letter and is applicable to certain states.

UnitedHealthcare Dental
2300 Clayton Road
Suite 1000
Concord, CA 94520
Phone: **1-855-918-2265**
Fax: **1-844-881-4963**

8.2 Quality of care issues

A provider who has demonstrated behavior inconsistent with the provision of quality of care is subject to review, corrective action, and/or termination. Questions of quality-of-care may arise for, but are not limited to, the following reasons:

- Chart audit reveals clear and convincing evidence of under- or over utilization, fraud, upcoding, overcharging, or other inappropriate billing practices.
- Multiple quality-of-care related complaints or complaints of an egregious nature for which investigation confirms quality concerns.
- Malpractice or disciplinary history that elicits risk management concerns.

Note: A provider cannot be prohibited from the following actions, nor may a provider be refused a contract solely for the following:

- Advocating on behalf of an enrollee
- Filing a complaint against the MCO
- Appealing a decision of the MCO
- Requesting a hearing or review

We may not terminate a contract unless we provide the practitioner with a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as described below.

- Cases which meet disciplinary or malpractice criteria are initially reviewed by an application review committee. Other quality-of-care cases are reviewed by the Peer Review Committee.
- The Committees make every effort to obtain a provider narrative and appropriate documents prior to making any determination.
- The Committees may elect to accept, suspend, unpublish, place a provider on probation, require corrective action or terminate the provider.
- The provider will be allowed to continue to provide services to members for a period of up to sixty (60) days from the date of the provider's notice of termination.
- The Hearing Committee will immediately remove from our network any provider who is unable to provide health care services due to a final disciplinary action. In such cases, the provider must cease treating members upon receipt of this determination.

8.3 Cultural competency

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The program breaks down linguistic and cultural barriers that can harm health care participation. You must support UnitedHealthcare Community Plan's Cultural Competency Program. Supporting the Cultural Competency Program can support your efforts to:

- Reduce racial/ethnic health care disparities
- Foster connections between patients and dental professionals
- Increase patient safety and eliminates miscommunications
- Improve dental health equity and care outcomes
- Increase patient satisfaction

UnitedHealthcare Community Plan offers the following support services:

- The following website contains valuable materials that will assist dental providers and their staff to become culturally competent. **https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.html**
- **Language interpretation**
  Providers must provide members with oral interpreter services for all appointments and emergency services. Providers must provide information to members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the member's condition and ability to understand.

- **Materials for limited English-speaking members**
  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

For more information, go to UnitedHealthcare **uhc.com** > **Language Assistance**.

Section 9: Claim submission procedures

9.1 Claim submission options

9.1.a Paper claims

To receive payment for services, practices must submit claims via paper or electronically. When submitting a paper claim, dentists are required to submit an American Dental Association (ADA) Dental Claim Form (2019 version or later). If an incorrect claim form is used, the claim cannot be processed and will be returned.

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached, when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures. Refer to the Exclusions, Limitations and Benefits section of this Manual to find the recommendations for dental services.

Refer to Section 9.2 for more information on claims submission best practices and required information. Appendix A will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

9.1.b Electronic claims

Electronic Claims Submission refers to the ability to submit claims electronically versus paper. This expedites the claim adjudication process and can improve overall claim payment turnaround time (especially when combined with Electronic Payments, which is the ability to be paid electronically directly into your bank account).

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may sign up with one to initiate this process. The UnitedHealthcare Community Plan website (**UHCdental.com/medicaid**) also offers the feature to directly submit your claims online through the provider portal / Dental Hub. Refer to Section 2.5 for more information on how to register as a participating user.

9.1.c Electronic payments

ePayment Center replaced the current electronic payment and statement process for UnitedHealthcare Dental Government Program Plans.

The ePayment center is an online portal which will allow you to enroll in electronic delivery of payments and electronic remittance advice (ERA).

Through the ePayment Center, we will continue to offer a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the ePayment Center enrollment portal.

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7

- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

1. Visit **UHCdental.epayment.center/register**
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into **UHCdental.epayment.center**
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

Need additional help? Call **1-855-774-4392** or email **help@epayment.center**.

In addition to a no-fee ACH option, other electronic payment methods are available through Zelis Payments.

The Zelis Payments advantage:

- Access all payers in the Zelis Payments network through one single portal
- Experience award winning customer service
- Receive funds weeks faster than mailed checks and improve the accuracy of your claim payments
- Streamline your operations and improve revenue stability with virtual card and ACH
- Protect your account with 24/7 Office of Foreign Assets Control (OFAC) fraud monitoring
- Reduce costs and boost efficiency by simplifying administrative work from processing payments
- Gain visibility and insights from your payment data with a secure provider portal. Download files (10 years of storage)
  in various formats (XLS, PDF, CSV or 835)

Each Zelis Payments product gives you multiple options to access data and customize notifications. You will have access to several features via the secure web portal.

All remittance information is available 24/7 via **provider.zelispayments.com** and can be downloaded into a PDF, CSV, or standard 835 file format. For any additional information or questions, please contact Zelis Payments Client Service Department at **1-877-828-8770**.

9.2 Claim submission requirements and best practices

9.2.a Dental claim form required information

The most current Dental ADA claim form (2019 or later) must be submitted for payment of services rendered.

One claim form should be used for each patient and the claim should reflect only 1 treating dentist for services rendered. The claims must also have all necessary fields populated as outlined in the following:

Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services.

Subscriber information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Subscriber ID number

Patient information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Patient ID number

Primary payer information

Record the name, address, city, state and ZIP code of the carrier.

Other coverage

If the patient has other insurance coverage, completing the "Other Coverage" section of the form with the name, address, city, state and ZIP code of the carrier is required. You will need to indicate if the "other insurance" is the primary insurance. You may need to provide documentation from the primary insurance carrier, including amounts paid for specific services.

Other insured's information (only if other coverage exists)

If the patient has other coverage, provide the following information:

- Name of subscriber/policy holder (last, first and middle initial)
- Date of birth
- Gender
- Subscriber ID number
- Relationship to the member

Billing dentist or dental entity

Indicate the provider or entity responsible for billing, including the following:

- Name
- Address (street, city, state, ZIP code)
- License number
- Social Security Number (SSN) or tax identification number (TIN)
- Phone number
- National provider identifier (NPI)

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

- Certification – Signature of dentist and the date the form was signed
- Name (use name provided on the Practitioner Application)
- License number
- TIN (or SSN)
- Address (street, city, state, ZIP code)
- Phone number
- NPI

Record of services provided

Most claim forms have 10 fields for recording procedures. Each procedure must be listed separately and must include the following information, if applicable. If the number of procedures exceeds the number of available lines, the remaining procedures must be listed on a separate, fully completed claim form.

Missing teeth information

When submitting for periodontal or prosthodontal procedures, this area should be completed. An “X” can be placed on any missing tooth number or letter when missing.

Remarks section

Some procedures require a narrative. If space allows, you may record your narrative in this field. Otherwise, a narrative attached to the claim form, preferably on practice letterhead with all pertinent member information, is acceptable.

ICD-10 instructions

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**")

A _____ C _____

B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

29a **Diagnosis Code Pointer:** Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

29b **Quantity:** Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01".

34 **Diagnosis Code List Qualifier:** Enter the appropriate code to identify the diagnosis code source: **B** = ICD-9-CM **AB** = ICD-10-CM (as of Oct. 1, 2013)

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

34a **Diagnosis Code(s):** Enter up to 4 applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter "A."

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

By Report procedures

All "By Report" procedures require a narrative along with the submitted claim form. The narrative should explain the need for the procedure and any other pertinent information.

Using current ADA codes

It is expected that providers use Current Dental Terminology (CDT). For the latest dental procedure codes and descriptions, you may order a current CDT book by calling the ADA or visiting the ADA store at **engage.ada.org**.

Supernumerary teeth

UnitedHealthcare recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must

be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 7 years.

Insurance fraud

All insurance claims must reflect truthful and accurate information to avoid committing insurance fraud. Examples of fraud are falsification of records and using incorrect charges or codes. Falsification of records includes errors that have been corrected using "white-out," pre- or post-dating claim forms, and insurance billing before completion of service. Incorrect charges and codes include billing for services not performed, billing for more expensive services than performed, or adding unnecessary charges or services.

Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained on the claim is true and accurate.

Invalid or incomplete claims

If claims are submitted with missing information, incomplete or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent to the provider. For example, if the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

9.2.b Coordination of Benefits (COB)

Our benefits contracts are subject to coordination of benefits (COB) rules. We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan as a secondary payer, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

9.2.c Timely submission (Timely filing)

All claims should be submitted within 365 calendar days from the date of service.

All adjustments or requests for reprocessing must be made within 365 days from date of service, or date of eligibility posting, only if the initial submission time period has been met. An adjustment can be requested in writing or telephonically.

Secondary claims must be received within 90 calendar days of the primary payer's determination (see section 9.2.b).

Refer to the Quick Reference Guide for address and phone number information.

9.3 Prompt payment

UnitedHealthcare Community Plan shall pay provider pursuant to the state contract and applicable state and federal law and regulations, including but not limited to 42 C.F.R § 447.46. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or state third party liability

law and the terms of the state contract. Unless UnitedHealthcare Community Plan otherwise requests assistance from provider, UnitedHealthcare Community Plan will be responsible for third party collections in accordance with the terms of the state contract.

9.4 Provider remittance advice

9.4.a Explanation of dental plan reimbursement (remittance advice)

The Provider Remittance Advice is a claim detail of each patient and each procedure considered for payment. Use these as a guide to reconcile member payments. As a best practice, it is recommended that remittance advice is kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER- Provider Name and ID number – Treating dentists name, Practitioner ID number (NPI National Provider Identifier, TIN Tax Identification Number)

PROVIDER LOCATION AND ID - Treating location as identified on submitted claim and location ID number

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

PATIENT PAY - Any amounts owed by the patient after benefits have been applied

OTHER INSURANCE - Amount payable by another carrier

PRIOR MONTH ADJUSTMENT - Adjustment amount(s) applied to prior overpayments

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

SUBSCRIBER/MEMBER NO - Identifying number on the subscriber's ID card

PATIENT DOB

PLAN - Health plan through which the member receives benefits (i.e., UnitedHealthcare Community Plan)

PRODUCT - Benefit plan that the member is under (i.e., Medicaid or Family Care)

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In or out-of-network coverage

LINE ITEM NUMBER - Reference number for item number within a claim

DOS - Dates of Service: Dates that services are rendered/performed

CODE - Procedure code of service performed

TOOTH NO. - Tooth Number procedure code of service performed (if applicable)

SURFACE(S) - Tooth Surface of service performed (if applicable)

PLACE OF SERVICE - Treating location (office, hospital, other)

QTY OR NO. OF UNITS

PAYMENT PERCENTAGE - Reflects benefit coverage level in terms of percentage to be paid by plan

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

NET AMOUNT (Services Detail) - Final amount to be paid

EXCEPTION CODES - Codes that explain how the claim was adjudicated

9.4.b Provider Remittance Advice sample (page 1)

UnitedHealthcare OH Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

UnitedHealthcare®

Please address questions to:

UnitedHealthcare OH Medicaid
PO Box 5555
Milwaukee, WI 53201

Contact: UnitedHealthcare Community Plan - Provider Services
Phone: (855)555-5555
Fax:

Dental Office Name
Street Address
City, State ZIP

Current Period:	**10/20/2017**
Payee ID:	55555
Phone:	(555)555-5555
Fax:	(555)555-5555
Tax ID:	555555555

Remittance Summary

Fee For Service:	**$2,164.33**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$2,164.33**

PROVIDER APPEALS
Determination of Claims payments are based on the terms and conditions of the member's benefit plan. All claims must be received within 365 days from the date of service unless otherwise agreed. Appeals of denied or disputed claims must be received within 60 days of receipt of the remittance advice. If the provider fails to request a review within this timeframe, the right to review is forfeited.
All appeals must be received in writing to the address below:
UnitedHealthcare Dental
ATTN: Provider Appeals
PO Box 1455
Milwaukee, WI 53201
Your written request for review must include:
- The member's name, identification number, and group policy number
- The actual service for which a no benefit coverage decision was made
- The reasons why you feel benefit coverage should be provided
- Any available medical information to support your reasons for reversing the benefit decision

Balance Billing – Billing or balance billing UnitedHealthcare Community Plan Medicaid members is prohibited and may violate federal and state medical assistance rules and regulations.

IMPORTANT NOTICE: In order to maintain HIPAA compliance, effective with claims received October 1, 2015, only ADA 2012 or later Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms dated prior to 2012, will not be accepted and will result in a rejection of the claim or pre-authorization request.
Additionally, when making a correction to a previously submitted claim, please send it clearly marked Corrected Claims on an ADA 2012 or later form to the Corrected Claims mailbox. Please contact the customer service toll free number if you have questions. If you are in need of the new Dental Claim forms, please visit the ADA website at www.ada.org for ordering information.
To report potential billing irregularities, please call our Anonymous Fraud Hotline at 888-233-4877.

Ref #: 34143 / 169 Page 1

9.4.c Provider Remittance Advice sample (page 2)

UnitedHealthcare OH Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Provider Name/ 55555	Dental Office Name / 55555	$4,785.00	$1,870.84	$0.00	$0.00	$0.00	$1,870.84
Provider Name / 55555	Dental Office Name / 55555	$1,110.00	$109.37	$0.00	$0.00	$0.00	$109.37
Provider Name / 55555	Dental Office Name / 55555	$450.00	$184.12	$0.00	$0.00	$0.00	$184.12
	Totals:	**$6,345.00**	**$2,164.33**	**$0.00**	**$0.00**	**$0.00**	**$2,164.33**

Ref #: 34143 / 170 Page 2

9.4.d Provider Remittance Advice sample (page 3)

UnitedHealthcare OH Medicaid

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 10/20/2017

Services Detail

FFS - Fee For Service	GBA - Global Budget Allocation
CAP - Capitation	CASE - Case Fee
ENC - Encounter Payment	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Ohio
Product: UHC OH Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/16/17	D2740 4	11	1	$885.00	0	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/16/17	D2954 4	11	1	$225.00	1	$109.37	100.00 %	$109.37	$0.00	$0.00	$0.00	$0.00	$0.00	$109.37	FFS
					$1,110.00		**$109.37**		**$109.37**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$109.37**	

ITEM: 1 Exception Code: 1096 Service Authorization not Found.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Ohio
Product: UHC OH Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D2392 29 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
2	10/12/17	D7140 30	11	1	$160.00	1	$52.28	100.00 %	$52.28	$0.00	$0.00	$0.00	$0.00	$0.00	$52.28	FFS
					$295.00		**$124.12**		**$124.12**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$124.12**	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Ohio
Product: UHC OH Medicaid Adult
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0120 00	11	1	$50.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	10/12/17	D0220 00	11	1	$25.00	1	$9.58	100.00 %	$9.58	$0.00	$0.00	$0.00	$0.00	$0.00	$9.58	FFS
3	10/12/17	D0230 00	11	1	$20.00	1	$7.98	100.00 %	$7.98	$0.00	$0.00	$0.00	$0.00	$0.00	$7.98	FFS
4	10/12/17	D0274 00	11	1	$50.00	1	$21.63	100.00 %	$21.63	$0.00	$0.00	$0.00	$0.00	$0.00	$21.63	FFS
5	10/12/17	D2392 13 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
					$280.00		**$111.03**		**$111.03**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$111.03**	

ITEM: 1 Exception Code: 1039 This service is not covered under the plan.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare Ohio
Product: UHC OH Medicaid
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	10/12/17	D0150 00	11	1	$55.00	1	$39.66	100.00 %	$39.66	$0.00	$0.00	$0.00	$0.00	$0.00	$39.66	FFS
2	10/12/17	D0210 00	11	1	$125.00	1	$40.72	100.00 %	$40.72	$0.00	$0.00	$0.00	$0.00	$0.00	$40.72	FFS
3	10/12/17	D1120 00	11	1	$60.00	1	$21.95	100.00 %	$21.95	$0.00	$0.00	$0.00	$0.00	$0.00	$21.95	FFS
4	10/12/17	D1208 00	11	1	$25.00	1	$11.98	100.00 %	$11.98	$0.00	$0.00	$0.00	$0.00	$0.00	$11.98	FFS
					$265.00		**$114.31**		**$114.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$114.31**	

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9.5 Overpayment

If you find an overpaid claim, notify us of the overpayment immediately. Send us the overpayment within the time specified in your Agreement. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer us to recoup the funds from your next payment, call Provider Services at **1-855-642-5483**.

If you prefer to mail a refund, send an Overpayment Return Check with the following information:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number
- Submit to:
  Overpayment
  P.O. Box 481
  Milwaukee, WI 53201

9.6 Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within 90 calendar days from the primary payer determination.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

9.7 Payment for services

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by signing into the Dental Hub at **UHCdental.com/medicaid**, calling Provider Services, or the Ohio Medicaid Eligibility System.
- Submit documentation needed to support the medical necessity of the requested procedure.

- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary.
- Non-covered services.
- Services provided to members not enrolled on the dates of service.

When non-covered services are provided for Medicaid members, providers shall hold members and UnitedHealthcare Community Plan harmless, except as outlined below.

In instances when non-covered services are recommended by the provider or requested by the member, an Informed Consent Form or similar waiver must be signed by the member confirming:

- That the member was informed and given written acknowledgement regarding proposed treatment plan and associated costs in advance of rendering treatment;
- That those specific services are not covered under the member's plan and that the member is financially liable for such services rendered.
- That the member was advised that they have the right to request a determination from the insurance company prior to services being rendered.

9.8 Radiology requirements

Guidelines for providing radiographs are as follows:

- Send a copy or duplicate radiograph instead of the original.
- Radiograph must be diagnostic for the condition or site.
- Radiographs should be mounted and labeled with the practice name, patient name and exposure date (not the duplication date).
- When a radiograph does not demonstrate a clinical condition well, an intra-oral photo and/or narrative are suggested as additional diagnostic aides.

Electronic submission, rather than paper copies of digital x-rays is preferred. Film copies are only accepted if labeled, mounted and paper clipped to the authorization. Please do not utilize staples.

X-rays submitted with Authorizations or Claims will not be returned. This includes original film radiographs, duplicate films, paper copies of x-rays and photographs.

Orthodontic and other models are not accepted forms of supporting documentation and will not be reviewed. Orthodontic models will be returned to you along with a copy of the paperwork submitted.

Please note: Authorizations, including attachments, can be submitted online at no additional cost by logging into the Dental Hub at **UHCdental.com/medicaid**.

9.9 Corrected claim submission guidelines

When should I submit a corrected claim?

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information.

A Corrected Claim must be submitted in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped and a new claim processed in its place with any necessary changes.

On the other hand, if a claim or service originally denied due to incorrect or missing information, or was not previously processed for payment, DO NOT submit a corrected claim. Denied services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing.

What scenarios are subject to the corrected claim process?

A corrected claim should only be submitted if the original service(s) PAID based on incorrect information.

Some examples of correction(s) that need to be made to a prior PAID claim are:

- Incorrect Provider NPI or location
- Payee Tax ID
- Incorrect Member
- Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

How do I submit a corrected claim?

- Electronically – Clearing House
- Electronically – Dental Hub
- Paper

Electronic submission are the most efficient and preferred method. If Providers do not have access to electronic submissions, and need to submit on paper, the following steps are required.

- Must be submitted to the Corrected Claims PO Box for proper processing and include the following:
  - Current version of the ADA form and all required information
  - The ADA form must be clearly noted “Corrected Claim”
  - In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.

NOTE: If all information does not fit in Box 35, please attach an outline of corrections to the claim form.

What scenarios ARE NOT subject to the corrected claim process?

A corrected claim should not be submitted if the original claim or service(s) which are the subject of the correction denied or were not previously submitted.

Some examples of items that are not considered claim corrections are:

- Any request to “Reprocess” a claim with no changes being made. This includes requests to reprocess a claim based on a new authorization being obtained.
- Any changes being made to a claim or service that denied for any reason such as missing tooth, quad, or arch information, incorrect code, age inappropriate code being billed, missing primary EOB, incorrect provider, etc.

- Any request to recoup a denied service. You DO NOT need to recoup a denied service as denied services are invalid and have no impact on member service/tooth history or accumulators.

If you received a claim or service denial due to missing/incomplete/incorrect information or you have since obtained authorization for services, please submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to your provider handbook for the proper method for submitting an appeal or reprocess request.

What happens if I submit a corrected claim to the wrong PO box or don't include the required documentation?

Following the above guidelines will allow you to receive payment as expediently as possible. Failure to follow these guidelines may result in unnecessary delay and/or rejection of your submission. As a reminder the Corrected Claim mailing address is found below.

Submit to:

Corrected Claims
PO Box 481
Milwaukee, WI 53201

Appendices for the State of Ohio

Appendix A: Resources and services — how we help you

Addresses and phone numbers

Need:	Address:	Phone Number:	Payer I.D.:	Submission Guidelines:	Form(s) Required:
Claim Submission (initial)	UnitedHealthcare OH Claims P.O. Box 2139 Milwaukee, WI 53201	**1-855-642-5483**	OHMD3	Within 365 calendar days from the date of service For secondary claims, within 90 calendar days from the primary payer determination	ADA* Claim Form, 2019 version or later
Corrected Claims	OH Corrected Claims P.O. Box 481 Milwaukee, WI 53201	**1-855-642-5483**	N/A	Within 365 days from date of determination.	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals (Appeal of a denied or reduced payment)	UnitedHealthcare Dental ATTN: Provider Appeals P.O. Box 1455 Milwaukee, WI 53201	**1-855-642-5483**	N/A	Within 60 days of receipt of the remittance advice	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	UnitedHealthcare OH Authorizations P.O. Box 2126 Milwaukee, WI 53201	**1-855-642-5483**	OHMD3	N/A	ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-800-895-2017 (TTY 711)**	N/A	Within 60 calendar days from the date of the adverse benefit determination	N/A

Appendix B: Reimbursement policy

Important note about this reimbursement policy

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Dental Terminology (CDT®*), Centers for Medicare and Medicaid Services (CMS), American Dental Association (ADA) or other coding guidelines. References to CDT or other sources are for definitional purposes only and do not imply any right to reimbursement. Current Dental Terminology (CDT), International Classification of Diseases (ICD), and Health Care Common Procedure Coding System are among the dental codes used for dental billing (HCPCS).

This reimbursement policy applies to all health care services billed on ADA Claim Forms, CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Dental Benefit Providers'® reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, regarding UnitedHealthcare Dental Benefit Providers® may use reasonable discretion in interpreting and applying this policy to dental and health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to regarding UnitedHealthcare Dental Benefit Providers® enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by regarding UnitedHealthcare Dental Benefit Providers® due to programming or other constraints; however, regarding UnitedHealthcare Dental Benefit Providers® strives to minimize these variations.

UnitedHealthcare Dental Benefit Providers® may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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B.1 Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the American Dental Association or 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care

professionals, including, but not limited to, non- network authorized and percent of charge contract physicians and other qualified health care professionals.

B.2 Policy

Overview

The policy outlines codes subject to prior authorization and other conditions and terms that may apply in the care of patients. Current Dental Terminology (CDT®) is utilized throughout this policy.

Reimbursement guidelines

UnitedHealthcare Dental Benefit Providers® offers medically necessary services to Medicaid members in the state of Ohio. All claims for services must meet standard coding guidelines to communicate the services rendered. Providers are responsible for the submission of timely and accurate claims.

For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**. We align benefit design to meet all regulatory requirements by your state's Medicaid and legislature included in your state's Medicaid Provider Billing Manual.

Plan limitations

Please refer to the benefits grid contained herein for applicable exclusions and limitations and covered services. Standard ADA coding guidelines are applied to all claims.

Any service not listed in the benefit grid below is generally not covered. Consideration may be given for non-covered services and those that exceed a quantity, frequency, or age limit when accompanied by a prior authorization request establishing medical necessity.

Please call Provider Services if you have any questions regarding frequency limitations.

This Dental Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

B.3 General exclusions

1. Unnecessary dental services.
2. Any dental procedure performed solely for cosmetic/aesthetic reasons.
3. Any procedure not performed in a dental setting that has not had prior authorization.
4. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
5. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
6. Dental services otherwise covered under the policy, but rendered after the date that an individual's coverage under the policy terminates, including dental services for dental conditions arising prior to the date that an individual's coverage under the policy terminates. Refer to Appendix B.3 for more information regarding Orthodontics.
7. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
8. Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

B.4 Required documentation/additional criteria benefit grid

The following Benefit Grid contains all covered dental procedures and is intended to align to all State and Federal regulatory requirements; therefore, this Grid is subject to change. For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**.

*See Appendix B.5 for additional information regarding Orthodontic treatment.

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D0120	Periodic Oral Exam	0-999	1 per 180 day(s) per member	N	
D0140	Limited Oral Evaluation - Problem Focused	0-999		N	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per 5 year(s) per member/ per provider or location	N	
D0180	Comprehensive periodontal evaluation	0-999	1 per 365 day(s) per member	N	
D0210	Intraoral - Comprehensive Series of Radiographic Images	0-999	1 per 5 year(s) per member	N	
D0220	Intraoral - Periapical First Radiographic Image	0-999		N	
D0230	Intraoral - Periapical Each Additional Image	0-999		N	
D0240	Intraoral - Occlusal Radiographic Image	0-999		N	
D0250	Extraoral - 2D Projection Radiographic image	0-999		N	
D0270	Bitewing - Single Radiographic Image	0-999	1 per 6 month(s) per member	N	
D0272	Bitewings - Two Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0273	Bitewings - Three Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0274	Bitewings - Four Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	0-999		N	
D0330	Panoramic Radiographic Image	0-5	1 per 60 month(s) per member	Y	Narrative of Medical Necessity
D0330	Panoramic Radiographic Image	6-999	1 per 60 month(s) per member	N	
D0340	2D Cephalometric Radiographic Image	0-999		N	
D0350	Oral/Facial Photographic Images	0-999		N	
D0367	Cone Beam - Both Jaws	0-999	1 per 5 year(s) per member	Y	Narrative of Medical Necessity
D0372	intraoral tomosynthesis - comprehensive series of radiographic images	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0373	intraoral tomosynthesis - bitewing radiographic image	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0374	intraoral tomosynthesis - periapical radiographic image	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0387	intraoral tomosynthesis - comprehensive series of radiographic images - image ca	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0388	intraoral tomosynthesis - bitewing radiographic image - image capture only	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D0389	intraoral tomosynthesis - periapical radiographic image - image capture only	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0396	3D Printing of a 3D Dental Surface Scan	0-999			
D0470	Diagnostic Casts	0-999		N	
D0604	antigen testing for a public health related pathogen, including coronavirus	0-999		N	
D0605	antibody testing for a public health related pathogen, including coronavirus	0-999		N	
D0606	Molecular testing for a public health related pathogen, including coronavirus	0-999		N	
D0801	3D dental surface scan - direct	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0802	3D dental surface scan - indirect A surface scan of a diagnostic cast	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0803	3D facial surface scan - direct	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0804	3D facial surface scan - indirect A surface scan of constructed facial feature	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D1110	Prophylaxis - Adult	14-999	1 per 180 day(s) per member	N	
D1120	Prophylaxis - Child	0-13	1 per 180 day(s) per member	N	
D1206	Topical Application Of Fluoride Varnish	0-20	1 per 180 day(s) per member	N	
D1208	Topical Application of Fluoride	0-20	1 per 180 day(s) per member	N	
D1301	Immunication Counseling	0-999			
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	0-999	2 per 365 day(s) per member	N	
D1321	counseling for the control and prevention of adverse oral, behavioral, and system	0-999	2 per 365 day(s) per member	N	
D1351	Sealant - Per Tooth	0-20	1 per year per tooth of permanent first and second molars	N	
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	3 per 1 year per patient per tooth	N	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-20		N	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20		N	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20		N	
D1520	Space Maintainer - Removable - Unilateral - per quadrant	0-20		N	
D1526	Space Maintainer - Removable - Bilateral, maxillary	0-20		N	
D1527	Space Maintainer - Removable - Bilateral, mandibular	0-20		N	
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per 365 days per tooth	N	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per 365 days per tooth	N	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per 365 days per tooth	N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per 365 days per tooth	N	
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per 365 days per tooth	N	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per 365 days per tooth	N	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per 365 days per tooth	N	
D2335	Resin-Based Composite - Four or More Surfaces, Anterior	0-999	1 per 365 days per tooth	N	
D2390	Resin-Based Composite Crown, Anterior	0-999	1 per 365 days per tooth	N	
D2391	Resin-Based Composite - One Surface, Posterior	0-999	1 per 365 days per tooth	N	
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	1 per 365 days per tooth	N	
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	1 per 365 days per tooth	N	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999	1 per 365 days per tooth	N	
D2740	Crown - Porcelain/Ceramic	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2752	Crown - Porcelain Fused To Noble Metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2790	Crown – full cast high noble metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2791	Crown – full cast predominantly base metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2792	Crown – full cast noble metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2920	Re-Cement or Re-Bond Crown	0-999	1 per 12 months per tooth	N	
D2928	Prefabricated Porcelain / Ceramic Crown - Permanent Tooth	0-999	1 every 36 months per anterior	N	
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	0-999	1 every 36 months per anterior	N	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999	1 every 36 months	N	
D2931	Prefabricated stainless steel crown – Permanent tooth	0-999	1 every 36 months	N	
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-999	1 every 36 months per anterior	N	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-999	1 every 36 months per tooth	N	
D2940	Protective Restoration	0-999	1 per 180 days per tooth; Max 5 per lifetime	N	
D2950	Core Buildup, Including Any Pins When Required	0-999	1 per 60 months per tooth	N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999	Pin retention is reimbursed per tooth, up to a maximum of 3 pins per tooth	N	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-999	1 per 60 months per tooth, permanent anterior teeth	Y	Current pre-op x-rays; For any tooth with endodontic procedure planned or performed, a periapical x-ray of the final endodontic procedure is required
D2954	Prefabricated Post And Core In Addition To Crown	0-999	1 per 60 months per tooth, permanent anterior teeth	Y	Current pre-op x-rays; For any tooth with endodontic procedure planned or performed, a periapical x-ray of the final endodontic procedure is required
D2956	Removal of an Indirect Restoration on a Natural Tooth	0-999		Y	Current pre-op x-rays
D2976	Band Stabilization - per tooth	0-999	1 per lifetime		
D2989	Evacation of a Tooth Resulting in the Determination of Non-restorability	0-999			
D2991	Application of Hydroxyapatite Regeneration Medicament - per tooth	0-999	2 times per tooth per year		
D3220	Therapeutic Pulpotomy	0-999	1 per code per tooth every lifetime	N	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999	1 per code per tooth every lifetime	N	
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999	1 per code per tooth every lifetime	N	
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999	1 per code per tooth every lifetime	N	
D3351	Apexification / Recalcification - Initial Visit	0-999		N	
D3352	Apexification / Recalcification - Interim	0-999		N	
D3353	Apexification / Recalcification - Final Visit	0-999		N	
D3410	Apicoectomy - Anterior	0-999	1 per tooth per lifetime, permanent teeth	N	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999	1 per code per quadrant every 12 months	Y	Current pre-op x-rays; Complete current 6 point periodontal charting; Narrative of medical necessity
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999	1 per every 12 months per patiend per quad	Y	Current pre-op x-rays; Complete current 6 point periodontal charting; Narrative of medical necessity
D4286	removal of non-resorbable barrier	0-999		Y	Narrative of medical necessity
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-999	1 per 24 month(s) per member	Y	Panoramic x-ray or full series Complete, current 6 point periodontal; charting
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0-999	1 per 24 month(s) per member	Y	Panoramic x-ray or full series Complete, current 6 point periodontal; charting
D4910	Periodontal Maintenance	0-999	1 per 12 month(s) per member	N	Perio history - Date of previous periodontal surgical or scaling and root planing with claim
D5110	Complete Denture - Maxillary	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D5120	Complete Denture - Mandibular	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5130	Immediate Denture - Maxillary	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5140	Immediate Denture - Mandibular	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5211	Maxillary Partial Denture - Resin Base	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5212	Mandibular Partial Denture - Resin Base	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5225	Maxillary Partial Denture - Flexible Base (Including Retentive/ Clasping Materials, Rests, and Teeth)	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5226	Mandibular Partial Denture - Flexible Base (Including Retentive/ Clasping Materials, Rests, and Teeth)	0-999	1 per 8 year(s) per member	y	Panoramic x-ray or full mouth series
D5511	Repair Broken Complete Denture Base - Mandibular	0-999	1 per 12 months per member	N	
D5512	Repair Broken Complete Denture Base - Maxillary	0-999	1 per 12 months per member	N	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999	1 per tooth every 12 months	N	
D5611	Repair Resin Partial Denture Base - Mandibular	0-999	1 per 12 months per member	N	
D5612	Repair Resin Partial Denture Base - Maxillary	0-999	1 per 12 months per member	N	
D5621	Repair Cast Partial Framework - Mandibular	0-999	1 per 12 months per member	N	
D5622	Repair Cast Partial Framework - Maxillary	0-999	1 per 12 months per member	N	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999	1 per tooth every 12 months	N	
D5640	Replace Broken Teeth - Per Tooth	0-999	1 per tooth every 12 months	N	
D5650	Add Tooth To Existing Partial Denture	0-999	1 per tooth every 12 months	N	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999	1 per tooth every 12 months	N	
D5750	Reline Complete Maxillary Denture (Indirect)	0-999	1 per 3 year(s) per member	N	
D5751	Reline Complete Mandibular Denture (Indirect)	0-999	1 per 3 year(s) per member	N	
D5760	Reline Maxillary Partial Denture (Indirect)	0-999	1 per 3 year(s) per member	N	
D5761	Reline Mandibular Partial Denture (Indirect)	0-999	1 per 3 year(s) per member	N	
D5899	Unspecified Removable Prosthodontic Procedure, By Report	0-999		Y	Panoramic x-ray or full mouth series; Narrative of medical

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D5913	Nasal Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5915	Orbital Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5916	Ocular Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5931	Obturator Prosthesis, Surgical	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5932	Obturator Prosthesis, Definitive	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5934	Mandibular Resection Prosthesis With Guide Flange	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5935	Mandibular Resection Prosthesis Without Guide Flange 0-999	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5955	Palatal Lift Prosthesis, Definitive	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999		Y	Pre-op x-rays; Narrative of medical necessity
D6089	Accessing and Retorquing Loose Implant Screw - per screw	0-999			
D6096	Remove Broken Implant Retaining Screw	0-999		Y	Narrative of medical necessity
D6105	Removal of implant body not requiring bone removal or flap elevation	0-999		Y	Narrative of medical necessity
D6106	Guided tissue regeneration - resorbable barrier, per implant	0-999		Y	Narrative of medical necessity
D6107	guided tissue regeneration - non-resorbable barrier, per implant	0-999		Y	Narrative of medical necessity
D6180	Implant Maintenance Procedure	0-999	1 per every year	Y	Panoramic x-ray , Narrative of medical necessity
D6193	Replacement of an Implant Screw	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity
D6197	Replacement of restorative material use to close an access opening of a screw-retained implant supported prosthesis	0-999		Y	Narrative of medical necessity
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	1 per tooth per life per member	N	
D7210	Extraction, Erupted Tooth	0-999	1 per 1 lifetime per member	N	
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per 1 lifetime per member	N	Tooth #1, #16, #17, and #32 do not require prior authorization for this code.
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per 1 lifetime per member	Y	Teeth 2-15, 18-31; Current pre-op panoramic x-ray; Narrative of medical necessity
D7230	Removal Of Impacted Tooth - Partially Bony	0-999	1 per 1 lifetime per member	N	
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray; Narrative of medical necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray; Narrative of medical necessity
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	1 per 1 lifetime per member	Y	Current Pre-op x-ray; Narrative of medical necessity
D7259	Nerve Dissection	0-999		Y	Narrative of medical necessity
D7260	Oroantral Fistula Closure	0-999	1 per 1 lifetime per member	N	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-999		N	
D7280	Exposure of an Unerupted Tooth	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray or PA of entire tooth; Narrative of medical necessity
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-999	1 per 1 lifetime per member	Y	Current Pre-op x-ray; Narrative of medical necessity
D7284	Excisional Biopsy of Minor Salivary Glands	0-999		Y	Narrative of medical necessity
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999		N	
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999		Y	Narrative of Medical Necessity
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant	0-999		Y	Narrative of Medical Necessity
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant	0-999		Y	Narrative of Medical Necessity
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	0-999		N	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	0-999		N	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	0-999		N	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	0-999		N	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999	1 per lifetime per arch	N	
D7472	Removal Of Torus Palatinus	0-999	1 per lifetime	N	
D7473	Removal Of Torus Mandibularis	0-999	1 per lifetime	N	
D7509	Marsupialization of Odontogenic Cyst	0-999		Y	Narrative of Medical Necessity
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999		N	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999		N	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	0-999		N	
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth	0-999		Y	Current panoramic x-ray; Narrative of medical necessity
D7899	Unspecified TMD Therapy, By Report	0-999		Y	Narrative of medical necessity; TMJ radiographs
D7956	Guided Tissue Regeneration, Edentulous Area - Resorbable Barrier, Per Site	0-999		Y	Narrative of Medical Necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D7957	Guided Tissue Regeneration, Edentulous Area - Non-resorbable Barrier, Per Site	0-999		Y	Narrative of Medical Necessity
D7961	Buccal / Labial Frenectomy (Frenulectomy)	0-18 months	1 per lifetime	Y	Narrative of medical necessity accompanied by corroborating physician note
D7961	Buccal / Labial Frenectomy (Frenulectomy)	19 months -999	1 per lifetime	N	
D7962	Lingual Frenectomy (Frenulectomy)	0-18 months	1 per lifetime	Y	Narrative of medical necessity accompanied by corroborating physician note
D7962	Lingual Frenectomy (Frenulectomy)	19 months -999	1 per lifetime	N	
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999	1 per lifetime per arch	N	
D7979	Non-Surgical Sialolithotomy	0-999		Y	Narrative of Medical Necessity
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-20	1 per 1 lifetime per member	Y	ODM 03630 form; Extra/Intraoral photos; Ceph; Diag model images; Treatment plan
D8210	Removable Appliance Therapy	0-999		N	
D8220	Fixed Appliance Therapy	0-999		Y	Narrative of medical necessity
D8670	Periodic Orthodontic Treatment Visit	0-999	7 per 1 lifetime per member	Y	Approved D8080 case
D8680	Orthodontic Retention (removal of appliances, construction and placement of retainer(s)	0-999	2 per 1 lifetime per member	Y	Diagnostic quality photos submitted with prior authorization or with claim submission
D8695	Removal Of Fixed Orthodontic Appliances	0-999		Y	Narrative of Medical Necessity
D9130	Temporomandibular Joint Dysfunction - Non-invasive Physical Therapies	0-999		Y	Narrative of Medical Necessity
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per 1 day per member	N	
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	4 per 1 day per member	N	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-20		N	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	21-999		Y	Narrative of medical necessity
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 per 1 day per member	N	
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	4 per 1 day per member	N	
D9610	Therapeutic Parenteral Drug, Single Administration	0-999	1 per 1 day per member	N	
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	0-999	1 per 1 day per member	N	
D9613	Infiltration of sustained release therapeutic drug, per quadrant	0-999		Y	Narrative of Medical Necessity
D9920	Behavior Management, By Report	0-999		Y	Narrative of Medical Necessity
D9944	Occlusal Guard-hard appliance, full arch	0-999	1 per 3 years per member	N	
D9945	Occlusal Guard-soft appliance, full arch	0-999	1 per 3 years per member	N	
D9946	Occlusal Guard-hard appliance, partial arch	0-999	1 per 3 years per member	N	
D9947	Custom sleep apnea appliance fabrication and placement	0-999		Y	Narrative of Medical Necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D9948	Adjustment of custom sleep apnea appliance	0-999		Y	Narrative of Medical Necessity
D9949	Repair of custom sleep apnea appliance	0-999		Y	Narrative of Medical Necessity
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	0-999		Y	Narrative of Medical Necessity
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	0-999			
D9955	Oral Appliance Therapy (OAT) Titration Visit	0-999			
D9961	Duplicate / Copy Patient's Records	0-999		Y	Narrative of Medical Necessity
D9990	Translation Services	0-999		Y	Narrative of Medical Necessity
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999		N	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999		Y	Narrative of Medical Necessity
D9997	Dental case management	0-999		Y	Narrative of Medical Necessity
D9999	Unspecified Adjunctive Procedure, By Report	0-999		Y	Description of procedure and narrative of medical necessity

B.5 Orthodontic Treatment

Orthodontic treatment is considered to be medically necessary in the presence of a handicapping malocclusion. The ODM 03630 Evaluation for Comprehensive Orthodontic Treatment is used to determine the presence of a handicapping malocclusion. Orthodontic treatment is considered to be medically necessary when one of the following criteria has been met:

- An automatically qualifying condition as reported in Section A of the ODM 03630 form, including:
  - Overjet greater than 9.0 mm
  - Reverse overjet greater than 3.5 mm
  - Anterior crossbite of two or more teeth with evidence of gingival recession
  - Impinging overbite with tissue laceration and/or clinical attachment loss
  - Anterior impactions where eruption is impeded but extraction is not indicated (excluding third molars)
  - Jaws and/or dentition profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma, or pathology
  - Crowding greater than 8.0 mm in the maxillary arch only
- A total score of 22 or more on Section B of the ODM 03630 form, reporting elements of malocclusion related to:
  - Overjet
  - Overbite
  - Mandibular protrusion (reverse overjet/underbite)
  - Anterior open bite
  - Ectopic teeth
  - Congenitally missing posterior teeth
  - Anterior crowding of the maxilla
  - Anterior crowding of the mandible
  - Labio-lingual spread

  - Posterior crossbite
  - Posterior impactions
  - Psychosocial or speech impairment diagnosed by a qualified specialist
- The presence of other medical, psychosocial, or speech conditions that are exacerbated by a handicapping malocclusion, as documented in Section C of the ODM 03630 form, including but not limited to:
  - Clinically significant distress or impaired psychosocial functioning (with supporting documentation from a psychologist or psychiatrist)
  - Significant speech impairment (with supporting documentation from a speech therapist)
  - Other provider-documented reasons as noted in the provider notes section

Removal of fixed orthodontics appliances for reasons other than completion of treatment

Removal of fixed orthodontic appliances for reasons other than completion of treatment is a decision to be made by the treating provider based on an individual patient basis. Reasons include, but are not limited to:

- Patient non-compliance (AAOMS)
- Military deployment (Department of the Army)
- Prior to radiation therapy to the head or neck if the appliances will be in the radiation field (NIH, AAPD)
- Prior to highly stomatotic chemotherapy (NIH, AAPD)
- Complications related to IV bisphosphonates and other medical conditions (AAOMS)
- If the member becomes ineligible for medicaid during the course of treatment, coverage and payment will continue through the end of the last quarter during which the patient is eligible. It is then the responsibilty of the patient and the dentist to determine how payment is to be made for subsequent treatment

Orthodontic continuity of care

Providers may submit Continuity of Care (COC) requests using three (3) methods of submission:

1. Online via the provider web portal (Dental Hub) at **UHCdental.com/medicaid**
2. Electronic submission via payer ID OHMD3
3. By mail to:
   UnitedHealthcare Community Plan of Ohio
   P.O. Box 2126
   Milwaukee, WI 53201

All COC requests must be submitted on the ADA form and must include the following contents:

- Code D8999 to recognize COC case
- Code D8670 identifying the number of adjustments remaining/requested
- Copy of EOB/remit showing paid banding
- Copy of original approval from prior Medicaid vendor or private insurer
- Payment history from prior insurer(s)

Periodic treatment visits

Reimbursement for code D8670 (periodic orthodontic treatment visit) will be switching from monthly to quarterly payments, in alignment with the new policy. This change ensures that periodic visits are reimbursed on a quarterly basis, supporting consistent and adequate orthodontic care for members.

B.5.a ODM 03630 Evaluation for Comprehensive Orthodontic Treatment Form (page 1)

Ohio Department of Medicaid

EVALUATION FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Last Name	First Name	Medicaid ID Number	Date of Birth

Cases must be considered, reviewed, and approved on a case-by-case basis. Generally, comprehensive orthodontic care (D8080) will require management of all permanent teeth except 3rd molars and as a guideline can begin for females at age 10 years and males at 12 years or if all permanent teeth except 2nd molars are at least partially present unless missing or impacted. This will allow for adequate treatment time for growth modification, if necessary, and control of all permanent teeth.

PROCEDURE *(use this score sheet and a Boley Gauge or disposable ruler):*

- **Indicate by checkmark next to A, B, or C, which criteria you are submitting for review**
- Position the patient's teeth in centric occlusion for photos and cephalometric radiographs with the lips relaxed for both
- Record all measurements in the order given and round off to the nearest millimeter (mm)
- ENTER SCORE "0" IF CONDITION IS ABSENT IN SECTION B

A. ☐ CONDITIONS 1 – 7 ARE AUTOMATIC QUALIFIERS *(place "X" if present)*		Provider	Plan Only
1.	Overjet: greater than 9.0 mm	☐	☐
2.	Reverse overjet: greater than 3.5 mm	☐	☐
3.	Anterior crossbite of 2 or more teeth with evidence of gingival recession	☐	☐
4.	Impinging overbite – tissue laceration and/or clinical attachment loss must be present	☐	☐
5.	Anterior impactions where eruption is impeded but extraction is not indicated	☐	☐
6.	Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma, or pathology	☐	☐
7.	Crowding greater than 8.0 mm in maxillary arch only	☐	☐

CONTINUE TO SECTION BELOW AND SCORE ALL PRESENT CONDITIONS

B. ☐ CONDITIONS 8 – 19 MUST SCORE 22 POINTS OR MORE TO QUALIFY		Provider	Plan Only
8.	**Overjet** (measurement must be greater than 2 mm – see instructions on page 2) mm____ x 1=		
9.	**Overbite** (measurement must be greater than 2 mm – see instructions on page 2) mm____ x 1=		
10.	**Mandibular protrusion** (reverse overjet, **"underbite"** – see instructions on page 2) mm____ x 5=		
11.	**Anterior open bite** (do not count ectopic teeth – see instructions on page 2) mm____ x 4=		
12.	**Ectopic teeth** (excludes 3rd molars) # teeth (score 0 if crowding is claimed) #____ x 3=		
13.	**Congenitally missing posterior teeth** (excluding third molars) #____ x 3=		
14.	**Anterior crowding of maxilla** (greater than 3.5 mm) if present score as 5 x 5=		
15.	**Anterior crowding of mandible** (greater than 3.5 mm) if present score as 5 x 5=		
16.	**Labio-lingual spread** (either measure a displaced tooth from the normal arch form, the labial-lingual distance between adjacent anterior teeth, or the anterior mesio-distal spacing between adjacent anterior teeth – see rules on page 2) mm____ x 1=		
17.	**Posterior crossbite** (2 or more teeth – 1 must be a molar), score only once as 4 4=		
18.	**Posterior impactions (**see scoring rules on page 2, excludes 3rd molars) #____ x 3=		
19.	**Psychiatrist/psychologist/speech therapist-diagnosed condition** (instructions on page 2) x 10=		
	TOTAL SCORE *(must score **22** points or more to qualify)*		

C. ☐ Other reason to consider orthodontic case *(see provider notes)*

Provider Signature *(Provider attests to the accuracy stated above)*	Date

First Name	Last Name	NPI Number	Phone Number

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B.5.a ODM 03630 Evaluation for Comprehensive Orthodontic Treatment Form (page 2)

Other Conditions and Provider Notes

Plan Only Notes

INSTRUCTIONS FOR COMPLETING ODM 03630 SCORING INSTRUCTIONS

The provider is encouraged to score the case and exclude any case that obviously would *not* qualify for treatment.
Upon completion of the Form 03630 score sheet, review all measurements and calculations for accuracy.

1. Indicate by checkmark next to Section A, B, or C to indicate which criteria you are submitting for review.
2. Position the patient's teeth in centric occlusion for lateral and frontal intraoral photographic images.
3. Record all measurements in the order given and round off to the nearest millimeter (use a ruler to show measurements).
4. Enter the score of "0" for section elements in the B Section if using Section B to qualify and the condition is absent.

A. CONDITIONS 1 - 7 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

B. CONDITIONS 8 - 19 MUST SCORE 22 POINTS OR MORE TO QUALIFY

8. **Overjet** --this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of the lower incisor to the incisal edge of upper incisor. Measure parallel to the occlusal plane. Only use central incisors. The measurement may apply to only one (1) tooth if it is severely protrusive. Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient. Enter measurement if greater than 2 mm and multiply by one (1).
9. **Overbite** --a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do *not* use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor - from the incisal edge to the pencil mark. Do *not* record overbite and open bite on the same patient. Enter measurement if greater than 2 mm and multiply by one (1).
10. **Mandibular (dental) protrusion or reverse overjet** --measured from the labial surface of the upper incisor to the incisal edge of the lower incisor. Measure parallel to the occlusal plane. Only use central incisors for this measurement. Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement is entered on the score sheet and multiplied by five (5).
11. **Open bite** --measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record overbite and open bite on the same patient. The measurement is entered on the score sheet and multiplied by four (4).
12. **Ectopic eruption*** -- Refers to an unusual pattern of eruption, such as a high canine. Count each tooth excluding third molars. Enter the number of teeth and multiply by three (3). If anterior crowding of either arch is claimed, ectopic eruption must be scored as "0."
13. **Congenitally missing posterior teeth** –, excluding third molars. Enter number of teeth and multiply by three (3).
14. **Anterior crowding of maxilla*** --anterior arch length insufficiency *must* exceed 3.5 mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for a maxillary arch with anterior crowding and multiply by five (5).

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B.5.a ODM 03630 Evaluation for Comprehensive Orthodontic Treatment Form (page 3)

15. **Anterior crowding of mandible*** -- anterior arch length insufficiency *must* exceed 3.5 mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for mandibular arch with anterior crowding and multiply by five (5).
16. **Labio-lingual spread** --use a measurement tool is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index. Additionally, anterior spacing may be measured as the total score in mm of the spacing from the mesial of the canine to the mesial of the opposite canine, totaling both arches. Score only the greater score attained by either of these two methods, and multiply by one (1).
17. **Posterior crossbite** --this condition involves two (2) or more posterior teeth, one (1) of which *must* be a molar. The crossbite *must* be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.
18. **Posterior impactions** – where eruption is impeded but extraction is not indicated, excluding third molars. Enter number of teeth and multiply by three (3).
19. **A) Psychosocial Injury Cases**** – Patient experiences clinically significant distress or impaired psychosocial functioning substantially contributed to by the patient's malocclusion. This is supported by a diagnosis verified with documentation from a psychologist or psychiatrist following a screening examination or interview. Score as 10; or,
    B) Speech Impairment Cases** – Patient experiences significant speech impairment which is diagnosed as a speech or language pathology caused by the patient's malocclusion. This is verified with documentation from a speech therapist following a screening evaluation or interview. Score as 10.
    ***** Either ectopic eruption or anterior crowding in the same arch may be counted, but not both.**
    ****** 19.A or 19.B (not both)** must be combined with scored conditions: **19A** with points from 8, 10, 11, 12, 14, and 16; **OR 19B** with points from 8, 10, 11, 16, and 17 for total scoring.

C. Other reason to consider orthodontic case – enter reason(s) in provider notes section.

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Appendix C: Authorization for treatment

C.1 Dental treatment requiring authorization

To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services. These services may include specific restorative, endodontic, periodontic, prosthodontic and oral surgery procedures. No prior authorization is needed for emergency services. For a complete listing of procedures requiring authorization, refer to the benefit grid.

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment.

For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line.

You can submit your authorization request electronically, by paper through mail, or online at **UHCdental.com/medicaid**. All documentation submitted should be accompanied with ADA Claim Form and by checking the box titled: "Request for Predetermination/Preauthorization" section of the ADA Dental Claim Form to the address referenced in the appendix of this manual.

C.2 Authorization timelines

The following timelines will apply to requests for authorization:

- We will make a determination on standard authorizations within 7 calendar days of receipt of the request.
- We will make a determination on expedited authorizations within 48 hours of receipt of the request.
- Authorization approvals will expire 1 year from the date of determination.

C.3 Appealing a denied authorization

Members have the right to appeal any fully or partially denied authorization determination. Denied requests for authorization are also known as "adverse benefit determinations." An appeal is a formal way to share dissatisfaction with an adverse benefit determination.

As a treating provider, you may advocate for your patient and assist with their appeal. If you wish to file an appeal on the member's behalf, you will need their consent to do so.

You or the member may call or mail the information relevant to the appeal within 60 calendar days from the date of the adverse benefit determination.

Member Denied Authorization Appeal Mailing Address:

UnitedHealthcare Community
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364
Toll-free: 1-800-895-2017 (TTY 711)

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

The member has the right to:

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member's health.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the provider, you cannot ask for a continuation. Only the member may do so.

C.4 Peer-to-Peer Review

The treating provider can request a Peer-to-Peer Review with the dental consultant within 60 calendar days of adverse benefit determination. The MCO medical professional conducting the peer-to- peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines. To make the request call Provider Services Line — 1-855-642-5483. Hours: 8 a.m.- 6 p.m. (ET) Monday-Friday.

Please note:

- Peer-to-Peer Review is only for prior authorizations. You must file an appeal for post authorization as the services have already been rendered and are not eligible for Peer-to-Peer.
- Peer-to-Peer Review is only valid within 60 days of issuance of denial. Providers who have appealed services are not eligible for a Peer-to-Peer request.
- UnitedHealthcare will offer a peer-to-peer consultation within a mutually agreed upon time within 24 business hours of a provider's request for a peer-to-peer consultation.

C.5 Appeal determination timeframe:

- We resolve a standard appeal 10 calendar days from the day we receive it.
- We resolve an expedited appeal 48 hours from when we receive it.

C.6 External medical review

The review process conducted by an independent, external medical review (EMR) entity that is initiated by a care provider who disagrees the decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity. Permedion is contracted by ODM to perform EMRs.

Requesting an EMR

To request an EMR, you must first appeal the decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity using our internal care provider appeal or claim dispute

resolution process. Failure to exhaust the internal appeals or claim dispute resolution process results in your inability to request an EMR. EMR is only available to care providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE.

An EMR can be requested as a result of:

- A service authorization denial, limitation, reduction, suspension or termination (includes pre-service, concurrent or retrospective authorization requests) based on medical necessity
- A claim payment denial, limitation, reduction, suspension or termination based on medical necessity

Denials, limitations, reductions, suspensions or terminations based on lack of medical necessity include, but are not limited to, decisions made by UnitedHealthcare Community Plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent and retrospective reviews)
  - Clinical judgement or medical decision making (i.e. referred to a licensed practitioner for review) is involved
  - A clinical standard or medical necessity requirement (e.g. InterQual®, MCG®, ASAM or OAC 5160-1-01, including EPSDT criteria, and/or the MCO's clinical coverage or utilization management policy or policies) is not met

We inform you of your option to request an EMR as part of any denial notification.

Submitting an EMR

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or care provider claim dispute process has been exhausted.

Complete the Ohio Medicaid MCE External Review Request form located at **gainwelltechnologies.com/permedion** > *Ohio Medicaid* and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other informationthat you want considered in reviewing case

Upload the request form and all supporting documentation to Permedion's provider portal located at **ecenter.hmsy.com**. If you are a new user, send your documentation through secured email at **imr@gainwelltechnologies.com** to establish portal access. Note: When requesting an EMR, you may submit new or other relevant documentation as part of the EMR request.

If Permedion determines that your EMR request is not eligible for an EMR and you disagree, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with your right to request a peer-to-peer review, a member's right to request an appeal or state hearing or the timeliness of appeal and/or state hearing resolutions.

Once you have submitted the EMR request, you do not need to take further action.

EMR results

- After the EMR request has been submitted, Permedion shares the documentation with UnitedHealthcare Community Plan

- Following the review of the information, we may reverse the denial, in part or in whole
  - If reversed, you will receive a written decision within 1 business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify Permedion
  - If we decide to reverse the decision in part, the remaining will continue as an EMR
- Permedion has 30 calendar days for a standard request and 3 business days for an expedited request to perform its review and issue a decision
- If the decision reverses the coverage decision in part or in whole, that decision is final and binding
- If the decision agrees with UnitedHealthcare Community Plan's decision to deny, limit, reduce, suspend or terminate a service, that decision is final
- For reversed service authorization decisions, we authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when we receive the EMR decision
- For reversed decisions associated solely with care provider payment (i.e. the service was already provided to the member), we pay for the disputed services within the timeframes established for claims payment in Exhibit C of the Provider Agreement

Call Permedion at 1-800-473-0802 (option 2) for more information about the EMR.

C.7 State Fair Hearing

A state fair hearing lets members share why they think Ohio Medicaid services should not have been denied, reduced or terminated.

Members have 90 days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

ODJFS Bureau of State Hearings
P.O. Box 182825
Columbus, OH 43218-2825

Phone: 1-866-635-3748
Fax: 1-614-728-9574
Email: bsh@jfs.ohio.gov. In the subject, put "State Hearing Request".
Complaints: https://secure.jfs.ohio.gov/ols/RequestHearing/

The member may ask UnitedHealthcare Community Plan Customer Service for help writing the letter.

The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

- As quickly as the member's health condition requires or
- No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the State Fair Hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Appendix D: Member rights and responsibilities

For the most updated information regarding Member Rights and Responsibilities, please review the Member Handbook.

D.1 Member rights

Members of UnitedHealthcare Community Plan of Ohio have a right to:

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination.
- A reasonable opportunity to choose a Dentist and to change to another provider in a reasonable manner.
- Consent for or refusal of treatment and active participation in decision choices.
- Ask questions and receive complete information relating to your medical condition and treatment options, including specialty care.
- Voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a State Fair Hearing from UnitedHealthcare Community Plan of Ohio and/or the Department.
- Timely access to care that does not have any communication or physical access barriers.
- Prepare Advance Medical Directives.
- Assistance with requesting and receiving a copy of your medical records.
- Timely referral and access to medically indicated specialty care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be furnished health care services in accordance with federal and state regulations.

D.2 Member responsibilities

Members of UnitedHealthcare Community Plan of Ohio agree to:

- Work with their Dentist to protect and improve their health.
- Find out how their health plan coverage works.
- Listen to their Dentist's advice and ask questions when in doubt.
- Call or go back to their Dentist if they do not get better or ask to see another provider.
- Treat health care staff with the respect they expect themselves.
- Tell us if they have problems with any health care staff by calling Member Services at 1-877-698-7011.
- Keep their appointments, calling as soon as they can if they must cancel.
- Use the emergency department only for real emergencies.
- Call their Dentist when you need medical care, even if it is after-hours.



Dental Benefit Providers®

All documents regarding the recruitment and contracting of providers, payment arrangements, and detailed product information are confidential proprietary information that may not be disclosed to any third party without the express written consent of Dental Benefit Providers, Inc.

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOC.CER.06.

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