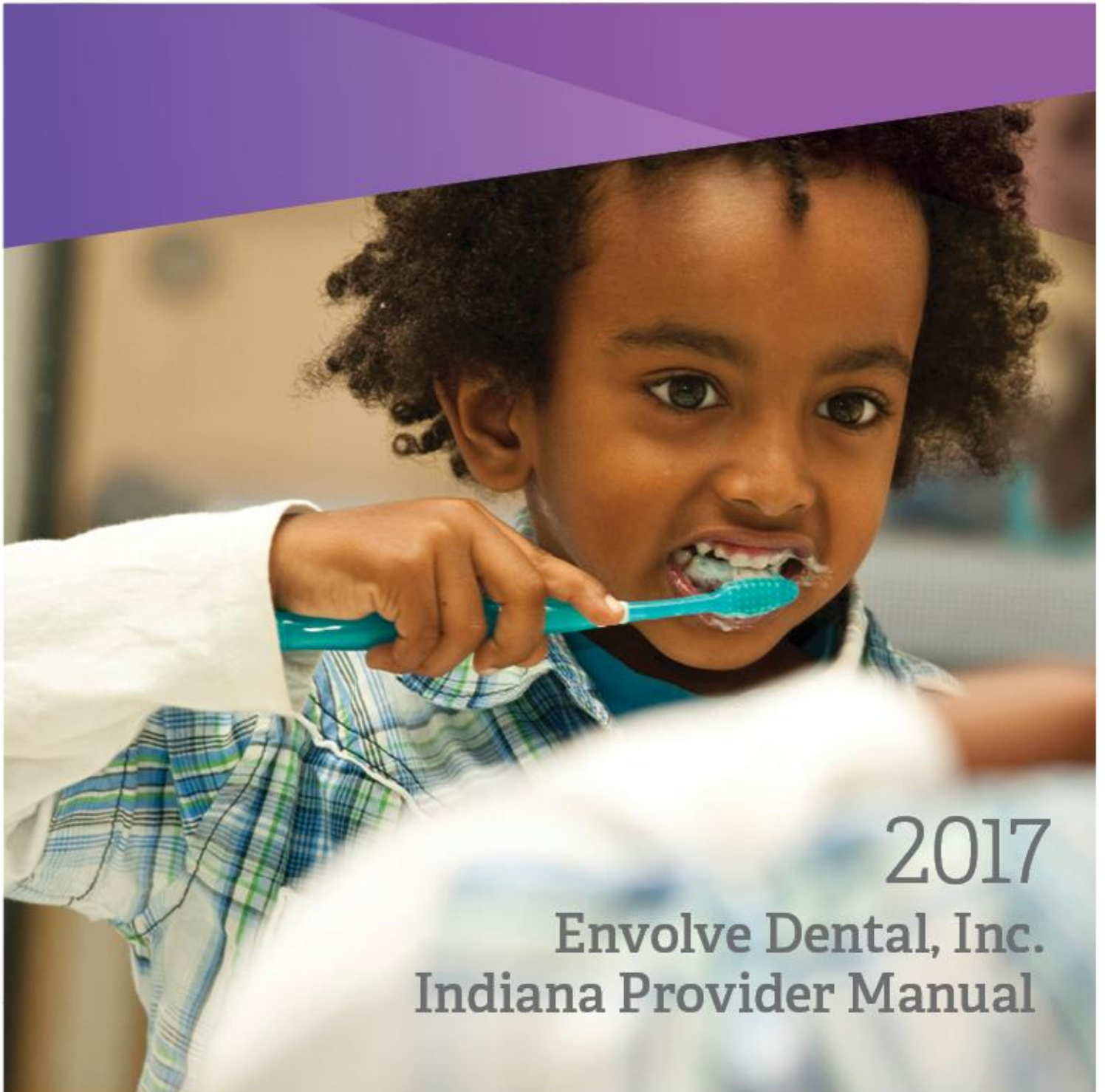




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Benefit Options



2017

Envolve Dental, Inc. Indiana Provider Manual

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Quick Reference Guide

Provider Web Portal

Everything You Need ● When You Need It ● 24/7/365

Our user-friendly Provider Web Portal features a full complement of resources.

Real-time eligibility

Authorizations – submit & view status

Claims – submit & view status

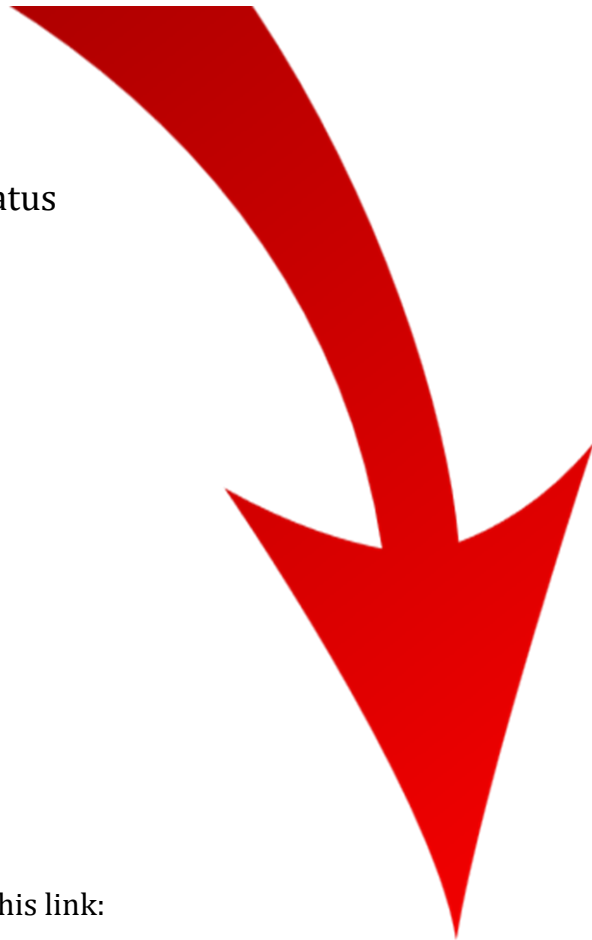
Clinical guidelines

Referral directories

Electronic remittance advice

Electronic Funds Transfer (EFT)

Up-to-date Provider Manual



Access the Provider Web Portal by clicking this link:

<https://pwp.envolvedental.com>

Contacts

For information about...	Contact...
Provider Web Portal	https://pwp.envolvedental.com
Provider Services	1-855-609-5157
MHS Member Services (including translation assistance)	1-877-647-4848
MHS Member Services Transportation Assistance (with LCP Transportation, LLC)	1-877-647-4848
Credentialing	1-844-847-9807 fax
Fraud & Abuse	1-800-345-1642
Authorization Address	Envolve Dental Authorizations: IN PO Box 20847 Tampa, FL 33622-0847
Paper Claim Address	Envolve Dental Claims: IN PO Box 20847 Tampa, FL 33622-0847
Appeals and Corrected Claim Address	Envolve Dental Appeals and Corrected Claims: IN PO Box 20847 Tampa, FL 33622-0847

Summary

Quick Reference Guide	
Member Eligibility	<p>Providers may access eligibility through one of the following. You must provide your NPI number to access member details.</p> <ul style="list-style-type: none"> • Provider Web Portal - https://pwp.envolvedental.com • Call Interactive Voice Response (IVR) eligibility hotline: 1-855-609-5157 • Call Provider Services: 1-855-609-5157
Authorization Submission	<p>Prior authorization submissions must be received in one of the following formats:</p> <ul style="list-style-type: none"> • Provider Web Portal at - https://pwp.envolvedental.com • Electronic clearinghouses using payor ID 46278: <ul style="list-style-type: none"> ○ Change Healthcare (formerly Emdeon, www.changehealthcare.com) ○ DentalXChange (www.dentalxchange.com) ○ Trizetto (www.trizetto.com) ○ Include attachments with NEA <i>FastAttach</i>® number • Alternate, pre-arranged HIPAA-compliant 837D file • Paper authorization via a 2006 or later ADA Claim Form and mailed to: Mailed authorizations must be sent to: <p style="margin-left: 40px;">Envolve Dental Authorizations: IN PO Box 20847 Tampa, FL 33622-0847</p>
Pre-Payment Review Submission	<p>Pre-payment reviews are post-treatment authorizations submitted with claims. Required documentation for each code – listed in the benefit grids – must be included and meet specified clinical criteria.</p> <p>Submit pre-payment review authorizations as claims, according to claim submission options.</p>
Dental Services in a Hospital Setting	<p>Providers must use a participating MHS hospital and receive prior authorization. To obtain the most recent listing of hospitals in your area:</p> <ul style="list-style-type: none"> • Visit MHS' website: mhsindiana.com • Call MHS Provider Services: 1-866-601-0524 <p>Prior authorization requests must be made to Envolve Dental at the same time that dental service authorization is requested.</p>

Quick Reference Guide	
Claims Submission	<p>The timely filing requirement for MHS is 90 calendar days from the date of service.</p> <p>Turn-around time for clean paper claims is 30 calendar days and for electronic claims 21 calendar days.</p> <p>Submit claims in one of the following formats:</p> <ul style="list-style-type: none"> • Envolve Dental Provider Web Portal at https://pwp.envolvedental.com • Electronic claim submission through selected clearinghouses: Payor ID 46278 • Alternate pre-arranged HIPAA-compliant electronic submissions • Paper claims must be submitted on a 2006 or later ADA claim form and mailed to: <ul style="list-style-type: none"> Envolve Dental Claims: IN PO Box 20847 Tampa, FL 33622-0847
Corrected Claim Submission	<p>Providers who receive a claim denial and need to submit a corrected claim may resubmit it on the Provider Web Portal or send a paper claim on a 2006 or later ADA form including ALL codes originally submitted, plus the corrected code with supporting documentation, within 67 calendar days from the date of notification or denial to:</p> <p style="padding-left: 40px;">Envolve Dental Corrected Claims: IN PO Box 20847 Tampa, FL 33622-0847</p>
Provider Appeals - Claims	<p>Claim payment appeals must be filed within 67 calendar days from the date of notification of payment or denial. All written provider appeals will be resolved within 30 calendar days.</p> <p>To request a reconsideration of a claims denial, a provider may:</p> <ul style="list-style-type: none"> • Call: 1-855-609-5157 for information • Write: <ul style="list-style-type: none"> Envolve Dental Appeals: IN PO Box -20847 Tampa, FL 33622-0847
Inquiries and Grievances	<p>To make an inquiry or grievance:</p> <ul style="list-style-type: none"> • Call: 1-855-609-5157 • Write: <ul style="list-style-type: none"> Envolve Dental Appeals: IN PO Box 20847 Tampa, FL 33622-0847

Quick Reference Guide

Provider Appeals - Authorizations	<p>Authorization appeals must be filed within 33 days following the date the denial letter was mailed.</p> <p>To request reconsideration of a denied authorization, a provider may:</p> <ul style="list-style-type: none"> • Call: 1-844-464-5630 • Write: <ul style="list-style-type: none"> Envolve Dental Appeals: IN PO Box 20847 Tampa, FL 33622-0847
Member Appeals	<p>Members must submit appeals within 33 calendar days of receiving an adverse Notice of Action. Members submit written appeals to:</p> <p style="padding-left: 40px;">MHS Appeals 1099 N. Meridian, Ste. 400 Indianapolis, IN 46204 Phone: 1-877-647-4848 Fax: 1-866-714-7993 Email: appeals@mhsindiana.com</p> <p>Members who are not satisfied with the MHS appeal decision may request an external, independent review within 120 calendar days. Members may also request a State Fair Hearing at the Indiana Family and Social Services Administration, but not at the same time as the external review. A State Fair Hearing must be requested within 33 days of exhausting MHS appeal procedures.</p> <p>Members can initiate a State Fair Hearing by calling MHS Member Services at 1-877-647-4848 or by writing to:</p> <p style="padding-left: 40px;">Hearing and Appeals Section, MS-04 Indiana Family and Social Services Administration 402 West Washington Street, Room E034 Indianapolis, IN 46204</p>
Additional Provider Resources	<p>For information about additional provider resources:</p> <ul style="list-style-type: none"> • Call Envolve Dental Provider Services: 1-855-609-5157 • Access the Provider Web Portal at https://pwp.envolvedental.com • Send an email to: providerrelations@envolvehealth.com
Other Contacts	<p>For more information, please contact:</p> <ul style="list-style-type: none"> • MHS Member Services: 1-877-647-4848 • Indiana Family and Social Services Administration (FSSA): 1-800-403-0864 • Indiana Office of Medicaid Policy and Planning (OMPP): 1-800-403-0864

Welcome

Welcome to the Envolve Dental provider network! We are pleased you joined our provider network, composed of the best providers in the state to deliver quality dental healthcare. Envolve Dental, Inc., formerly Dental Health & Wellness, Inc., is a subsidiary of Centene Corporation, a Fortune 200 company with more than 30 years' experience in Medicaid managed care programs. We partnered with Managed Health Services (MHS), our sister company, to administer the dental benefit for their members. MHS is a managed care entity (MCE) that is contracted with the state of Indiana to serve Medicaid recipients enrolled in the Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW) – including the Children's Health Insurance Program (CHIP) – and Hoosier Care Connect. The state of Indiana's Family and Social Services Administration (FSSA) administers the state and federal benefit plans through the Indiana Health Coverage Programs (IHCP).

This Envolve Dental provider manual supplies useful information about working with us. We strive to make information clear and user-friendly. If you have questions about specific portions of the manual or if you have suggestions for improvements, we welcome your input. Please contact Provider Services at 1-855-609-5157, Monday through Friday, 8:00 AM to 5:00 PM CST or send us an email at providerrelations@envolvehealth.com.

Envolve Dental retains the right to modify items in this provider manual.

Provider Participation, Contracting and Credentialing

Provider Participation

Why participate? The Medicaid program is the nation's largest health insurer, funding one sixth of total personal health care spending in the United States. More than one in three children is covered by Medicaid. However, participating in the Envolve Dental provider network has many advantages. Among them are the following:

- Envolve Dental has a user-friendly, state-of-the-art web portal, creating opportunities for providers to see more members, spend less time on administration, and receive claim payments and authorization determinations promptly.
- MHS' managed care model for dental services maintains a fee-for-service payment arrangement, so individual dental offices have less financial risk than a capitated model.
- Providers can choose a level of network participation based on their individual office needs. For example, providers can choose to:
 - accept only members who are currently patients in their office;
 - accept new patients and be listed in an Envolve Dental provider directory;
 - be excluded from a provider directory but accept new patients directed to the office by Envolve Dental;
 - treat only special needs cases or emergencies on an individual basis.

All licensed dentists interested in participating with Envolve Dental are invited to apply for participation in our network by signing a provider agreement (contract) and submitting a credentialing application. Details follow.



State-Required Provider Enrollment

The Indiana Family and Social Services Administration (FSSA) requires providers to be enrolled with the Indiana Health Coverage Program (IHCP) in order to provide services to Envolve Dental members. Providers who are not already enrolled with the IHCP must apply and obtain an IHCP identification (ID) number. Further information for completing the enrollment can be found at <http://provider.indianamedicaid.com/become-a-provider/ihcp-provider-enrollment-transactions.aspx>. Providers must report their IHCP ID number to Envolve Dental as soon as it is obtained. Submit it to dentalcredentialing@envolvehealth.com.

Contracting

Dentists must sign a Provider Agreement and apply for network participation by submitting all credentialing documentation. Envolve Dental Provider Agreements are available from the following sources:

- Online on our secure web portal at <https://providers.envolvedental.com>. Enter code “IN” and click *Enter* to access the electronic Provider Agreement.
- Call Provider Services at 1-855-609-5157. Our corporate-based representatives can send a packet or arrange for your local Envolve Dental network representative to deliver one personally.
- Email Envolve Dental at networkdevelopment@envolvehealth.com with your specific requests.

Prior to applying, note that the following are required for Indiana dentists to participate:

1. A State of Indiana Provider Medicaid ID number by registering as an IHCP provider. To obtain one, go to <http://provider.indianamedicaid.com/become-a-provider/ihcp-provider-enrollment-transactions.aspx> and complete the enrollment application.
2. Enroll as a provider with MHS using *the IHCP MCE Practitioner Enrollment Form*: <http://provider.indianamedicaid.com/media/47189/mce%20provider%20enrollment%20form.pdf>
3. A National Provider Identifier (NPI) number, as mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. You must have an individual NPI number and a billing NPI number. To apply for an NPI, do one of the following:
 - Complete the application online at <https://nppes.cms.hhs.gov>
 - Download and complete a paper copy from <https://nppes.cms.hhs.gov>
 - Call 1-800-465-3203 to request an application

To the extent that a provider executes a contract with any other person or entity that in any way relates to a provider's obligations under the Participating Provider Agreement or an Addendum, including any downstream entity, subcontractor or related entity, the provider shall require that such other person or entity assume the same obligations that the provider assumes under the Participating Provider Agreement and all Addendums.

If you have any questions about the contents of the Provider Agreement or how to apply, please call Provider Services at 1-855-609-5157.

Credentialing

The credentialing process is required to protect Medicaid beneficiaries from receiving services from unqualified providers, such as those with suspended licenses or Medicaid- or Medicare-excluded individuals. Envolve Dental adheres to all federal and state requirements for credentialing providers before they are approved for network participation. Specifically, the Envolve Dental Credentialing Committee evaluates applications according to the National Committee for Quality Assurance (NCQA) and URAC standards, as well as federal codes § 42 C.F.R. 438.214 and § 42 C.F.R. 438.12(A)(2), and state codes. See the sidebar for databases reviewed as part of the credentialing process.

Providers should complete the following steps for the Envolve Dental credentialing process:

Step 1: To complete online, go to <https://credentialingportal.envolvedental.com> or call Provider Services to receive the paperwork.

Step 2: Return to Envolve Dental:

- Completed credentialing application online or a CAQH ID #
- Copy of Drug Enforcement Agency (DEA) license
- Copy of malpractice insurance
- Completed Disclosure of Ownership (DOO) form
- State Medicaid ID number

You can also return documents by

Email: dentalcredentialing@envolvehealth.com
 Fax: 1-844-847-9807
 Mail: Envolve Dental
 Network Development
 PO Box 25656
 Tampa FL 33622-5656

Databases Reviewed for Credentialing

- Office of Inspector General's List of Excluded Individuals and Entities
- General Services Administration System for Award Management
- CMS/Medicare Exclusion Database
- State Board of Examiners
- National Practitioner Data Bank
- Health Integrity and Protection Databank
- State listings of excluded providers

- Step 3: Expect to receive an acknowledgement letter from the Envolve Dental Credentialing only if you need to submit missing documentation. The Credentialing Committee will review your application only when all documents have been received. All documents we receive are stored electronically and securely; we do not send them back or destroy them.
- Step 4: Review the Envolve Dental Credentialing Committee determination about your application, which will be communicated with a letter mailed to your listed office address. The possible results and your options are listed in Table 1.

Table 1. Credentialing Committee Determination and Results

Committee decision	What this means	What you can do
1. Accept application without restrictions	You are accepted to the Envolve Dental provider network when the Provider Agreement is signed.	Sign and return the Provider Agreement (if not done so previously). Register on the Envolve Dental Provider Web Portal. Start seeing members on the effective date.
2. Accept application with restrictions	The Credentialing Committee will recommend to the Executive Subcommittee a specific action, which can be approved or denied. Examples: (1) A provider with sanctions may be accepted, but Cost Containment division will closely monitor claims for six months; (2) If a provider incurs additional sanctions after approval, Envolve Dental has the right to withdrawal credentialing acceptance and network participation.	Sign and return the Provider Agreement (if not done so previously). Register on the Envolve Dental Provider Web Portal. Start seeing members on the effective date. Cooperate with Cost Containment and Credentialing requests for new information. Advise Credentialing when external sanctions are lifted.
3. Table application	The Credentialing Committee wants additional information about a questionable matter before making determination. OR The Credentialing Committee is waiting for a known external investigation to be concluded before making a final decision.	Provide as soon as possible any requested information to our Credentialing Specialists. Envolve Dental will reach out to request information. Provide up-to-date information to Envolve Dental Credentialing when the investigation concludes.
4. Decline application	The Credentialing Committee recommends denial to the Executive Subcommittee and it concurs.	Providers can appeal initial denial by submitting new information. A second appeal is possible if denied twice.

Envolve Dental and MHS have the exclusive right to decide which dentists it accepts as participating providers in the network. As of this publication date, the Envolve Dental credentialing process is administered by Envolve Dental, Inc. Envolve Dental does not discriminate based on age, gender, lifestyle, race, ethnicity, religion, disability, specialty or licensure type, geographic location, or financial status in making credentialing determinations.

Envolve Dental will notify MHS if any provider incurs sanctions or disciplinary actions, after which time the provider will be evaluated for continued participation in the network. Other important credentialing details include the following:

- Each provider must be credentialed, but only one application per provider is required whether he or she practices in one or multiple locations.
- Re-credentialing is required every three years. Envolve Dental will mail you a letter by US Mail to your office address alerting you that an updated credentialing application and all supporting documents must be submitted by a certain date for continuous network participation.
- If a provider's malpractice insurance, Drug Enforcement Administration (DEA) license and/or state Controlled Substance (CDS) license expires prior to the three-year Envolve Dental re-credentialing timetable, the provider must submit updated copies to Envolve Dental as soon as they are received from the issuing organization.
- The Disclosure of Ownership (DOO) statement should be updated and submitted to Envolve Dental annually if any changes occur.

Appeals for Adverse Credentialing Determinations

Providers whose credentialing applications are denied have the option to appeal the determination. Information about how to appeal will be specified in the denial letter.


To begin the appeal process, a provider needs to submit a letter with the subject line "Credentialing appeal," and write a narrative explaining a) why specific sanctions and/or negative information are on the provider's record and b) what the provider has done to correct the deficiency. Providers should also submit any new documents, written testimonials and other information that would support the Credentialing Committee reversing its initial determination. The committee will consider all original documents and the new information.

Upon reviewing the entire appeal, the Credentialing Committee has the option to accept the application, accept the application with restrictions, table the application, or uphold the denial. Providers whose applications are denied at the appeal level have the option to submit a second-level appeal. Submit a letter with the subject line "Credentialing second-level appeal." Include with the letter any additional information that would support acceptance. The second-level appeal will be carried out by a Peer Review Committee and its determination will be considered final.

Call Envolve Dental Credentialing at 1-855-609-5157 if you have any questions or need further assistance with any credentialing details.

Electronic Funds Transfer (EFT)

Envolve Dental makes available to providers Electronic Funds Transfer (EFT) for claims payments that are faster than paper checks sent via US Mail. EFT payments are directly deposited into the Payee's selected and verified bank account. To begin receiving electronic payments, complete an EFT form and submit it – with a voided check – to dentalcredentialing@envolvehealth.com or mail it with your credentialing documents. Forms are processed within one week; however, activation begins after four to five check runs, based on confirmation from your bank that the set-up is complete. Remittance statements explaining the payment will be available on the Provider Web Portal in the “Documents” tab for all providers active with EFT.



Benefit Options

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

To enroll in Envolve Dental's EFT payment program, complete this form and return it with a **voided check** via one of the following:

Mail: Envolve Dental Fax: 844-847-9807 Email: networkmanagement@envolvehealth.com
P.O. Box 25656
Tampa, FL, 33622-5656

I – CHECK APPLICABLE REASON FOR SUBMISSION

New EFT Authorization OR EFT setup revision (e.g. account number or bank changes)

II – PROVIDER/PAYEE INFORMATION

Payee name: _____

Tax Identification Number (TIN): (Designate SSN or EIN) _____

Payee address, city, state, zip code: _____

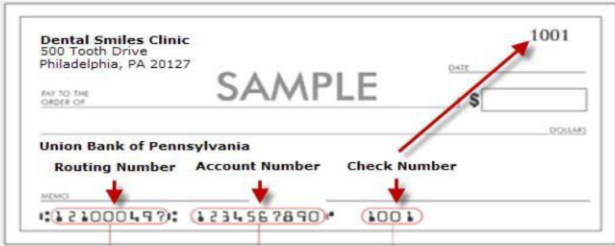
III – DEPOSITORY INFORMATION (Financial Institution)

Your bank/depository name: _____

Account type (check one):
 Checking Savings

Depository routing transit number
(Nine digits. Include any leading zeroes):

Depositor account number
(Include any leading zeroes):



IV – CONTACT INFORMATION

Name of billing contact person: _____

Phone number of billing contact: _____

Email address of billing contact: _____

V – AUTHORIZATION

I hereby authorize Envolve Dental to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of authorized billing contact: _____ Date: _____

© 2016 Envolve Inc. All rights reserved. ED PA EFT Form and flyer PA_Draft2_20160504

ELECTRONIC FUNDS TRANSFER (EFT) Terms of Use

The following terms and conditions, as amended from time to time ("Agreement") apply to all use of the Envolve Dental's Electronic Funds Transfer solution, and the use of any service provided in connection therewith (collectively the "EFT Services"). In this Agreement, the words "you", "your" and "yours" means the individual(s) entity or entities identified on the attached Electronic Fund Transfer (EFT) Authorization Agreement, and the words "we," "our," "us" refers to Envolve Dental affiliates and designees. Your enrollment or use of the EFT Services signifies your agreement to be legally bound by the terms and conditions set forth herein. **ACH and Wire Transfers.** This Agreement is subject to Article 4A of the Uniform Commercial Code -- Funds Transfers. By signing this Agreement, you authorize Envolve Dental, acting on behalf of any third party administrator, health care coalition, or health plan carrier (each a "Carrier") that participates in the EFT Services, to credit or debit the accounts listed on your Enrollment Form (the "Accounts") in connection with processing transactions between you and the Carriers. We may rely upon all Account information and identifying numbers provided by you on the Authorization Agreement to receive payment. We may rely on the routing and account numbers you provided even if they identify a financial institution, person or account other than the one named on the Enrollment Form. You agree to be bound by National Automated Clearing House Association (NACHA) rules. These rules provide, among other things, that payments made to you, are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the Uniform Commercial Code. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your Account and the Carrier that originated or instructed such payment will not be considered to have paid the amount so credited. We are not required to give you any notice of debits or credits to your Accounts. We may make adjustments to your Accounts whenever a correction or change is required. For example, if we make an error with respect to your Account, you agree that we may correct such error immediately and without notice to you. Such errors may include, but are not limited to, reversing an improper credit to your Account, making adjustments for returned items, and correcting calculation and input errors. Our right to make adjustments shall not be subject to any limitations or time constraints, except as required by law. **Accounts.** You represent and warrant that (a) you are the owner of each of the Accounts and (b) none of the Accounts is used primarily for personal, family or household purposes. **Confidentiality.** During the term of this Agreement, from time to time, we may disclose or make available to you, whether orally, electronically or in physical form, confidential or proprietary information concerning us and/or our business, products or services in connection with this Agreement (together, "Confidential Information"). Confidential Information includes, without limitation, business plans, health plan relationships, acquisition plans, systems architecture, information systems, technology, data, computer programs and codes, processes, methods, operational procedures, finances, budgets, policies and procedures, customer, employee, provider, member, patient and beneficiary information, claims information, vendor information (including agreements, software and products), product plans, projections, analyses, plans, results, and any other information which is normally and reasonably considered confidential. You agree that during the term of this Agreement and thereafter: (i) you will use Confidential Information belonging to us solely for the purpose(s) of this Agreement; and (ii) you will take all reasonable precautions to ensure that you do not disclose Confidential Information belonging to us to any third party (other than to your employees, contractors and/or professional advisors on a need-to-know basis who are bound by obligations of nondisclosure and limited use precautions at least as stringent as those contained herein) without first obtaining our written consent. **Confidentiality Exclusions.** For purposes hereof, "Confidential Information" will not include any information that you can establish by convincing written evidence: (i) was independently developed by you without use of or reference to any Confidential Information belonging to us; (ii) was acquired by you from a third party having the legal right to furnish same to the you without disclosure restrictions; or (iii) was at the time in question (whether at disclosure or thereafter) generally known by or available to the public (through no fault of you). **Amendments and Termination.** Envolve Dental may add, remove, change or otherwise modify any term of this Agreement at any time. We may also terminate or discontinue some or all of the EFT Services at any time without notice to you. **Governing Law and Venue.** The laws of the State of WI shall govern this Agreement and all disputes arising hereunder. You hereby consent that jurisdiction and venue are proper in the State of WI for the resolution of any dispute arising under this Agreement. **Severability.** If any provision of this document is found to be unenforceable according to its terms, all remaining provisions will continue in full force and effect. **Headings.** Headings in this document are for convenience or reference only and will not govern the interpretation of the provisions. **Construction.** Except where it would be unreasonable or illogical to do so, words and phrases used in this document should be construed so the singular includes the plural and the plural includes the singular. **Cooperation.** You agree to cooperate fully with us in furnishing any information, documentation or performing any action requested by us. You shall furnish us, upon forty-eight (48) hours notice, with true, accurate and complete copies of such records, documentation or any other information we or our authorized employees, representatives, agents and any regulatory agencies may request; provided, however, that you shall not be required to divulge any records to the extent prohibited by applicable law. **Ownership.** Except as provided in this Agreement, Envolve Dental shall have and own all rights, title and interests in the EFT Services and any information arising from or in connection therewith. You hereby acknowledge the specific ownership interests of Envolve Dental as set forth herein and you shall not acquire any ownership rights by virtue of this Agreement. **Assignment.** You agree not to assign this Agreement, directly or by operation of law or subcontract, delegate or appoint any third-party agent to perform any or all of its duties obligations or services hereunder without our written consent, and any such attempted assignment, subcontracting, delegation or appointment without such consent shall be void. All written notices shall be delivered by registered or certified mail, return receipt requested, and shall be deemed effective seventy-two (72) hours after the same is mailed via certified mail as described above with postage prepaid. Notice sent by any other method shall be effective only upon actual receipt. The parties to this Agreement, by notice in writing, may designate another to whom notices shall be given pursuant to this Agreement. **Relationship of the Parties.** The relationship between both parties under this Agreement is that of independent contractor. Nothing herein contained shall be construed as constituting a partnership, joint venture or agency between the parties hereto. **Entire Agreement.** This Agreement, which is an integral part hereof and are incorporated herein as a part of this Agreement, constitute the only agreement between the parties hereto relating to the subject matter hereof, except where expressly noted herein, and all prior negotiations, agreements and understandings relating to the subject matter hereof, whether oral or written, are superseded or canceled hereby. **Force Majeure.** Envolve Dental shall not be liable for a delay in performance or failure to perform any obligation under this Agreement to the extent such delay is due to causes beyond our control, including, but not limited to, governmental requests, regulations or orders, utility or communications failure, delays in transportation, national emergency, war, civil commotion or disturbance, war conditions, fires, floods, storms, earthquakes, tidal waves, failure or delay in receiving electronic data, equipment or systems failure or communication failures. **Warranties.** ENVOLVE DENTAL HEREBY DISCLAIMS ALL WARRANTIES WITH RESPECT TO THE SERVICES AND PRODUCTS PROVIDED HEREUNDER, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING WITHOUT LIMITATION ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR USE FOR A PARTICULAR PURPOSE. Under no circumstances shall the financial responsibility of Envolve Dental for any failure of performance by us under this Agreement exceed the fees or charges paid by you to Envolve Dental for the transaction, or activity that is or was the subject of the alleged failure of performance. IN NO EVENT SHALL ENVOLVE DENTAL, ITS PARENT, AFFILIATES, SUBSIDIARIES, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES BE LIABLE FOR SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES OR CLAIMS BY YOU OR ANY THIRD PARTY RELATIVE TO THE TRANSACTIONS HERE UNDER. **Indemnification.** You shall be liable to and shall indemnify, defend and hold Envolve Dental its directors, officers, employees, representatives, successors and permitted assigns harmless from and against any and all claims, demands by third parties, losses, liability, cost, damage and expense, including litigation expenses and reasonable attorneys' fees and allocated costs for in-house legal services, to which Envolve Dental, its directors, officers, employees, representatives, successors and permitted assigns may be subjected or which it may incur in connection with any claims which arise from or out of or as the result of (a) your breach of this Agreement; (b) your performance, duties and obligations under this Agreement; or (c) the negligence or willful misconduct of you, your directors, officers, employees, agents and affiliates in the performance of their duties and obligations under this Agreement. You shall bear all risk of loss of items, records, data and materials during transit from you to Envolve Dental's location or that of Envolve Dental's agents or sub-contractors. **Waiver.** No waiver or failure to exercise any option, right, or privilege under the terms of this Agreement on any occasion or occasions shall be construed to be a waiver of the same or any other option, right or privilege on any other occasion.

Member Rights & Responsibilities

Member Rights

Members have the right to:

- Receive information about MHS as well as MHS services, practitioners, providers and their rights and responsibilities. We will send them a member handbook when they become eligible and a member newsletter four times a year. In addition, detailed information on MHS is located on our website at mhsindiana.com. Or they may also call MHS Member Services at 1-877-647-4848.
- Be treated with respect and with due consideration for their dignity and privacy
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand
- A candid discussion of appropriate or medically-necessary treatment options, regardless of cost or benefit coverage
- Participate with practitioners in decisions regarding their healthcare, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations on the use of restraints and seclusion
- Request and receive a copy of their medical records and request they be amended or corrected as allowed in federal healthcare privacy regulations
- Voice complaints, grievances or appeals about the organization or the care it provides
- Make recommendations about our Member Rights and Responsibilities Policy
- An ongoing source of primary care appropriate to their needs and a person formally designated as primarily responsible for coordinating their healthcare services
- Personalized help from MHS staff so they can ensure they are getting the care needed, especially in cases where they or their child have “special healthcare needs,” such as dealing with a long-term disease or severe medical condition. We make sure they get easy access to all the care needed and will help coordinate the care with the multiple doctors and get case managers involved to make things easier for them. If they have been determined to have a special healthcare need by an assessment under 42 CFR 438.208(c)(2) that requires a course of treatment or regular care monitoring, we will work with them to provide direct access to a specialist as appropriate for their condition and needs.
- Have timely access to covered services
- Have services available 24 hours a day, seven days a week when such availability is medically necessary
- Get a second opinion from a qualified healthcare professional at no charge. If the second opinion is from an out-of-network provider, the cost will not be more than if the provider was in-network.
- Direct access to women’s health specialists for routine and preventive care, including family planning, annual women’s tests and OB service without approval by MHS or their MHS doctor. This includes birth control, HPV tests, chlamydia tests and annual Pap smears.

- Receive written notice of a decision to deny a service authorization request or to authorize a service in an amount, duration or scope less than requested. They will receive this information as quickly as needed so their medical needs are met and treatment is not delayed. We will not jeopardize their medical condition waiting for approval of services. Authorizations are reviewed based on their medical needs and made in compliance with state timeframes.

Member Responsibilities

Members are responsible for:

- Provide information (to the extent possible) needed by MHS, its practitioners and other healthcare providers so they can properly care for them
- Follow plans and instructions for care in which they have agreed to with their MHS doctors
- Understand their health problems and participate in developing mutually-agreed-upon treatment goals to the degree possible
- To follow plans and instructions for care they have agreed to with their practitioners

Provider Rights & Responsibilities

Envolve Dental applies the following rights and responsibilities to all network providers.

Provider Rights

Providers have the right to:

- Be treated with respect and dignity by members, other healthcare workers and Envolve Dental staff;
- Expect that members will keep appointments and follow agreed-upon treatment plans;
- Expect complete and accurate medical histories from members;
- Receive accurate and timely authorization determinations and claims payments;
- Access Envolve Dental quality improvement program information;
- Advise or advocate on behalf of their patients;
- Make a complaint against a member, MHS, or Envolve Dental; and
- File an appeal with Envolve Dental.

Provider Responsibilities

Providers are responsible for:

- Treating members with respect, fairness, and dignity, including HIPAA-compliant privacy standards;
- Not discriminating against members on the basis of race, color, national origin, age, gender, sexual orientation, religion, mental or physical disability, limited English proficiency, marital status, arrest record, conviction record, or military involvement;
- Following all state and federal laws regarding member care and patient rights;
- Making covered services available on a timely basis, based on medical appropriateness;
- Providing to members an understandable notice of your office's privacy rights and responsibilities;
- Confirming member eligibility on date of service;
- Providing members with access to and copies of their medical records when requested;
- Following Envolve Dental clinical criteria guidelines and reporting responsibilities;
- Allowing a member to stop treatment when the member requests it, and accompany the action with information about the implications of stopping care;
- Allowing members (with written documentation) to appoint a family member or other representative to participate in care decisions
- Answering member questions honestly and in an understandable manner;
- Allowing members to obtain a second opinion and how to access healthcare services appropriately;
- Notifying Envolve Dental if members have other insurance coverage;
- Reporting improper payments or overpayments to Envolve Dental; and
- Reporting to appropriate channels possible fraud and abuse by a member or provider.

Eligibility & Member Services

Member Eligibility and General Benefits by Program

Table 2. MHS Membership Eligibility and General Dental Benefit Descriptions			
Eligibility	Member Description	General benefits	Co-payments
HIP 2.0 Basic Hospital Presumptive Eligibility (HPE)	<p>Not eligible for Medicare or another Indiana Medicaid program, but eligible for HIP if in one of these groups:</p> <ul style="list-style-type: none"> • Adults age 19-64 with income ≤100% FPL • Pregnant women (members have the option to enroll in HIP Maternity, with same HIP State Plan benefits) 	<p>No dental benefit for most members.</p> <p>Pregnant women have Indiana Medicaid/Hoosier Healthwise dental benefits. Members age 19 to 20 have some Indiana Medicaid/Hoosier Healthwise dental benefits, including one cleaning per 180 days</p>	None
HIP 2.0 Plus	<p>Not eligible for Medicare or another Indiana Medicaid program, but eligible for HIP Plus if in one of these groups:</p> <ul style="list-style-type: none"> • Adults age 19-64 with income ≤100% FPL • Adults age 19-64 with income < 100% and ≥ 138% FPL • Pregnant women • Native Americans 	<p>Dental benefits include:</p> <ul style="list-style-type: none"> • Evaluations and cleanings (one per 12 months, adults age 21-64; one per 6 months, adults age 19-20) • Bitewing radiographs (four per benefit year) • Comprehensive radiographs (one complete set every three years) • Minor restorative procedures, such as fillings or extractions (four per benefit year) • Major restorative procedures, such as crowns (one per benefit year) 	None
HIP 2.0 State Plan Basic	<p>Ensures members who are otherwise eligible for Medicaid or have a qualifying health condition have enhanced benefits. Members may be:</p> <ul style="list-style-type: none"> • Medically Frail • Low-income Parents or Caretaker Adults • Low-income 19- and 20-year olds • Transitional Medical Assistance 	<p>Same benefits as Indiana Medicaid/Hoosier Healthwise (comprehensive dental benefits). Age limitations apply to certain codes.</p>	\$4 outpatient co-pay per service category, per date of service for all services except preventive and diagnostic.

Table 2. MHS Membership Eligibility and General Dental Benefit Descriptions

Eligibility	Member Description	General benefits	Co-payments
HIP 2.0 State Plan Plus	<p>Ensures members who are otherwise eligible for Medicaid or have a qualifying health condition have enhanced benefits.</p> <ul style="list-style-type: none"> • Medically Frail • Low-income Parents or Caretaker Adults • Low-income 19- and 20-year olds • Transitional Medical Assistance • Native Americans 	<p>Same benefits as Indiana Medicaid/ Hoosier Healthwise (comprehensive dental benefits). Age limitations apply to certain codes.</p>	None
Hoosier Care Connect	<p>Age 65+ with Medicaid. Children and adults with blindness or a disability. Certain children may voluntarily enroll, e.g., foster children.</p>	<p>Indiana Medicaid/Hoosier Healthwise benefits (comprehensive dental benefits). Age limitations apply to certain codes.</p>	None
Hoosier Healthwise	<p>Package A: Standard Plan for qualified children, pregnant women, and families.</p> <p>Package C: CHIP (Children’s Health Insurance Plan)</p>	<p>Dental benefits include:</p> <ul style="list-style-type: none"> • One cleaning every 12 months for adults age 21+; one cleaning every 6 months for members under age 21 • Radiographs and restorations • Extractions (based on medical necessity) • Fluoride treatment every six months for members 0 to 20 years old • Orthodontia for children, based on medical necessity • Dentures, partials, and repairs (with limits) • Dental surgery (with limits) • Emergency dental services 	None

Member Identification Card

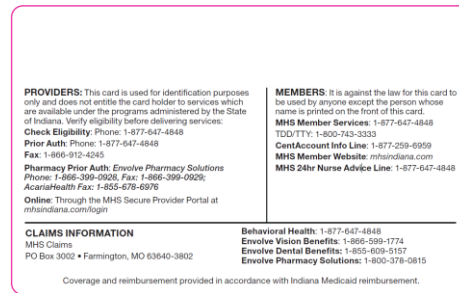
MHS issues identification cards to members on a regular basis and members are responsible for presenting the card on the date of service. Envolve Dental recommends dental offices make a photocopy of the member's ID card each time treatment is provided. It is important to note the ID card does not need to be returned should a member lose eligibility. Providers are responsible for verifying member eligibility at the time services are rendered and for determining if members have other health insurance. Presenting a Member ID card does not guarantee eligibility.

MHS member ID card samples for each product:

Hoosier Healthwise (front)



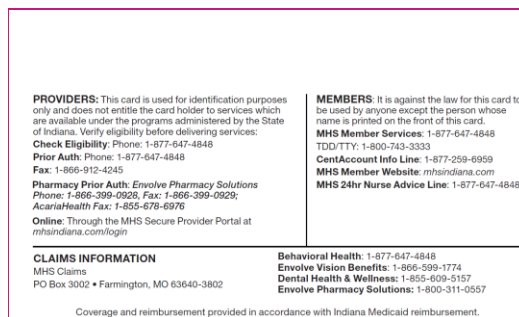
Hoosier Healthwise (back)



Hoosier Care Connect (front)



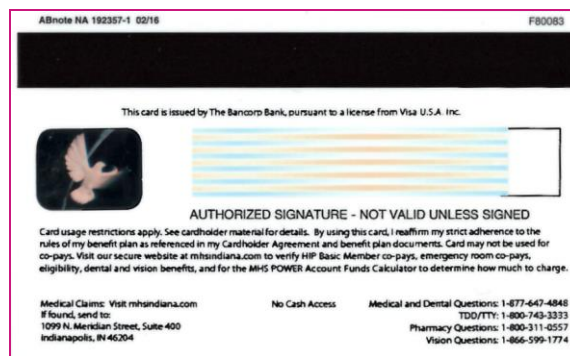
Hoosier Care Connect (back)



HIP (front)



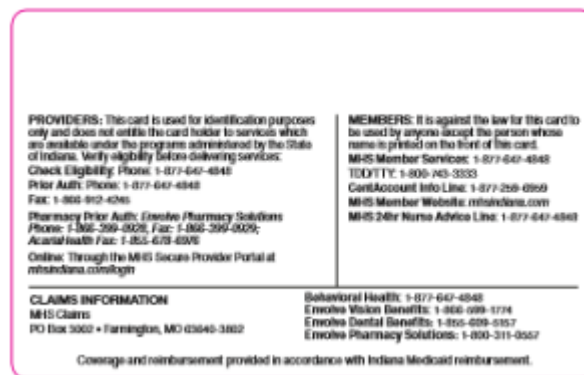
HIP (back)



HIP Maternity (front)



HIP Maternity (back)



Eligibility Verification

The local county office of the Division of Family Resources (DFR), a division of the Indiana Family & Social Services Administration, determines member eligibility. Eligibility data is updated to Envolve Dental nightly. On each date of service, providers are responsible for verifying member eligibility on the Envolve Dental Provider Web Portal or by phone on our Interactive Voice Response (IVR) system.

You will need the following information to verify eligibility:


Member Details

- Member Medicaid identification number or Social Security number
- Member date of birth
- Member name
- Date of service

Provider Details

- Provider NPI number

When you have this information ready, verify eligibility on the internet or via telephone. Using the Provider Web Portal on the internet requires registration. If you have not yet registered, call Provider Services at 1-855-609-5157.

Provider Web Portal via Internet	IVR via Telephone
Go to https://pwp.envolvedental.com Log in with your username and password.	Call 1-855-609-5157 for the Envolve Dental IVR system.
Go to the "Eligibility" tab. Enter the member's information and date of service. 	Follow the prompts on the automated system to input information: <ul style="list-style-type: none">• Provider NPI number• Press 1 to enter member ID• Press 2 to enter member Social Security number• Press 4 to return to main menu• Press 5 to speak to a Provider Services Representative

Note: Due to possible eligibility status changes, eligibility information provided does not guarantee payment.

HIP Plus 2.0 Benefit Renewal Date Verification

The HIP Plus Benefit Renewal Date is the date when benefits renew for amalgams, resins, prefabricated crowns and extractions. This only applies to members enrolled in HIP Plus, which has a limit of 4 restorations or extractions and one pre-fabricated crown per benefit year.

Transportation Assistance

MHS covers unlimited rides to and from doctor visits, to the pharmacy immediately following a doctor visit and to re-enrollment appointments, for all *Hoosier Healthwise (Pkg. A), Healthy Indiana Plan and Hoosier Care Connect members.

*CHIP and Hoosier Healthwise (Pkg. C) members receive emergency transportation services only. Eligible members should call MHS' transportation vendor at 1-877-647-4848 to schedule transportation at least 72 hours in advance of the appointment. Members with urgent appointments may be assisted on the day of the appointment, if necessary. Eligible, able-bodied MHS members may be provided with a bus or taxi voucher on a case-by-case basis. For emergency transportation services, please refer to the MHS provider manual at <http://www.mhsindiana.com/for-providers/provider-guides/>. MHS does not provide transportation services for out-of-network services.

Member Translation/Interpreter and Hearing Impaired Services

Members requiring language assistance should contact MHS Member Services at 1-877-647-4848. MHS will provide members with access to trained, professional interpreters. MHS offers American Sign Language, face-to-face or telephonic interpreter services. MHS requires a five-day prior notification for face-to-face services. Telephonic interpreter services are available for many different languages 24 hours a day, seven days a week. There is no cost to members. TTY/TDD access is available to members who are hearing-impaired at 1-800-743-3333.

Appointment Availability Standards

Appointment availability standards are set by MHS and Envolve Dental to ensure members receive dental services within a time period appropriate to health conditions. Providers should meet or exceed the standards to provide quality service, maintain member satisfaction, and eliminate unnecessary emergency room visits.

Member calls for . . .	Appointment must be scheduled and services provided within . . .
routine dental care (for example, a cleaning)	three months
routine symptomatic care (non-urgent)	72 hours
urgent care – defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury, and the member will not suffer adverse consequences if treatment is received within 24 hours.	forty-eight (48) hours
emergency care – defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury that will result in the member having adverse consequences if not treated immediately.	Immediately

On the appointment date, waiting time in the office must not exceed one hour from the scheduled appointment time. Envolve Dental will keep providers informed about appointment standards, monitor office adequacy, and take corrective action if warranted.

After-Hours Care

All dental providers are required to supply after-hours coverage for member needs or emergencies, accessible by using the office’s daytime phone number. The coverage must be available 24 hours a day, seven (7) days a week, and can be an answering service, call forwarding, or another method, whereby the caller can speak to a qualified person who will make a clinical decision about the member’s oral health status. MHS requires callback times to be no more than 30 minutes.

Referrals to Specialists

Envolve Dental does not require general or pediatric dentists to obtain an authorization or referral to dental specialists. If a specialist is needed, providers should recommend to members a specialist in the Envolve Dental network. Participating network specialists can be found on the MHS “Find a Provider” page at www.mhsindiana.com. If the *specialist* requires a referral before he/she will schedule an appointment for the member, please consult directly with the specialist for that office’s referral requirements.

General dentists are responsible for providing necessary x-rays and chart documentation to the specialist. Records should also be available at no cost to members upon request.

Missed Appointments

Envolve Dental recommends that providers contact members by phone at least 24 hours prior to scheduled appointments to confirm the commitment and your office location. Please note:

- Providers can discontinue providing services to a member if he/she misses three appointments in a 12-month period. Be sure to keep a record of occurrences in the member's record, and refer the member to MHS at 1-877-647-4848 to identify a new dental provider.
- Your office's missed appointment and dismissal policies for MHS members cannot be stricter than your private or commercial patient policies.
- Providers are not allowed to charge MHS members for missed appointments.

Balance Billing and Payment for Non-Covered Services

Envolve Dental network providers are contractually obligated to abide by billing requirements, which are established by Envolve Dental, MHS, and the Centers for Medicare and Medicaid Services. These conditions include the following:

- Providers cannot bill members for any type of unauthorized cost sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit that is not dictated by the member's health plan.
- Providers must accept the Envolve Dental payment as "payment in full," and cannot balance bill members – that is, for the difference between the provider-billed amount and the Envolve Dental payment amount.
- Providers cannot bill members for medical records.

Providers may bill a member *only for non-covered* dental services, with the condition that the provider must inform the member in detail and obtain a signed, detailed agreement from the member (or his/her guardian) *prior to* services being rendered. Providers also agree to hold harmless Envolve Dental, MHS and the State for payment of non-covered services. An example form follows.

NON-COVERED SERVICES LIABILITY ACKNOWLEDGEMENT

Provider Name: _____
Provider NPI: _____
Member Name: _____
Member ID: _____
Health Plan: _____
Date of Service: _____

I (the member or if a minor, guardian of the member as listed above) acknowledge that it has been explained to me that certain health care services (s) or supplies that I have requested or wish to purchase will not be covered under the terms of my Health Plan benefit schedule. The non-covered services(s) that I have requested are:

_____ \$ _____
_____ \$ _____
_____ \$ _____
_____ \$ _____
_____ \$ _____

The total cost for the non-covered services/items is: \$ _____

I also acknowledge that I have been advised that these services are optional and as such, I will be responsible for payment for these non-covered services and agree to make payment arrangements directly with the Provider for these services.

Date Signed _____
Print Member Name _____
Member Signature _____
Name of Parent or Legal Guardian (if applicable) _____
Signature of Parent or Legal Guardian (if applicable) _____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and must be maintained in the patient's dental record.

Member Information and HIPAA

The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996, commonly known as “HIPAA,” includes a Privacy Rule to protect individually identifiable health information and a Security Rule that specifies administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of electronic-protected health information. A major goal of the Security and Privacy rules is to allow the flow of health information to promote high quality health care while properly protecting individual health information.

Envolve Dental complies with HIPAA rules and expects network providers to adhere to HIPAA rules as well. Examples of important definitions and practical applications are listed in Table 3.

Table 3. HIPAA Definitions and Applications

Security Rule Requirement	Definition	Application Example
Confidentiality	Protected Health Information (PHI) and electronic PHI (e-PHI) is not disclosed or available to unauthorized persons.	Envolve Dental will ask callers for their name, Tax ID number, and/or NPI number to verify identity. Callers requesting patient information must also provide member name, date of birth, and member ID or social security number before Envolve Dental will share member-related information.
Integrity	E-PHI is not altered or destroyed in an unauthorized manner.	Patient data should be backed up to prevent loss in case of system crashes. Controls should be in place to identify data changes due to human error or electronic failures. Clinical notes cannot be modified or deleted, but addendums can be added. Patients do have the right to ask for a change in their medical records.
Availability	The property that data or information is accessible and usable upon demand by an authorized person.	Envolve Dental enables only authorized, registered users to access the Provider Web Portal containing patient information. The portal is available 24 hours a day and seven days a week.

Table 3. HIPAA Definitions and Applications

Security Rule Requirement	Definition	Application Example
Protect against threats or disclosures	Potential threats or disclosures to e-PHI that are <i>reasonably anticipated</i> must be identified and protected.	All email correspondence that includes patient name and personal health details must be sent via a secure email service. <i>Providers should never initiate to Envolve Dental an email that is not encrypted and contains patient details.</i> Envolve Dental can initiate a secure, encrypted email to providers who can then reply while maintaining the security of the email. Call Provider Services for details.
Staff compliance	People employed by provider offices and health plans (covered entities under HIPAA) adhere to rules.	At least one staff person must be designated as a security official responsible for implementing HIPAA requirements, ensuring training is completed by all staff upon hiring and annually, overseeing compliance, and carrying out appropriate sanctions for violations.

Source: Department of Health & Human Services @ www.hhs.gov/ocr/privacy/index.html

For additional details about HIPAA, visit the U.S. Department of Health and Human Services' website at HHS.gov.

Utilization Management & Review

Utilization Management

Utilization management aims to manage health care costs before services are rendered by specifically defining clinical criteria that are based on accepted dental practices. Envolve Dental covers all state-required benefits and applies clinical standards to them, explicitly outlining for providers what conditions must be present in order for the covered benefits to apply. Please see the clinical criteria for MHS members in this manual, which should be used in conjunction with the benefit grids that include required documentation that substantiates the criteria.

The prior authorization and pre-payment review processes are additional means of managing utilization by appropriateness of care. Several procedures, such as orthodontia, always require prior authorization review and approval before services can be rendered and reimbursable. Other services require authorization but can be approved with a pre-payment review. That is, as long as the clinical criteria for a service are met and the required documentation supports the criteria, then the authorization will be approved and the claim will be paid. See the next section for specific details about prior authorizations and pre-payment reviews and submission options for each.

Envolve Dental makes utilization management decisions based solely on medical necessity, appropriateness of care and benefit coverage parameters. Providers are not encouraged or rewarded to alter treatment decisions for financial gains, nor are they influenced to make decisions that result in underutilization. If providers disagree with an Envolve Dental utilization management decision, providers have the right to appeal.

Utilization Review

Utilization review considers practice standards and patterns based on claims data history, in comparison to other providers in the same geographic area. Envolve Dental conducts utilization reviews to analyze variations in treatment patterns that may be significantly different among providers in the same area. General dentists are not compared to specialty dentists.

If significant differences *are* evident, Envolve Dental may initiate an audit of member records to determine the practice's appropriateness of care.

Practical Applications

Providers can facilitate good utilization management by

- Reviewing clinical criteria and comprehensively documenting member's condition based on them;
- Maintaining accurate, up-to-date dental records and medical histories for each member, including perio-charting and treatment plans, even for routine cases;
- Ensuring x-rays are high quality for accurate diagnoses;
- Submitting all required documentation for authorizations and claims accurately and completely; and

- Maintaining good communication with Envolve Dental by calling Provider Services with questions and concerns: 1-855-609-5157.

Fraud, Abuse, and Waste

Envolve Dental is dedicated to upholding integrity in the Medicaid program. Most individuals who work with Medicaid and Medicare are honest, but some people take advantage of the system, costing the program – and ultimately taxpayers – unnecessary expenses. As a responsible administrator, Envolve Dental expects its providers, contractors and subcontractors to comply with all applicable laws and regulations pertaining to fraud, abuse, and waste, as required by law. The Centers for Medicare and Medicaid Services define them as

Fraud: When someone intentionally executes or attempts to execute a scheme to obtain money or property of any health care benefit program. Examples of fraud:

- Medicaid is billed for services never rendered.
- Documents are altered to gain a higher payment.
- Dates, descriptions of services, or the beneficiary's identity are misrepresented.
- Someone falsely uses a beneficiary's Medicaid card.

Abuse: When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to the health care benefit program. Examples of abuse include:

- Billing for services that were not medically necessary;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

The primary difference between fraud and abuse is intention.

Waste: Providing medically unnecessary services.^{1,2}

Envolve Dental is obligated to report suspected fraud or abuse by members and health care providers. Providers also are required to report possible incidents, which can be done so anonymously by calling a fraud and abuse hotline.

Fraud and Abuse Hotlines

Envolve Dental hotline: 1-800-345-1642

MHS Fraud and Abuse hotline: 1-866-685-8664

Indiana Family and Social Services Administration: 1-800-403-0864

¹ *Module: 10 Medicare and Medicaid Fraud and Abuse Prevention, 2014 National Training Program, Centers for Medicare & Medicaid Services*

² *Medicare Fraud & Abuse: Prevention, Detection, and Reporting, Centers for Medicare & Medicaid Services, August 2014*

Table 4 summarizes applicable federal laws pertaining to fraud and abuse. Additional details are available on the Centers for Medicaid Services website: www.cms.gov.

Table 4. Federal Laws for Medicaid Fraud and Abuse		
Law or Regulation	Premise	Example and Penalty/Award
False Claim Act (FCA)	Knowingly submitting a false or fraudulent claim to a federally funded government program.	A provider submits claims for a higher level of services than provided. Fines of \$5,500 to \$11,000 per false claim and up to three times the amount of damages sustained by the government.
Qui Tam Provision (Whistleblower protection)	Under the FCA, allows citizens with evidence of fraud to sue, on behalf of the government, to recover stolen funds.	Awards 15 to 25 percent of recovered funds to the informant and provides protection for those who may be discharged for taking reasonable action under the FCA.
Physician Self-Referral Law (Stark Law)	Prohibits health care providers from making a referral for certain health services when the provider (or a family member) has an ownership interest in the referral designation.	A provider refers a patient to another office or business where the provider has a financial interest. Penalties include fines, claim repayment, and potential exclusion from federal health care programs.
Anti-Kickback Statute (AKS)	Knowingly and willfully offering, paying, soliciting, or receiving remuneration to induce or reward referrals reimbursable by a federal health care program.	A provider receives cash or other benefits for referrals. Civil penalties can be up to three times the kickback amount.
Criminal Health Care Fraud Statute	Knowingly and willfully executing a scheme in connection with the delivery of or payment for health benefits or services to defraud the program or obtain under fraudulent pretenses any money from the program.	Several providers conspire to defraud the Medicaid program by coordinating a scheme for services that are not medically necessary. Penalties can include fines, imprisonment, or both.
Source: Centers for Medicare and Medicaid Services @ Medicare Fraud & Abuse		

Authorizations, Pre-Payment Reviews and Documentation Requirements

Envolve Dental has specific clinical criteria and authorization processes to manage service utilization according to medical necessity and appropriateness of care. Please refer to the clinical criteria requirements for services in this manual. Required documentation to support authorization requests are listed per code in the benefit grids in Appendix A. Providers should measure intended services to the clinical criteria before treatment begins to assure appropriateness of care. Authorization requests are considered according to the following:

Authorization Type	Conditions	What to do
Prior Authorizations	Required prior to treatment for certain codes identified in the benefit grids.	Check the “Quick Reference Guide” and corresponding benefit grid for requirements.
Urgent/Emergent Authorizations	Defined as situations involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury.	<p>Treat the member.</p> <p>Call Envolve Dental within two business days to report the urgent service in the member’s Envolve Dental record.</p> <p>Submit the completed claim and all required documentation as a Pre-Payment Review no later than 90 calendar days from service date.</p> <p>If you choose to receive prior authorization for urgent cases, call Provider Services at 1-855-609-5157 for options and directions about submission via a HIPAA-compliant secure e-mail initiated by Provider Services.</p>
Pre-payment Reviews	Provider is confident that the member’s condition and the clinical criteria in this manual are equivalent, and codes are (1) consistent for appropriate treatment and (2) are covered benefits.	Submit claim with all required authorization documentation within 90 days of the date of service.

Prior authorizations address issues of eligibility at time of request, medical necessity, and appropriateness of care. They are not a guarantee of payment. Approval for payment is based upon the member’s eligibility on the date of service, dental record documentation, and any policy limitations on the date of service.

If you are uncertain whether a procedure will be paid when submitted as a Pre-payment Review due to potentially unmet clinical criteria, you have the option of first submitting a request for prior authorization before services are rendered.

Prior Authorization

Due to the nature of dental services requests, please submit prior authorization requests with complete documentation requirements to Envolve Dental seven (7) calendar days before a scheduled procedure that requires prior authorization.

Determinations are made based on whether the service is a covered benefit, is medically necessary, if a less expensive service would adequately meet the member's needs, and whether the proposed service conforms to commonly accepted dental standards.

Envolve Dental will make an authorization determination within seven (7) calendar days from the date the request is received, provided all information is complete. For urgent/expedited requests, where you indicate that the member's ability to attain, maintain or regain maximum function would be compromised by waiting seven days, contact Provider Services at 1-855-609-5157 to request an urgent review. Envolve Dental will make urgent determinations within three business days. The authorization will be auto-granted if Envolve Dental does not make a determination within seven calendar days.

Envolve Dental notifies providers with an approval authorization number or with a denial notification via fax within one business day after the determination. *Be certain your fax number is always up to date with Envolve Dental.* Authorization determinations are also visible on the Envolve Dental Provider Web Portal.

- Your office should contact members to schedule appointments when you receive an approved authorization number. Members receive authorization notices *only* for denials or to authorize a service in an amount, duration or scope that is less than requested.
- Prior authorizations are valid for 180 days from the issue date; however, an authorization does not guarantee payment. The member must be eligible at the time services are provided. Providers are responsible for verifying eligibility on the service date.
- Providers are not allowed to bill the member, MHS or Envolve Dental if services begin before authorization is determined and authorization is subsequently denied.

Pre-payment Review Authorizations

Urgent/emergent oral health conditions are defined as situations that involve severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. Such authorization requests are immediately granted. Dental providers are encouraged to treat the member, then call Envolve Dental within two business days after the service to record the incident in the member's Envolve Dental record, and then submit within 90 calendar days the completed claim with all required authorization documents on a 2006 or later ADA claim form marked "Pre-payment Review" on the top of the form. All urgent/emergent authorization requests are evaluated by the Chief Dental Officer, a licensed physician, or a licensed dental consultant to certify that the services were urgent or emergent as defined above. All dental consultants, including the Chief Dental Officer, are graduates of an accredited dental school and licensed to practice dentistry in the state in which they reside, at a minimum. Providers starting treatment before authorization approval are at financial

risk and may not balance bill the member if the utilization management reviewer determines conditions were not met.

Providers who choose to pursue prior authorization for urgent cases before treatment should call Provider Services at 1-855-609-5157 for directions about submission via a HIPAA-compliant secure e-mail initiated by an Envolve Dental representative.

Pre-payment Reviews (PPR) are also available for selected codes, identified in the benefit grids in Appendix A, and in the following Quick Reference Guide table. Submit the completed claim with all required authorization documents on a 2006 or later ADA claim form marked "Pre-payment Review."

Peer-to-Peer Review

Envolve Dental utilization management staff use clinical criteria detailed in this manual to make all authorization determinations. When determinations are made, Envolve Dental sends a notice of the outcome via facsimile (fax) to the provider's fax number on record. The determination is also available on the provider's account on the Envolve Dental Provider Web Portal.

For denied or partially denied authorization requests when additional clinical information exists which was not previously provided, the treating dentist may request a peer-to-peer phone call review within 30 calendar days from the date of the denial. The Envolve dental consultant who reviewed the authorization, claim, or appeal is the primary peer-to-peer dentist for the call. If the adverse determination dental consultant is not available for the peer-to-peer call, then another dentist is selected to complete the call. Information from the adverse determination will be made available to any dentist completing the peer-to-peer call. All Envolve dental consultants maintain active and current unrestricted dental licenses.

Note that only the treating dentist, and not an office assistant or dental hygienist, may request the peer-to-peer review and conduct the peer-to-peer review call during a mutually agreed time.

To request a peer-to peer review, write to Envolve Dental at:

Envolve Dental
Authorizations -IN
PO Box 20847
Tampa, FL 33622-0847

or call Envolve Dental Provider Services at 1-855-609-5157. The request will be processed by Envolve Dental utilization management staff who will call the office within one business day to schedule a phone appointment between the requesting dentist and the Envolve dental consultant at a mutually agreed date and time.

The peer-to-peer discussion includes, at a minimum, the clinical basis for Envolve Dental's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. After discussion, the dental consultant will complete an additional advisor review. Using the new information obtained

in the call, the dental consultant will decide to uphold, partially uphold, or reverse the previous determination. The decision is logged into the Envolve Dental system, where the provider can access details in his/her Provider Web Portal account. The decision is also mailed to the requesting provider via US Postal Service.

Peer-to-peer review is not a part of the formal Envolve Dental appeal process. Providers have the option to submit an appeal instead of a peer-to-peer review, or providers can appeal a decision after a peer-to-peer review results in an upheld denial.

Authorization Submission Procedures

Authorization requests must be received at least seven (7) business days in advance in one of the following formats:

1. Envolve Dental Provider Web Portal at <https://pwp.envolvedental.com>
2. Electronic clearinghouses, using Envolve Dental payor identification number 46278
3. Alternate, pre-arranged, HIPAA-compliant electronic files
4. Paper request on a completed ADA (2006 or later) claim form by mail
5. For urgent requests, call Provider Services at 1-855-609-5157.

1. Provider Web Portal Authorization Submissions

Providers can submit authorization requests directly to Envolve Dental on our Provider Web Portal, including attachment uploads. Submissions on the portal are quick and easy and facilitate faster processing and determinations. To submit, log on to <https://pwp.envolvedental.com>. A user guide is included in Appendix B in this manual. If you have questions about submitting authorization requests or accessing the Envolve Dental Provider Web Portal, call Provider Services at 1-855-609-5157 or email providerrelations@envolvehealth.com.

2. Clearinghouse Authorization Submissions

Providers can use their preferred clearinghouse for authorization requests. .

Use Envolve Dental payor identification number **46278** for all clearinghouses. As of this manual publication date, we currently work with the following:

- Change Healthcare (formerly Emdeon, website: www.changehealthcare.com; Phone: 1-888-363-3361)
- DentalXChange (Website: www.dentalxchange.com; Phone: 1-800-576-6412)
- Trizetto (Website: www.trizetto.com; Phone: 1-800-556-2231)

Please use the following Master ID numbers as indicated for each health plan product:

463026	ENVD IN MHS- HP Basic (19-20 yrs old)
463027	ENVD IN MHS- HP Plus
463028	ENVD IN MHS- HIP Basic, Plus, Pregnancy
463029	ENVD IN MHS- Hoosier Care Connect
463030	ENVD IN MHS - Ambetter
463031	ENVD IN MHS Hoosier Healthwise Package A

Envolve Dental will receive the requests electronically and process them with our state-of-the-art authorization administration modules. Be sure to include all required documentation listed in the benefit grids when submitting on their portals, using a NEA *FastAttach*® tracking number in the remarks section. A Dental Review Specialist assigned to MHS will make the determination.

Electronic Attachments for Clearinghouse Submissions

Envolve Dental promotes electronic authorization and claim processing for fast and efficient decisions and payments. Our Envolve Dental Provider Web Portal is the preferred method for submissions that include attachments, but if your office uses a clearinghouse, we can accept attachments from National Electronic Attachment, Inc. (NEA).

NEA, through *FastAttach*®, enables providers to securely send attachments electronically – x-rays, EOBs, intraoral photographs, perio charts, and more. To use the system, go to www.nea-fast.com, install the software, and follow the steps to begin using it. The steps are simple: a provider scans required documents, transmits them to NEA's secure repository, selects Envolve Dental as the payor (ID #46278) and receives an NEA unique tracking number. Next, the provider includes the NEA tracking number in the remarks section to Envolve Dental. See the Master ID numbers for each health plan product as listed above.

Images you transmit are stored for three years in NEA's repository and can only be viewed by your office and Envolve Dental. Data and images remain secure with HIPAA-compliant standards and you should only give your office's NEA account login and password to authorized users. If you have specific questions about using *FastAttach*®, call NEA at 1-800-782-5150.

3. Alternate HIPAA-Compliant 837D File

Electronic authorization submissions must be HIPAA-compliant. Envolve Dental strongly recommends using our custom Provider Web Portal because we stay current with HIPAA regulations. If your office uses an alternative electronic system that requires direct integration using an 837D file, Envolve Dental will consider options to assist. To schedule an appointment with our technical specialist to discuss alternatives, please email us at providerrelations@envolvehealth.com or call 1-855-609-5157.

4. Paper Authorization Submission

Paper authorization requests must be submitted on a 2006 or later ADA claim form with the following information:

- Member name
- Member Medicaid ID Number
- Member date of birth
- Provider name and location
- Billing location
- Provider NPI and Tax Identification number (TIN)

For services requested, include:

- Approved ADA codes as published in the current CDT book or as defined in this manual
- All quadrants, tooth numbers and tooth surface identifications per dental code
- Required documentation, such as x-rays and treatment plans, listed in the benefit grids in Appendix A.

Missing or incorrect information could result in an authorization denial or determination delay.

Mail paper authorization requests and all required documents with correct postage to:

Envolve Dental
Authorizations: IN
PO Box 20847
Tampa, FL 33622-0847

A sample ADA form follows. Originals for use can be obtained from the American Dental Association.

ADA-Approved Claim Form

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION															
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX															
2. Predetermination/Preauthorization Number					POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)										
3. Company/Plan Name, Address, City, State, Zip Code															
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
13. Date of Birth (MM/DD/CCYY)					14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)								
16. Plan/Group Number					17. Employer Name										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION															
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)															
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only)															
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)															
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)											
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other													
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code															
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other															
19. Reserved for Future Use															
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
21. Date of Birth (MM/DD/CCYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)											
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. Cdy	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.)						34. Diagnosis Code List Qualifier		31a. Other Fee(s)							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
34a. Diagnosis Code(s)						A _____		C _____							
32. 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17						B _____		D _____		32. Total Fee					
35. Remarks															
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION										
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X Patient/Guardian Signature _____ Date _____					38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")			39. Enclosures (Y or N) <input type="checkbox"/>							
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X Subscriber Signature _____ Date _____					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)			41. Date Appliance Placed (MM/DD/CCYY)							
					42. Months of Treatment			43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)							
					44. Date of Prior Placement (MM/DD/CCYY)										
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident					46. Date of Accident (MM/DD/CCYY)										
					47. Auto Accident State										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)					TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
48. Name, Address, City, State, Zip Code					53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X _____ Signed (Treating Dentist) _____ Date _____										
49. NPI		50. License Number		51. SSN or TIN		54. NPI			55. License Number						
52. Phone Number () -		52a. Additional Provider ID		57. Phone Number () -			58. Additional Provider ID								
56. Address, City, State, Zip Code					59. Provider Specialty Code										

© 2012 American Dental Association
 J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
 or go online at adacatalog.org

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM, AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

Prior Authorization for Facility and Hospital Services

Dental services that require treatment in a facility or hospital must receive prior authorization from Envolve Dental. Note that facilities used must be MHS participating facilities. If no participating hospitals are within acceptable distance requirements (30 miles in urban areas and 60 miles in rural areas), providers can make a non-par single case agreement request to Envolve Dental.

When submitting the authorization request, include the following:

1. An Envolve Dental Hospital/Outpatient Facility Medical Necessity Form
2. A completed Indiana Health Coverage Programs Prior Authorization Fax Form with detailed information about the facility and “MHS” selected for the appropriate benefit group. Include on the form medical CPT codes for sedation services and a date range when the appointment may be scheduled, up to 180 days
3. All procedure codes, including D9999 for the facility
4. All required documentation per code, as listed in Appendix A

Once all information is received, Envolve Dental makes a determination about the authorization request and the resulting response is initiated:

Responses to Facility Authorization Requests	
Approved	Denied
<ul style="list-style-type: none"> • Envolve Dental will send an automated fax approval letter to the requesting dentist. • Envolve Dental will fax the IHCP Prior Authorization Form to MHS with the dental service authorization number. • MHS will issue a facility/anesthesia authorization number and fax it to the hospital and the provider who initiated the request. • The requesting provider calls the facility to schedule the services and informs the member. 	<ul style="list-style-type: none"> • Envolve Dental will fax a denial letter to the requesting provider, including information about how to appeal. • Envolve Dental will mail a denial letter to the member (called a “Notice of Action”), with information about how to appeal the determination. • The provider or member can initiate an appeal.

A copy of the Facility Medical Necessity form and the IHCP forms follow.

Hospital / Outpatient Facility Medical Necessity Form
(Revised 2014)

Member name: _____

Member DOB: _____

Member ID number: _____

Requesting Provider name and NPI: _____

Contact person name: _____

Contact person phone number: _____

Medically necessary: The use of Hospital / Outpatient facilities services during the delivery of dental services is considered medically necessary when submitted documentation (including narrative, radiographs, etc.) demonstrates the presence of any of the following circumstances:	Check if applicable
1. Young children requiring extensive operative procedures (such as multiple restorations, treatment of abscesses or oral surgical procedures), when in-office treatment (nitrous oxide, GA / IV sedation or oral sedation) is not appropriate or available and hospitalization is not solely based upon reducing, avoiding or controlling apprehension; or	
2. Individuals requiring extensive dental procedures and classified by the American Society of Anesthesiologists (ASA) as Class 3 or class 4; or	
3. Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures; or	
4. Individuals requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy or other medical condition that renders in-office treatment not medically appropriate; or	
5. Individuals requiring extensive dental procedures who have documentation of significant behavioral health conditions or psychiatric disorders that require special treatment (e.g., severe panic disorder); or	
6. Cognitively disabled individuals requiring extensive procedures whose prior history indicates hospitalization is appropriate; or	
7. Hospitalized individuals who need extensive restorative or surgical procedures	

* Diagnostic quality pre-operative radiographs / photos taken prior to admission into the OR (or in the OR before treatment begins) should be present in the patient's chart. If documentation cannot validate retrospective review of treatment submitted recoupment of paid claims may occur.

Indiana Health Coverage Programs Prior Authorization Request Form

Check the box of the entity that must authorize the service (for managed care, check the member's plan unless the service is delivered as fee-for-service).

Fee-for-Service	<input type="checkbox"/> Cooperative Managed Care Services (CMCS)	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	<input type="checkbox"/> Anthem Hoosier Healthwise	P: 866-408-7187	F: 866-406-2803
	<input type="checkbox"/> Anthem Hoosier Healthwise – SFHN	P: 800-291-4140	F: 800-747-3693
	<input type="checkbox"/> MDwise Hoosier Healthwise	See www.mdwise.org	
	<input type="checkbox"/> MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan	<input type="checkbox"/> Anthem HIP	P: 866-398-1922	F: 866-406-2803
	<input type="checkbox"/> MDwise HIP	See www.mdwise.org	
	<input type="checkbox"/> MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	<input type="checkbox"/> Anthem Hoosier Care Connect	P: 866-408-7187	F: 866-406-2803
	<input type="checkbox"/> MDwise Hoosier Care Connect	P: 844-293-6309	F: 844-407-6454
	<input type="checkbox"/> MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245

Please complete all appropriate fields.

Patient Information				
Medicaid ID/RID#:				
DOB:				
Patient Name:				
Address:				
City/State/ZIP Code:				
Patient/Guardian Phone:				
PMP Name:				
PMP NPI:				
PMP Phone:				
Ordering, Prescribing, or Referring (OPR) Provider Information				
OPR Physician NPI#:				
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)				
Dx1		Dx2		Dx3

Requesting Provider Information	
Requesting Provider NPI#:	
Tax ID#:	
Service Location Code:	
Provider Name:	
Rendering Provider Information	
Rendering Provider NPI#:	
Tax ID#:	
Name:	
Address:	
City/State/ZIP Code:	
Phone:	
Fax:	
Preparer's Information	
Name:	
Phone:	
Fax:	

Please check the requested assignment category below:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> DME | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Purchased | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Rented | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers	Requested Service	Taxonomy	POS	Units	Dollars

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____

Prior Authorization for Orthodontic Care

Orthodontic procedures are covered only for members younger than 21 years old meeting certain clinical criteria. The Indiana Office of Medicaid Policy & Planning (OMPP) requires the following for all orthodontia services:

- A prior authorization must be obtained.
- Prior authorization requests must be made on the IHCP Medical PA Form (not the IHCP PA Dental Request Form).
- Only providers who are members of a recognized craniofacial anomalies team, such as a member of the American Cleft Palate-Craniofacial Association, are qualified to diagnose members.
- The diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions.
- The provider must submit a step-wise treatment plan with the treatment phase and length of treatment specified.
- Members must be treated by a licensed practitioner who minimally accepts routine craniofacial patients for orthodontic services.
- Only members with a diagnosis or condition listed in Table 5 can qualify for orthodontic services.

The following documentation must be submitted with PA requests:

- Frontal and lateral photographs of the face and the occlusion;
- Panoramic film,
- Lateral cephalometric film.

For patients with vertical skeletal problems, also include a posterior-anterior cephalometric film.

The IHCP expects that most patients who meet the criteria require comprehensive orthodontic treatment, which is billable on a fee-for-service basis using one of three codes:

- D8070 - Comprehensive orthodontic treatment of the transitional dentition
- D8080 - Comprehensive orthodontic treatment of the adolescent dentition
- D8090 - Comprehensive orthodontic treatment of the adult dentition

Maintenance visits, appliances, retainers, and repair or replacement of retainers are included in the fee for comprehensive treatment and may not be billed separately if comprehensive treatment is rendered.

Members are expected to continue treatment with the same provider for the entire period of treatment that is prior authorized. In the unlikely event that a member changes provider mid-treatment, the new provider must submit a PA request for the remaining treatment.

PA requests for limited or interceptive orthodontic treatment (D8010 through D8220) are reviewed on a case-by-case basis. For codes D8210 and D8220, the member must meet the criteria in the IHCP policy and have a harmful habit in need of correction, such as thumb sucking.

Table 5. Diagnoses and Conditions Appropriate for Orthodontic Services

Category I. The following diagnoses or conditions are appropriate for orthodontic services and do not require additional information to be submitted for approval for PA requests.		
Cleft lip and palate and facial clefts	Crouzon Syndrome	Neurofibromatosis of the Facial Region
Oculoauriculovertebral Dysplasia	Apert Syndrome	Holoprosencephaly
Mandibulofacial Dysostosis (Treacher-Collins Syndrome)	Pfeiffer's Syndrome	Gorlin Syndrome
Pierre Robin	Ectodermal Dysplasia	Beckwith-Wiedmann Syndrome
Cleidocranial Dysplasia	Hemifacial Microsomia	Klippel-Feil Syndrome
Frontonasal Malformation	Amniotic Band Syndrome	
Category II: The following conditions, when accompanied by moderate to severe malocclusions, are appropriate for orthodontic services, and do not require additional information to be submitted for approval for PA requests.		
Fetal Alcohol Syndrome	Cerebral Palsy	Hemimandibular Hypertrophy
Encephalocele	Achondroplasia	Condylar Hyperplasia
Down Syndrome	Osteogenesis Imperfecta	Condylar Hypoplasia
Werdnig-Hoffman Disease	Arthrogryposis of the TMJ (Congenital Contractures)	Arcofacial Dysostosis
Spina Bifida	Ankylosis of the Mandibular Condyles	Rieger Syndrome
Developmental Disturbances Related to Oncology Radiation	VATER Association	
Category III: For with Severe Atypical Craniofacial Skeletal Pattern accompanied by moderate to severe malocclusion the following conditions are appropriate for orthodontic services.		
Cleft lip and palate, and other craniofacial anomalies with a severe functional compromise of the occlusion	Anterior or posterior crossbite with greater than two mm discrepancy	Dysplasia of the vertical dimension of occlusion, lower facial height (LFH) greater than 59% or less than 52%.
Hypodontia or malalignment (one tooth or more per quadrant), precluding routine restorative dentistry	Lateral or anterior openbite greater than four mm	Facial skeletal vertical asymmetry greater than two standard deviations from the norm for menton-zygoma or gonion-zygoma (left or right)
Overjet greater than six millimeters (mm)	Severe overbite with gingival or palatal trauma	
Reverse overjet (underbite) less than one mm.	Impaction or impeded eruption of teeth (other than third molars)	

Claim Submission Procedures

Submit claims and encounters electronically or by mail within 90 calendar days of the date of service by using one of the following options. Important: Do NOT highlight any items on your submissions.

1. Envolve Dental Provider Web Portal at <https://pwp.envolvedental.com>
2. Electronic clearinghouses, using Envolve Dental payor identification number 46278
3. Alternate, pre-arranged HIPAA-compliant 837D electronic files
4. Paper claims on a completed ADA (2006 or later) claim form by mail

Providers should have all required information for a claim ready to insert into the electronic fields or the paper claim form prior to initiating submission. Electronic attachment options for x-rays, charts, photos and other items are available as detailed below.

1. Provider Web Portal Claim Submissions

The Envolve Dental Provider Web Portal is user-friendly and is the fastest way for claims to be processed and paid. Our state-of-the-art web portal has specific fields to enter all required information. It also contains an upload feature to attach all required documents, x-rays and other supporting information. To avoid claim denials or delayed payments, refer to the benefit grids in Appendix A to ensure you include all required information before submitting.

To access the Envolve Dental provider web portal, go to

<https://pwp.envolvedental.com>

Log on with your username and password. If you have not yet registered for the web portal, or if you have questions about how to submit claims on it, call Provider Services at 1-855-609-5157 or send us an email at providerrelations@envolvehealth.com. See [Appendix B for details on claim submissions](#).

2. Electronic Clearinghouse Claim Submission

Envolve Dental works with selected electronic clearinghouses to facilitate dental offices that use one electronic source for all their insurances. Please check with your preferred vendor so that your software is up-to-date, and confirm your first submission to Envolve Dental using the clearinghouse was successful before sending additional claims. Electronic attachments may be available with your preferred clearinghouse, or can otherwise be submitted to us via *FastAttach*® (details follow).

Use Envolve Dental payor identification number **46278** for all clearinghouses. As of this manual publication date, we currently accept claims from the following:

- Change Healthcare (formerly Emdeon, website: www.changehealthcare.com; Phone: 1-888-363-3361)
- DentalXChange (Website: www.dentalxchange.com; Phone: 1-800-576-6412)
- Trizetto (Website: www.trizetto.com; Phone: 1-800-556-2231)

If you use a different electronic clearinghouse and would like us to consider participating, please send your request to providerrelations@envolvehealth.com, indicating your practice name, technical point-of-contact details and average monthly claim volume.

3. Alternate HIPAA-Compliant Electronic Submission

Electronic claim submissions must be HIPAA-compliant. Envolve Dental strongly recommends using our custom Provider Web Portal for all claim submissions because we stay current with HIPAA regulations. If your office uses an alternative electronic claims system that requires direct integration using an 837D file, Envolve Dental will consider options to assist. To schedule an appointment with our technical specialists to discuss alternatives, please email us at providerrelations@envolvehealth.com or call 1-855-609-5157.

4. Paper Claim Submission

The following information must be included on the 2006 or later ADA claim form for timely claims processing:

- Member name
- Member Medicaid ID number
- Member date of birth
- Provider name
- Provider location and service setting
- Billing location
- NPI and Tax Identification number (TIN)
- Date of service for each service line
- ADA dental codes in the current CDT book for each service line
- Provider signature

Be sure to include all required identifiers (quadrants, tooth numbers, and surfaces) as detailed in the benefit grids for each code (see Appendix A).

Mail paper claims with any required supporting documentation to:

Envolve Dental
Claims
PO Box 20847
Tampa, FL 33622-0847

Postage due mail will be returned to sender.

Claim/Encounter Submission for FQHCs, CHCs and RHCs

Facilities such as Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs), and Rural Health Clinics (RHCs) are reimbursed in Indiana via a fee-for-service system. Providers can choose one of the four claim submission options to submit encounters. Note the following requirements:

- Submit claims for every service to ensure member utilization data is complete.

- Ensure every code includes corresponding tooth numbers, quads, arches and any other required identifiers, according to Appendix A.
- Include applicable authorization numbers.
- Include all documentation requirements in Appendix A for each code.

Electronic Attachments

Envolve Dental promotes electronic authorization and claim processing for fast and efficient decisions and payments. Our Envolve Dental Provider Web Portal is the preferred method for submissions that include attachments, but if your office uses a clearinghouse, we can accept attachments from National Electronic Attachment, Inc. (NEA).

NEA, through *FastAttach®*, enables providers to securely send attachments electronically – x-rays, EOBs, intraoral photographs, perio charts, and more. To use the system, go to www.nea-fast.com, install the software, and follow the steps to begin using it. The steps are simple: a provider scans required documents, transmits them to NEA’s secure repository, selects Envolve Dental as the payor (ID #46278) and receives an NEA unique tracking number. Next, the provider includes the NEA tracking number in the remarks section of authorization requests and claims submissions to Envolve Dental.

Please use the following Master ID numbers as indicated for each health plan product:

463026	ENVD IN MHS- HP Basic (19-20 yrs old)
463027	ENVD IN MHS- HP Plus
463028	ENVD IN MHS- HIP Basic, Plus, Pregnancy
463029	ENVD IN MHS- Hoosier Care Connect
463030	ENVD IN MHS - Ambetter
463031	ENVD IN MHS Hoosier Healthwise Package A
463032	ENVD IN MHS Hoosier Healthwise Package C

Images you transmit are stored for three years in NEA’s repository and can only be viewed by your office and Envolve Dental. Data and images remain secure with HIPAA-compliant standards and you should only give your office’s NEA account login and password to authorized users. If you have specific questions about using *FastAttach®*, call NEA at 1-800-782-5150.

Member Co-pays

Members enrolled in HIP Basic (pregnant women and 19 to 20-year-olds), HIP Plus, HIP State Plan Plus, Hoosier Care Connect, and Hoosier Healthwise do not have co-payments for dental services. Providers are not permitted to charge these members any amount for covered dental benefits.

HIP Basic and HIP State Plan Basic members are responsible to pay a \$4.00 co-payment for each category of service provided in a single visit, except diagnostic and preventive codes have zero copay.

Service Category	Codes	Co-pay
Diagnostic	D0120 – D0486	\$0

Service Category	Codes	Co-pay
Dentures	D5110 – D5226	\$4.00

Preventive	D1110 – D1999	\$0	Prosthetic adjustments, repairs, etc.	D5281– 6930	\$4.00
Fillings and restorative	D2140 – D2394	\$4.00	Oral surgery	D7111 – D7999	\$4.00
Major restorative	D2910 – D2999	\$4.00	Orthodontics	D8010 – D8220	\$4.00
Endodontics	D3220 – D3430	\$4.00	Adjunctive general services	D9110 – D9920	\$4.00
Periodontics	D4210 – D4355	\$4.00			

Billing for Orthodontia

Orthodontia codes are billable after bracket/appliance placement. The IHCP does not cover periodic treatment visits. Reimbursement for covered codes constitutes the complete fee for the entire scope of orthodontic treatment. According to the IHCP, if a member must discontinue treatment with the original provider and continue treatment with a different provider, the original provider must refund part of the reimbursement to the IHCP. Generally, one-third of the reimbursement is for the evaluation and treatment plan, and two-thirds is for the actual treatment. Based upon the time remaining in the treatment rendered by a new provider, the original provider must prorate the amount to be refunded to Envolve Dental.

Billing for Crowns and Dentures

For crowns, the date of service must be billed according to the cementation date. For dentures, the billed date of service must be the “seat date”/ date of insertion.

Billing for Services in Emergency Situations

Members who have an urgent or emergent condition, defined as a situation involving severe pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury should be treated immediately for covered benefits. Within two business days, call Envolve Dental at 1-855-609-5157 to verbally report the incident in the member’s record. For billing, submit the claim with a narrative explaining the emergency and indicate “pre-payment review.” Include with the claim all required documentation for the code(s) as documented in Appendix A within 90 calendar days from the service date. If the call was not placed to Envolve Dental within two business days, include an explanation in the narrative, and submit as above.

Billing for Services Rendered Out-of-Office

Billing for all services should include the location code where services were rendered on a 2006 or later ADA claim form (Box #38-Place of Treatment) or on the appropriate section of an electronic claim submission. The code for treatment in an office setting is “11”. For services provided in an

out-of-service setting, such as a school or nursing home, bill with the appropriate location code. The most common are “03” for school, “15” for mobile unit, “22” for outpatient hospital, “24” for ambulatory surgical center, “31” for skilled nursing facility, “32” for nursing facility and “99” for “other”. A comprehensive list of locations can be found on the Centers for Medicare and Medicaid Services website: [CMS Place of Service Codes](#).

Billing Limitations

Envolve Dental advocates responsible billing practices and administers reimbursements of at least the minimum reimbursement required by the State. Note the following limitations when billing:

- **X-rays/Radiographs:** Maximum provider reimbursement per member per date of service is limited to the fee for a complete series. Limited x-rays may be billed by two different providers for the same member when one provider is a general dentist, the second is a dentist specializing in treating the member’s condition, and both providers do not share a common office location or billing practice.
- **Amalgams and Resins:** Payment for a restorative service includes tooth preparation and any base or liner placed beneath the restoration. Payment for a restorative service includes necessary local anesthesia.
- **Only one restoration code per tooth for restorations using the same material, performed on the same date by the same dentist for the same member.**
- **Endodontic therapy:** All diagnostic tests, evaluations, radiographs and post-operative treatment are included in the fee.
- **Denture-related services:** Lab fees are included in the denture placement reimbursement rate and cannot be billed separately to Envolve Dental or the member. All complete and partial denture relining procedures include six months of post-delivery care.
- **Cost-sharing:** Providers cannot bill members for any type of cost-sharing for covered dental services, including a co-payment, coinsurance, deductible, or deposit that are not dictated by the member’s plan.
- **Balance billing:** Providers must accept the Envolve Dental payment as “payment in full,” and cannot balance bill members – that is, for the difference between the provider-billed amount and the Envolve Dental payment amount.
- **Missed appointment billing:** Providers are not allowed to charge members for missed appointments.

Coordination of Benefits (COB)

Claim submissions for MHS members who have benefits with another insurer must be coordinated. In most cases, MHS will be the secondary insurer. Providers are responsible for asking members if they have multiple insurances and for submitting claims in the proper order:

- Submit claims to the primary insurer first.

- After receiving the primary insurer’s Explanation of Benefits (EOB), submit a claim for any remaining balance to Envolve Dental with the EOB statement within 90 days of the primary payer’s determination. Please contact us for further instructions if the third party does not respond within this timeframe.
- For electronic submissions, indicate the payment amount by the primary carrier in the “Capture Other Insurance Information” pop-up box from the claims entry page on the Provider Web Portal.

Payments to providers will not exceed the contracted Envolve Dental fee schedule. Claims are considered paid in full when the primary insurer’s payment meets or exceeds the contracted rate.

Claims Adjudication, Editing and Payments

Envolve Dental adjudicates all claims weekly with an automated processing system that imports the data, assesses it for completeness, and then analyzes it for correctness in terms of clinical criteria, coding, eligibility, and benefit limits, including frequency limitations. The system also evaluates claims requiring prior authorizations and automatically matches them to the appropriate member authorization records.

Once editing is complete, our system updates individual claim history, calculates claim payment amounts – including copayment amounts and deductible accumulations, if applicable – and generates a remittance statement and corresponding payment amount. Most paper clean claims are paid within 30 days of submission and electronic claims within 21 calendar days. Payments are made to the provider’s EFT account or to a check printer that delivers the paper check and remittance statement by US Mail. Remember:

- EFT is the quickest means to receive payments.
- Electronic remittance statements are available in the “Documents” tab in your Envolve Dental Provider Web Portal account. Insert the date span for remittances you want to view.
- Clearinghouses will not transmit Envolve Dental remittance statements to providers.
- Remittance statements will remain available on the Envolve Dental web portal indefinitely.
- You can call Provider Services at 1-855-609-5157 with questions about claims and remittances.

Corrected Claim Processing

Providers who receive a claim denial due to incorrect or missing information can submit a “corrected claim” within 67 days of the EOB. Claims are considered “corrected claims” if at least one code on the original submission was denied due to missing information such as a missing tooth number or surface identification, an incorrect member ID, an incorrect code, or an incorrect amount. To submit a corrected claim, providers may mail the corrected claim or resubmit the claim through the Provider Web Portal as follows::

Mail Submission

- Complete a 2006 or later ADA claim form with:
 - ALL codes originally submitted, including accurate code(s) and the corrected code(s), even if previously paid.
 - ALL required documentation only for the corrected, unpaid codes.
 - “CORRECTED CLAIM” written on the top of the form, with the original claim number.
- Corrections must be indicated on the ADA claim form as follows:
 - Make the correction on the service line that was in error (e.g., cross through the error and write in correct information.
 - In the “Remarks” section of the form (box #35), write in the details of the correction (e.g., add a tooth number, change to accurate service date, code, etc.).
 - Do NOT **highlight** any items on the form – doing so prevents our scanners from importing the information.
- Mail with correct postage to:

Envolve Dental
Corrected Claims
PO Box 20847
Tampa, FL 33622-0847

Provider Web Portal Submission

Providers can now resubmit previously processed claims directly through the web portal to correct inaccurate data. A corrected claim via the web portal may be submitted for incorrect service line information. Please note, that missing attachments cannot be sent via the web portal and would need to be a paper submission. When a corrected claim is submitted, the original claim is automatically backed out of the system and a new updated claim takes its place. Claim and service adjustments are created to compensate for changes in paid amounts from the original claim, and patient responsibility amounts are rolled back and then reprocessed to ensure accurate benefit consumption.

For a claim that has already been corrected, users can view a list of associated claims and if applicable, correct the latest claim of the series. For claims eligible for correction (fully processed and not already resubmitted as a corrected claim), a single click loads the data into the Claim Entry page, ready for users to update and submit.

Currently the corrected claims functionality is limited to those claims that do not require additional attachments or remarks. To correct those types of claims, please continue to resubmit the paper claims until further notice.

Corrected claim determinations are published on your remittance statement within 30 days of Envolve Dental receiving the corrected claim.

Claim Denials

Provider claims that are denied can be appealed when submitted to Envolve Dental within 67 calendar days after the denial was issued, or the non-payment notification was made, as indicated on the remittance advice. Please review the clinical criteria and benefit limitations in this manual when formulating a written appeal, citing why you believe the claim should be paid. To submit, mail an appeal with your name, NPI, contact details, and all supporting documentation to:

Envolve Dental
Appeals
PO Box 20847
Tampa, FL 33622-0847

Appeals, Complaints & Grievances

Envolve Dental is committed to providing high-quality dental services to all members and superior administrative services to all network providers. As part of this commitment, Envolve Dental supports MHS’ member grievances and appeals protocol and leads MHS’ dental provider appeals process. Table 4 summarizes the definitions and actions for each, and a more detailed narrative follows.

Table 4: Distinguishing Complaints, Grievances and Appeals		
	Providers	Members
Complaint	A verbal or written communication to Envolve Dental or MHS of dissatisfaction with a policy, procedure, or administrative function.	An expression of dissatisfaction about any matter <i>other than an action</i> .* Complaints are made by phoning MHS Member Services. Members not satisfied with the way a complaint is managed, or if it is not resolved within 24 hours, can file a grievance.
Grievance	Not formally defined for providers.	Any expression of dissatisfaction about any matter <i>other than an action</i> .* Can be filed verbally or in writing to MHS. Contact should be made as soon as possible after the incident, and no later than 60 days after the initial complaint date. Members should follow up calls in writing to support the grievance.
Appeal	A request for denied authorization or denied claim review, submitted in writing to Envolve Dental within 67 calendar days of receiving the authorization denial notice or denied claim notice.	A request for “Notice of Adverse Action”* review, submitted verbally or in writing to MHS within 33 calendar days of receiving the action.
External Independent Review	Within 120 calendar days of an appeal decision, providers can request an external, independent review about matters of medical necessity or experimental or investigational services.	Within 120 calendar days of an appeal decision, members can request an external, independent review about matters of medical necessity or experimental or investigational services.
State Fair Hearing Appeal	Not available.	An appeal to the state about an Adverse Action* or appeal result that is not resolved to the member’s satisfaction. Must be requested within 33 calendar days of exhausting MHS appeal procedures.

Table 4: Distinguishing Complaints, Grievances and Appeals

*An “action” or “Notice of Adverse Action” occurs when a member receives a denial or limited authorization for a provider-requested service, a provider receives a denied authorization or claim, or a member is not happy with the result of a grievance.

Provider Complaint and Appeal Procedures

Differences may develop between Envolve Dental and a network dentist concerning prior authorization decisions or payment for billed services. Differences can also result from misunderstanding of a processing policy, service coverage or payment levels. The following explains how to initiate a complaint or appeal.

Provider Complaints

The first level of managing a disagreement begins when a provider with a *complaint* – defined as an expression of dissatisfaction received verbally or in writing about a policy, procedure, claim, contracting, or other function about working with Envolve Dental. Envolve Dental strives to resolve complaints while on the call with the office representative.

Call, email, or write with complaints to:

Provider Services 1-855-609-5157	providerrelations@envolvehealth.com	Envolve Dental Grievances and Appeals-IN PO Box 20847 Tampa, FL 33622-0847
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Provider Appeals

An *Appeal* is the mechanism for providers to request a reconsideration of actions by Envolve Dental, such as a claim denial, prior authorization denial on behalf of the member or if the provider is aggrieved by any rule, policy or decision made by Envolve Dental. Providers must file an appeal within 33 calendar days of receiving the Envolve Dental notice of action (NOA) for authorizations. Verbal appeals must be followed up with a written appeal, and include a statement supporting the appeal and any corresponding records. Envolve Dental will confirm receipt of the appeal within three business days, and will indicate if any additional information is required to consider the appeal request.

Envolve Dental will resolve each Hoosier Care Connect appeal within 20 business days of receipt and HIP/Hoosier Healthwise appeal within 30 calendar days of receipt, and provide written notification of the decision, including

- The Envolve Dental decision;
- The date of the decision;
- For appeal decisions not in favor of the member, information about how a member or provider can pursue an independent external review or State Fair Hearing; and

- The member's right to receive benefits pending the hearing, explaining the member may be liable for the cost of services if the hearing results in a denial.

Expedited medical management appeals may be filed when the member's provider determines that the standard resolution process could seriously jeopardize the member's life, health or the ability to attain, maintain or regain maximum function. If the request for an expedited appeal is denied, the standard appeal resolution time limits will be followed.

Decisions for expedited medical management appeals are issued as expeditiously as the member's health condition requires. Within 48 hours of receiving the Hoosier Care Connect request (72 hours for HIP and Hoosier Healthwise requests), Envolve Dental will make a determination and communicate it to the provider verbally, or will notify the provider if there is missing information needed to make the determination. Envolve Dental will follow up the determination with a written notice within three business days.

External Independent Review

Providers or members can request an external, independent review for decisions made by MHS and Envolve Dental about matters of medical necessity or if a service is experimental or investigational. To request a review, a provider must have the member's verbal and written consent, and then the provider must call or write to MHS within 120 calendar days of the appeal decision. MHS will send the complete case file to an external, independent review agency with the Indiana Department of Insurance. The agency will have a same-specialty provider review the case and answer the provider and MHS within 15 business days.

Provider Claim Disputes

Informal claim disputes and objections must be submitted in writing to Envolve Dental within 67 calendar days from the date on the EOB. Upon receipt, Envolve Dental will review the claim and notify the provider within 30 days of the result when the denial is upheld, or via EOB if the denial is overturned. If a provider disagrees with the informal claim dispute resolution, the provider may file a formal claim dispute.

Formal Claim Disputes – Administrative Claim Appeals

Providers who are not satisfied with the informal claim dispute resolution can file an administrative claim appeal, or formal claim dispute, within 67 calendar days of the informal dispute resolution notice, or 90 calendar days from the date of the informal claim dispute submission. Administrative claim appeals must be submitted in writing on company letterhead with "appeal" and the claim number in the subject line, and must include all details to justify reconsideration. Envolve Dental will send an acknowledgement letter to the provider within five business days of receiving the administrative claim appeal.

If the original determination is upheld, the provider will be notified within 45 calendar days of receipt of the appeal. The written determination will include a detailed explanation of the factual and legal basis of the determination, as well as a notice of the provider's right to submit to binding arbitration within 60 calendar days.

In the event that Envolve Dental does not deliver a written determination within 45 calendar days of receiving the claim appeal, the initial decision will be overturned and the appeal ruled in favor of the provider.

If the original denial determination is overturned, the provider is notified via a new EOB showing the claim reprocessing and payment within 30 calendar days of the final determination date.

If a claim appeal lacks sufficient supporting documentation, Envolve Dental will make a determination of “denial for lack of supporting documentation.” The provider will be notified and have 30 days to submit the requested information. If after 30 days the appeal still lacks sufficient documentation, the denial will be upheld and final.

Arbitration

Envolve Dental follows the provider dispute process outlined in 406 Indiana Administrative Code 1-1.6-1 *et. seq.* for contracted and non-contracted providers. In the event that a provider is not satisfied with the outcome of the administrative claim appeal process, the provider may request arbitration.

To begin arbitration, providers must mail a written request on company letterhead to MHS within 60 calendar days after receiving the administrative claim denial. The letter should reference the appeal number, the request for arbitration, reasons the provider believes the claim should be paid, and any other supporting details. Mail the request to:

Managed Health Services
Attention: Arbitration
1099 N Meridian St
Suite 400
Indianapolis, IN 46204

MHS will work with Envolve Dental to research the case within 30 calendar days of receipt and respond by contacting the provider to (1) set up the arbitration hearing; (2) request additional information from the provider and discuss the case in detail; or (3) offer to settle the matter.

Binding arbitration is conducted in accordance with the rules and regulations of the American Health Lawyers Association, pursuant to the Uniform Arbitration Act as adopted in the state of Indiana at Indiana Code 34-57-2-1 *et. seq.*, unless the provier and MHS mutually agree to an alternative binding resolution process.

Member Complaints, Grievances and Appeals

Member Complaints

Members who are not satisfied with MHS programs and services, or services from a provider, can call MHS Member Services at 1-877-647-4848 to verbalize a complaint. MHS records each complaint and follows up with the member about a resolution. Members who are not satisfied with the result can file a grievance.

Member Grievances

A member grievance is defined as a member expression of dissatisfaction about any matter other than an adverse action. An adverse action is a denial or limitation of a service, communicated to members in writing, and is only considered via an appeals process.

Members or their designated representatives should file a grievance with MHS about their dental or medical care as soon as possible after the event causing dissatisfaction occurred, and no later than 60 calendar days following the date a complaint was placed. Envolve Dental will support the MHS Complaint and Grievances Coordinator with information gathering that can assist in formulating a response to the member.

Member grievances should be directed to:

MHS Member Services
1099 North Meridian, Ste. 400
Indianapolis, IN 46204
Phone: 1-877-647-4848

MHS will send members a letter within three business days to acknowledge the grievance and advise about next steps and patient rights. All member grievances are resolved within 20 business days, and the decision is sent to the member in writing within 25 business days. Members who are not satisfied with the grievance result can file an appeal.

Member Appeals

An appeal can be filed when a member is not satisfied with a grievance result or other decision made by MHS or Envolve Dental, such as a denial for a prior authorization request. When a dental prior authorization request for services is denied, limited, reduced or terminated, Envolve Dental mails to the member (and faxes to the provider) a notice of the adverse action. The member has the option to appeal the decision to MHS within 33 calendar days from the date on the notice of action. The member may choose to ask a provider or another person to represent him/her in the appeal process. MHS will resolve each appeal within 20 business days from the date MHS receives the appeal, and a written notice is mailed within 25 business days. Expedited appeals may be filed if the member's ability to attain, maintain, or regain maximum function would be jeopardized. In such cases, appeals are decided within two calendar days (48 hours) from the initial receipt.

External, Independent Review State Fair Hearing

Members can request an external, independent review for decisions made by MHS and Envolve Dental about matters of medical necessity or if a service is experimental or investigational. To request a review, members must call or write to MHS within 120 calendar days of the appeal decision for Hoosier Care Connect or 33 calendar days for HIP and Hoosier Healthwise. MHS will send the complete case file to an external, independent review agency with the Indiana Department of Insurance. The agency will have a same-specialty provider review the case and answer the member and MHS in approximately two weeks. Members can request an external, independent review and a State Fair Hearing, but not concurrently.

State Fair Hearing

Members can request a State Fair Hearing when an appeal and external independent review are not resolved in the member's favor. The request must be made within 33 calendar days of exhausting MHS appeal procedures. Members can request assistance in filing a State Fair Hearing by calling MHS Member Services at 1-877-647-4848 or by writing to the Family and Social Services Administration directly at:

Hearing and Appeals Section, MS-04
Indiana Family and Social Services Administration
402 West Washington Street, Room E034
Indianapolis, IN 46204

Members are entitled to receive all covered benefits while an appeal or State Fair Hearing is pending. If the final decision on the appeal is to deny the services, the member may have to pay for the services.

Dental Health Guidelines Ages 0–18 Years

The American Academy of Pediatric Dentistry (AAPD) advocates clinical guidelines and policies to promote optimal oral health for children. One initiative outlines recommended timeframes for providing oral health assessments, preventive care, and anticipatory guidance to children from birth to age 18, and their parents. The following chart represents the specific AAPD guidance for children who are developing normally and do not have extenuating medical conditions or special needs. Providers should assess each child for his or her unique health needs and make appropriate adjustments intended to optimize the child’s health.

Recommended Pediatric Dental Periodicity Schedule for Children					
Recommended Services	Age				
	6 to 12 Months	12 to 24 Months	2 to 6 Years	6 to 12 Years	12+ Years
Clinical oral examination ¹	X	X	X	X	X
Assess oral growth and development ²	X	X	X	X	X
Caries-risk assessment ³	X	X	X	X	X
Radiographic assessment ⁴	X	X	X	X	X
Prophylaxis and topical fluoride ^{3,4}	X	X	X	X	X
Fluoride supplementation ⁵	X	X	X	X	X
Anticipatory guidance/counseling ⁶	X	X	X	X	X
Oral hygiene counseling ⁷	Parent	Parent	Patient/ Parent	Patient/ Parent	Patient
Dietary counseling ⁸	X	X	X	X	X
Injury prevention counseling ⁹	X	X	X	X	X
Counseling for nonnutritive habits ¹⁰	X	X	X	X	X
Counseling for speech/language development	X	X	X		
Substance abuse counseling				X	X
Counseling for intraoral/perioral piercing				X	X
Assessment and treatment of developing malocclusion			X	X	X
Assessment for pit and fissure sealants ¹¹			X	X	X
Assessment and/or removal of third molars					X
Transition to adult dental care					X

- 1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.
- 2 By clinical examination.
- 3 Must be repeated regularly and frequently to maximize effectiveness.
- 4 Timing, selection, and frequency determined by child’s history, clinical findings and susceptibility to oral disease.
- 5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
- 6 Appropriate discussion and counseling should be an integral part of each visit for care.
- 7 Initially, responsibility of parent. As child matures, jointly with parent; then when indicated, only child.
- 8 At every appointment, initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
- 9 Initially play objects, pacifiers, car seats. When learning to walk, then playing sports, include importance of mouth guards.
- 10 At first, discuss the need for additional sucking: digits vs pacifier, then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding existing habits such as fingernail biting, clenching, or bruxism.
- 11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures – place as soon as possible after eruption.

Source: Adapted from the American Academy of Pediatric Dentistry

Benefit Summary

Benefit Descriptions

Plan Eligibility

MHS offers dental benefits through Envolve Dental providers for people eligible for and enrolled in the following plans:

- HIP Basic: 19-20 Year Olds, Pregnant Women, HPE (19-20 years)
- HIP Plus
- HIP Basic or Plus or Maternity for Pregnant Women
- HIP State Plan Basic
- HIP State Plan Plus
- Hoosier Care Connect
- Hoosier Healthwise:
 - Package A: Standard Medicaid plan for pregnant women, qualified children, and families
 - Package C: Children’s Health Insurance Program (CHIP)

HIP Basic (HPE)– Ages 19-20

MHS provides limited evaluations and cleanings only for members age 19-20. See details in Appendix A, Tables 1.0 to 1.1.

HIP Plus

MHS provides evaluation, periodic teeth cleanings, radiographs and limited restorative or extraction services. See details in the benefit grids in Appendix A, Tables 2.0 to 2.7.

HIP State Plan Basic, HIP State Plan Plus, HIP (Basic or Plus) – Pregnancy, HIP Maternity

MHS provides full dental services, including periodic teeth cleaning, tooth restorations, radiographs, extractions, and other dental services as outlined in the benefit grids in Appendix A, Tables 3.0 to 3.9. Applies to eligible members age 19 and over.

Hoosier Care Connect

MHS provides full dental services, including periodic teeth cleaning, tooth restorations, radiographs, extractions, and other dental services as outlined in the benefit grids in Appendix A, Tables 4.0 to 4.9. Applies to eligible members of all ages.

Hoosier Healthwise – Package A (Children and Adults) and Package C (Children’s Health Insurance Program)

MHS provides full dental services, including periodic teeth cleaning, tooth restorations, radiographs, extractions, and other dental services as outlined in the benefit grids in Appendix A,

Clinical Definitions

Teeth should be identified as follows:

Teeth	Identified by
Primary	Letters A through T
Permanent	Numbers 1 through 32
Supernumerary	Letters AS through TS* Numbers 51 through 82*

*Supernumerary designation 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.

Reimbursement Limitations for Selected Benefits

Envolve Dental advocates responsible billing practices and administers reimbursements accordingly. Note the following limitations when billing:

X-rays/Radiographs: Maximum provider reimbursement per member per date of service is limited to the fee for a complete series. Limited x-rays may be billed by two different providers for the same member when one provider is a general dentist, the second is a dentist specializing in treating the member's condition, and both providers do not share a common office location or billing practice.

- **Amalgams and resins:** Payment for a restorative service includes tooth preparation and any base or liner placed beneath the restoration. Payment for a restorative service includes necessary local anesthesia.

Clinical Criteria

When submitting for prior authorization/pre-payment review of these procedures, please note the documentation requirements when sending in the information to Envolve Dental.

Envolve Dental criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements.

The criteria Envolve Dental reviewers will look for in order to approve the request is listed below. Should the procedure need to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, Envolve Dental will require the same criteria/documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

Interim caries arresting medicament application

- Documentation describes medical necessity

Space maintainer – unilateral

- Planned extraction of primary molar or premature loss of primary molar in one quadrant
- Not in conjunction with active orthodontic treatment

Space maintainer – bilateral

- Replacing 2 or more primary molar teeth in same arch
- Not in conjunction with active orthodontic treatment

Apicoectomy/periradicular surgery/retrograde filling/root amputation

- Minimum 50% bone support
- No caries below bone level
- Repair of root perforation or resorptive defect
- Exploratory curettage for root fractures
- Removal of extruded filling materials or instruments
- Removal of broken tooth fragments
- Sealing of accessory canals, etc.

Gingival flap procedure

- Perio classification of Type III or IV
- Lack of attached gingiva

Osseous surgery

- History of periodontal scaling and root planing

- No previous history of osseous surgery
- Perio classification of Type III or IV

Crown lengthening

- Documentation supports procedure, greater than 50% bone support after surgery due to coronal fracture/caries and not on same day as restoration preparation

Bone replacement graft

- Documentation supports need to correct bone defect

Guided tissue regeneration

- Documentation supports need in conjunction with bone replacement or to correct deformities resulting from inadequate facial/lingual bone

Pedicle soft tissue graft

- Cover exposed root
- Eliminate gingival defect

Autogenous connective tissue graft/combined connective tissue and double pedicle graft

- Eliminate root sensitivity
- Eliminate frenum pull
- Extend vestibule
- Cover gingival interface with restoration
- Cover bone or ridge regeneration site
- Non-autogenous connective tissue graft/free soft tissue graft
- Eliminate frenum pull
- Extend vestibule
- Eliminate gingival recession
- Cover gingival interface with restoration
- Cover bone or ridge regeneration site

Scaling and root planing

- D4341
 1. Four or more teeth in the quadrant
 2. 4 mm or more pocketing on 2 or more teeth indicated on the perio charting and
 3. Presence of root surface calculus and/or noticeable loss of bone support on x-rays
- D4342
 - One to three teeth in the quadrant

- 4 mm or more pocketing on 1 or more teeth indicated on the perio charting and
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Full mouth debridement

- Extensive coronal calculus on 50% of teeth

Full dentures D5110, D5120

- Remaining teeth do not have adequate bone support or are not restorable
- If a primary source of nutrition is parental or enteral, a plan of care to wean the member from nutritional supplements must be included in the request
- Patient is physically and psychologically able to wear dentures

Immediate dentures D5130, D5140

- Remaining teeth do not have adequate bone support or are not restorable
- If a primary source of nutrition is parental or enteral, a plan of care to wean the member from nutritional supplements must be included in the request
- Patient is physically and psychologically able to wear dentures

Partial dentures D5211 – D5212

- Less than eight posterior teeth in occlusion, four maxillary, and four mandibular teeth (natural or prosthetic), excluding third molars, in functional contact with each other.
- Remaining teeth have greater than 50% bone support and are restorable

Partial dentures D5213 – D5214

- Less than eight posterior teeth in occlusion, four maxillary, and four mandibular teeth (natural or prosthetic), excluding third molars, in functional contact with each other.
- Only for members with facial deformity due to congenital, developmental, or acquired defects
- Only for members with facial deformity due to congenital, developmental, or acquired defects
- Remaining teeth have greater than 50% bone support and are restorable

Partial dentures D5225 – D5226

- Less than eight posterior teeth in occlusion, four maxillary, and four mandibular teeth (natural or prosthetic), excluding third molars, in functional contact with each other.
- Only for members with a documented allergic reaction to other denture materials, or for members with facial deformity due to congenital, developmental, or acquired defects
- Remaining teeth have greater than 50% bone support and are restorable

Unilateral partial denture D5281

- Replacing one or more missing teeth in one quadrant

- Only for members with facial deformity due to congenital, developmental, or acquired defects
- Remaining teeth have greater than 50% bone support and are restorable

Fractures – simple / compound

- X-rays or photos shows medical necessity for procedure

Reduction and dislocation and management of TMJ dysfunctions

- Diagnosis shows medical necessity for procedure

Orthodontia D8010 – D8090

- See details on p.44 of this manual for details.

General anesthesia (Dental Office Setting) D9223

- Mental incapacitation, including intellectual disability, organic brain disease, and behavioral problems associated with uncooperative but otherwise healthy children, such that the member's ability to cooperate with procedures is impaired.
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the member's ability to cooperate with procedures.
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication.

IV Sedation (Dental Office Setting) D9243

- Medicaid reimbursement is available for intravenous sedation in a dental office when provided for oral surgical services only

Non – intravenous conscious sedation (Dental Office Setting) D9248

- Mental incapacitation, including Intellectual disability, organic brain disease, and behavioral problems associated with uncooperative but otherwise healthy children, such that the member's ability to cooperate with procedures is impaired.
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the member's ability to cooperate with procedures.
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication.

Behavior management, by report

- Documentation (treatment history) supports indication of non-cooperative child under the age of nine (9) years
- Documentation supports indication of patient with a medical condition
- Unspecified procedures, by report

- Procedure cannot be adequately described by an existing code

OR (Hospital Operating Room or Outpatient Facility) request (Custom IN)

- SPU / Facility Name and Address on Referral form and Box 35 of the ADA claim form
- Treatment plan
- Documentation supporting treatment plan (x-rays, photos, etc.)
- D9999 entered on claim form

Frequently Asked Questions (FAQs)

Q. When will Envolve Dental become the dental vendor for Managed Health Services (MHS)?

A. Envolve Dental became the dental vendor for MHS on October 1, 2016 for the following products:

- Healthy Indiana Plan (HIP), including:
- HIP Basic
- HIP Plus
- HIP State Plan Basic
- HIP State Plan Plus
- Hoosier Care Connect
- Ambetter from MHS

On January 1, 2017, Envolve Dental will add Hoosier Healthwise for MHS members.

Q. Will Envolve Dental honor authorizations previously issued by former Dental Insurer?

A. Yes, to ensure members have continuity of care, Envolve Dental will honor approved authorizations from the former benefits administrator 90 days, or until the expiration date of the authorization.

Q. Does Envolve Dental offer a web portal for checking eligibility, submitting authorization requests and filing claims?

A. Yes, the provider portal is located at <https://pwp.envolvedental.com>. The Envolve Dental provider portal includes the following features:

- Real-Time Eligibility
- Authorizations – Submit & Check Status
- Claims – Submit & Check Status
- Clinical Guidelines
- Referral Directories
- Electronic Remittance Advice
- Electronic Fund Transfer
- Up-to-Date Provider Manual

Q. How can I submit prior authorization requests?

A. Prior Authorization submissions can be submitted using any of the following formats:

- Provider Web Portal at <https://pwp.envolvedental.com>
- Electronic submission via selected clearinghouses, using Payer ID 46278 (Change Healthcare [formerly Emdeon], DentalXChange, Trizetto)
- A pre-arranged HIPAA-compliant 837D file
- Paper authorization via a 2006 or later ADA Claim Form, mailed to:

Envolve Dental
Authorizations: IN
PO Box 20847
Tampa, FL 33622-0847

Q. How can I contact Envolve Dental if I have additional questions?

A. Envolve Dental's Provider Services department will be happy to assist with any questions. They can be reached via phone at 1-855-609-5157 or via email at providerrelations@envolvehealth.com. You can also refer to the Provider Dental Quick Reference Guide for additional information.

Appendix B: Provider Web Portal User Guide

The Envolve Dental secure Provider Web Portal simplifies and expedites benefit administration with easy-to-use web-based services. Benefits include:

- Faster authorization submissions and determinations
- Faster claim payments through streamlined submission and adjudication processes
- Lower administrative costs
- Access to view member information, claim and authorization history and payment records at any time

Access the Envolve Dental Provider Web Portal at:

<https://pwp.envolvedental.com>

The Provider Web Portal works on multiple web browsers, but screens are optimized when using Internet Explorer and Mozilla Firefox browsers. From the Provider Web Portal, providers and authorized office staff can log in for secure access to manage a variety of day-to-day tasks, including:

- Verify member eligibility
- Check patient treatment history
- Set up office appointment schedules, automatically verifying eligibility and prepopulating claim forms for online submission
- Submit claims and authorizations by simply entering procedure codes, relevant tooth numbers, etc.
- Send electronic attachments, such as digital X-rays and EOBs
- Check the status of in-process claims and authorizations, or review historical payment records
- Review provider clinical profiling data relative to peers (reports)
- Download and print provider manuals
- Check PCD Roster List

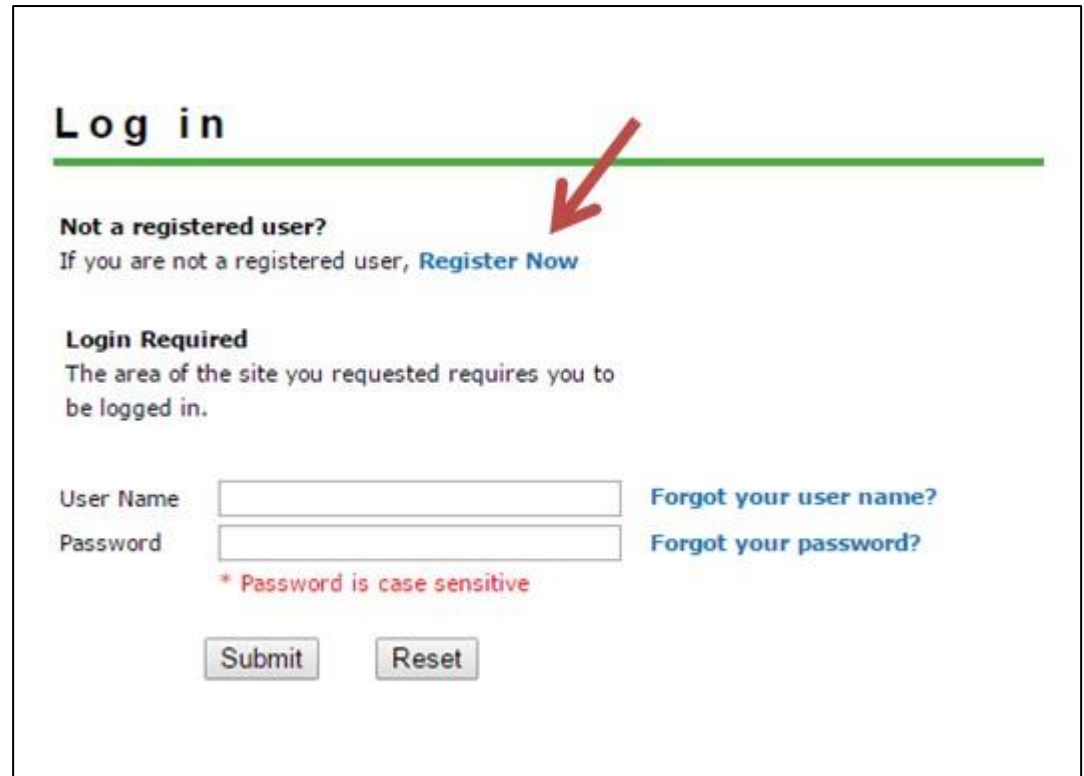
The image shows a screenshot of the Envolve Dental Provider Web Portal login page. At the top, the logo reads "Dental HEALTH & WELLNESS. → envolve. is becoming" with the tagline "Some company and dedication, new look coming soon!". Below the logo is a login form with fields for "User Name" and "Password", a "Login" button, and a "Forgot your User Name or Password?" link. There is also a "New User" section with a "Register Now" button. To the right of the login form is a yellow diamond-shaped icon with "COMPLETED" written inside, and text that says "Documents can be found under insurer documents now! EFT Form & Provider Manual". Below this is a link: "Screen shots from our Webinar on Enhanced Portal functions can also be found with your insurer documents. Thank you for your patience while we completed the construction." Below the login form is a section titled "We Are Rebranding!" with a photo of a dentist in a white coat looking at a tablet in a dental office. Below the photo is the "envolve." logo and the text "Dental Health & Wellness is becoming Envolve". A paragraph follows: "Over the coming months we will transition the Dental Health & Wellness rebrand to Envolve, a family of health solutions working together to make healthcare simpler, more effective, and more accessible for everyone. The name Envolve reflects our determination to encourage the overall health system to evolve and for us to involve everyone with a stake in that change." Another paragraph states: "Envolve Dental, one of the many service areas offered by Envolve, will continue to deliver quality dental care committed to improving the oral health of the community one smile at a time leading to improved overall individual health." At the bottom, it says "For more information visit envolvehealth.com".

Provider Web Portal Registration

A web browser, a valid user name, and a password are required for Provider Web Portal access. First-time users are required to register by calling Envolve Dental Provider Services at 1-855-609-5157 to obtain a unique Payee ID Number. Provider Services will verify your identity to ensure registration is completed and accessed only by an authorized user.

To register,

1. Go to <https://pwp.envolvedental.com>.
2. Click **Register Now**
3. Call 1-855-609-5157 Monday through Friday, 8:00 AM to 5:00 PM to obtain your Payee ID Number.



Log in

Not a registered user?
If you are not a registered user, [Register Now](#)

Login Required
The area of the site you requested requires you to be logged in.

User Name

Password

[Forgot your user name?](#)

[Forgot your password?](#)

* Password is case sensitive

4. On the “User Registration” pop-up screen, select “As a Payee” on the registration option.*
5. Add the Payee ID number from Provider Services.
6. Verify spelling/punctuation of Name, City, State and Zip
7. Fill in details in every field, ensuring you remember your user name and password.
8. Click “Submit.”

User Registration

Select how you would like to register:

As a payee ▼

Enter your identifying information:

Payee ID

Name

City

State

Zip

Enter your contact information:

First Name

Middle Name

Last Name

Email Address

Select a unique user name and password:

User Name:

Password * Password is case sensitive

Retype Password

*You can also register as a location or provider. Ask a Provider Relations Representative for more information.

Subaccounts

Subaccounts allow multiple users to share the same web portal access without sharing the same user name and password.

The subaccounts feature is available only for users who log in with "master" accounts. A "master" account is created when a user registers to use the Provider Web Portal (PWP). A "subaccount" is a user account that is tied to a "master account."

To set up a subaccount for other users,

1. Log in to your Payee account.
2. Go to the "Setup" tab, then "Entity Management" tab.
3. Click on "+Add New User."

The screenshot displays the Provider Web Portal interface. At the top, a navigation bar includes tabs for 'Welcome', 'Eligibility', 'Auths', 'Claims', 'Documents', 'Setup', and 'Profile'. The 'Setup' tab is highlighted with a blue circle. Below this, a secondary navigation bar shows 'Overview', 'Provider Billed Amounts', 'My Profile', 'Change Password', and 'Subaccounts', with 'Subaccounts' also highlighted by a blue circle. The main content area is titled 'Subaccounts' and features a checkbox for 'Display all accounts: active and inactive.' Below this, it states 'No subaccounts found.' A button labeled 'Create new subaccount' is circled in blue. A modal window titled 'Create Subaccount -- Webpage Dialog' is open, showing a form with the following sections:

- Personal Information:** Fields for First Name, Middle Name, and Last Name.
- Email Address:** A text field with a note: 'System-generated messages are sent to this email address.'
- User Name and Password:** Fields for User Name, Password, and Retype Password. A red asterisk indicates '* Password is case sensitive'.
- Account Status:** A checkbox for 'Active' which is checked.

 At the bottom of the modal are 'Save' and 'Cancel' buttons. On the right side of the portal, there is a 'Quick Help' section with links for 'About subaccounts' and 'Lock and unlock subaccounts', and a 'Videos' section with a video titled 'Working with subaccounts'. A 'Verified' logo and a login timestamp 'Last successful login was: 3/31/2015 at 2:36 PM' are also visible.

User Account Security

Master accounts can be manually locked and unlocked by a Provider Services Representative. If a master account is locked accidentally—for example, if the master account user enters an invalid password too many times, or if the password expires—the master account holder must call Provider Services to unlock account. In such cases, users with related subaccounts can continue to log on to the web portal.

Subaccounts can be managed only by the related master account. The master account user may check a subaccount as “inactive.” Subaccounts can be unlocked only by the associated master account. Subaccounts cannot be unlocked by Provider Services.

Subaccounts

Overview Provider Billed Amounts My Profile Chat

Display all accounts: active and inactive.

	Active	User Name
Edit	Yes	annsmith

Create new subaccount

Subaccount Details -- Webpage Dialog
<https://portalua.dentalhw.com/pwp/Dialogs/EditSubaccount.aspx?i=3058>

Personal Information

First Name: Ann
 Middle Name:
 Last Name: Smith
 User Name: annsmith
 Email Address: annsmith@dentalhw.com
 System-generated messages are sent to this email address.

Account Status

Not locked
 Active:

Save Cancel

If a subaccount gets locked out from Provider Web Portal, Click Edit, then check Active and Save.

Information Center

Once registered, use the Provider Web Portal to access the available resources and features to help streamline data entry. After logging in, you will view the Information Center on the home page. (Your dashboard may look slightly different if registered as “Provider” or “Location.”)

- **Review Fee Schedules** – All fee schedules that are linked to your participation are listed on the Payee Dashboard.
- **Track Open/Processed Authorization Records** – Status and final disposition of all authorizations can be reviewed on the Provider Web Portal. The number of open and processed authorizations is listed on the Information Center to allow providers to track authorization progress. Individual authorizations can be reviewed down to the service level by clicking on the Authorization Search.
- **Track Open/Processed Claim Records** – Status and final disposition of all claims can be reviewed via the Provider Web Portal. The number of open and processed claims is listed on the Information Center to allow providers to track payment progress. Individual claims can be reviewed down the service level by clicking on the linked pictured above. The Provider Web Portal also has search functionality allowing a specific claim to be retrieved by clicking on Claims Dashboard.
- **Access Electronic Remittances** – PDF copies of all EOPs/remittances are archived on the Provider Web Portal and can be retrieved at any time.

Home Claims Authorizations Patient Management Documents Reports Setup Contact Us Log Out

Verify Patient Eligibility / Start Claim

Location: Mock Dentistry (Tampa, FL, 33622)

Provider: Mock Mock

Date of Service:

Subscriber ID and date of birth

Subscriber ID:

Date of birth:

Last name and date of birth

[Reset](#) [Verify Eligibility](#)

Information Center

Claims

Received	0
In Process	2
Processed (last 30 days)	0

[Claims Dashboard](#)

Authorizations

Pending	4
Determined (last 30 days)	2

[Authorization Search](#)

Payments

[Recent](#) [Historical](#)

⚠️ No payment record.

Schedules

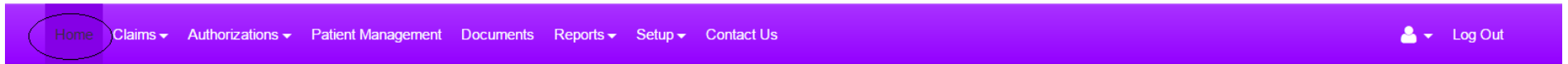
[Fee](#) [Authorization](#)

Current Previous Future

Fee Schedule	View
DHW - FL - Medicaid - 100%	View

Eligibility Verification

Use “Verify Patient Eligibility” on the Home tab to confirm a patient’s benefit coverage and eligibility for service on a specific date.



Verify Patient Eligibility / Start Claim ⓘ

Location

Provider

Date of Service

Subscriber ID and date of birth

Subscriber ID

Date of birth

Last name and date of birth

Information Center

Claims

Received	0
In Process	2
Processed (last 30 days)	0

Authorizations

Pending	3
Determined (last 30 days)	2

Payments

1. Click the Home tab.
2. Choose Location and Provider. Enter projected date of service, member’s Subscriber ID, and date of birth.
3. Click “Verify Eligibility” and review the *Eligibility Report* detailing the member’s coverage.

****TIP –** When checking eligibility, enter [ID + DOB] **or** [First Initial + Last Name + DOB]. Entering more information than necessary can lead to room for errors.

Example of Eligibility Report

Patient Eligibility Report

**This report is only accurate on the date and time it is rendered. The patient's information may have changed after this report has been generated.*

This patient is eligible for services on 10/05/2016 from Mock Mock at Mock Dentistry.

Patient Information

Lauren Bicuspid

1 Floss Way
Tampaf, FL 33603

DOB: 11/06/2002
Subscriber ID: 946458332

Provider Information

Mock Mock

Mock Dentistry
12345 Mock Ln
Tampa, FL 33622

Insurer Information

Dental Health & Wellness, Inc. - Florida

FL - MMA/CW Medicaid

Eligibility Details

Effective Date:	08/01/2016
Termination Date:	Open
*Total Dollars Consumed:	N/A

Patient Eligibility Report

**This report is only accurate on the date and time it is rendered. The patient's information may have changed after this report has been generated.*

This patient is NOT ELIGIBLE for services 10/05/2016.

Patient Information

Gene E Backey

306 N Fremont Ave
Tampa, FL 33606 1632
(813)361-8318

DOB: 12/08/1945
Subscriber ID: 7334351762

Provider Information

Mock Mock

Mock Dentistry
12345 Mock Ln
Tampa, FL 33622

Insurer Information

Dental Health & Wellness, Inc. - Florida

FL - MMA/CW Medicaid

Eligibility Details

Effective Date:	N/A
Termination Date:	N/A
*Total Dollars Consumed:	N/A

Authorization Entry & Submission

Submit authorization requests via the Provider Web Portal. Track authorization review status and determinations, as well as historical records for all authorizations processed.

Home Claims ▾ Authorizations ▾ Patient Management Documents Reports ▾ Setup ▾ Contact Us Log Out

Authorization Entry ⓘ

- Patient Eligibility and Provider Information ▾
- Diagnosis Codes ▾
- Ancillary Information ▾
- Missing Teeth ▾
- Services ▾
- Other Coverage ▾
- Attached Documents (0) ▾
 - [Attach Document\(s\)](#) Maximum file size: 9.8 Megabytes.
Allowed file types: doc, docx, gif, jpg, jpeg, odt, pdf, png, tif, tiff, txt, xls, xlsx, zip
 - There are currently no documents attached to this authorization.
- Remarks ▾

[Clear All](#) [Skip Review and Submit](#) [Review Requirements and Submit](#)

Enter the “Authorizations” tab, provide applicable narratives and attach any required documentation using the Provider Web Portal’s Authorization Entry functionality.

Home Claims Authorizations Patient Management Documents Reports Setup Contact Us Log Out

Authorization Entry ⓘ

⌵ ⌶

Patient Eligibility and Provider Information ⌵

Data Entry

Roster

<p>Patient Information</p> <p>Subscriber ID <input style="width: 100%;" type="text"/></p> <p>First Name <input style="width: 100%;" type="text"/></p> <p>Last Name <input style="width: 100%;" type="text"/></p> <p>Date of Birth <input style="width: 100%;" type="text"/></p> <p>Tentative Service Date <input style="width: 100%;" type="text"/></p>	<p>Provider Information</p> <p>Location Mock Dentistry (Tampa, FL, 33622) ⌵</p> <p>Provider Mock Mock (10530) ⌵</p> <p>Provider Specialty <input style="width: 100%;" type="text"/> ⌵</p> <p>Place of Service 11 - Office ⌵</p> <p style="text-align: right;">Verify Eligibility</p>
--	---

Diagnosis Codes ⌵

Ancillary Information ⌶

Treatment for Orthodontics? No Yes

Replacement of Prosthesis? No Yes

Treatment Related to: Employment Auto Accident Other Accident

Missing Teeth ⌵

Services ⌵

Other Coverage ⌵

Attached Documents (0) ⌶

Attach Document(s)

Maximum file size: 9.8 Megabytes.
Allowed file types: doc, docx, gif, jpg, jpeg, odt, pdf, png, tif, tiff, txt, xls, xlsx, zip

1. Click the Authorizations tab.
2. Enter member ID and date of birth, then choose location and provider from the drop-down menus.
3. Click “Verify eligibility” to confirm member’s coverage.
4. Use the check boxes inside the “Ancillary Authorization Information” box to notate service details, e.g., orthodontic treatment, accident-related, etc.

Services
^

	Code	Description	Surfaces					Oral Cavity	DiagPtr				Duration		Frequency		Tentative Service Dates		Billed Amt	
			Tooth	1	2	3	4		5	1	2	3	4	Value	Unit	Value	Unit	Qty		POS
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				

Clear Selected Service | Clear All Services
Total Billed \$ 0.00

Client Authorization Number

Referral Number

Other Coverage
v

Attached Documents (0)
v

Remarks
^

Clear All
Skip Review and Submit
Review Requirements and Submit

5. On the “Services” sub-tab, enter specific procedures by line, including tooth/surface/area information as required, projected date of service, quantity, and the billed rate.
6. Click on the “Remarks” sub-tab to add additional narratives, including an NEA number for attachment identification or other pertinent details.
7. Once submission data is entered, click the “Skip Review and Submit” button.
8. A pop-up window will open confirming that you want to submit the authorization.

Authorization Status

Authorization Search

Search Criteria

Authorization Information

Authorization Status: All ▼ Search for All, Pending or Determined Authorizations

Authorization Number:

Anticipated Service Date From: To: ← Search by Authorization number or by date spans:

Entered Date From: To: ← 1. Single authorizations can be accessed by entering authorization number

Determination Date From: To: ← 2. Batches of authorizations can be accessed by Date of Service date span or by Date Entered span

Member Information ← Search by Member and Product/Insurer:

First Name:

Last Name:

Subscriber ID:

Insurer: Dental Health & Wellness, Inc. - Flor ▼ ← 1. A specific member's authorization can be accessed by searching using a member name and subscriber ID number

Provider Information ← Search by Provider and/or Location:

Location: Mock Dentistry (Tampa, FL, 3362... ▼ ← 1. Authorizations can also be reviewed by provider and/or location. This is especially useful for large dental groups.

Provider: Mock Mock ▼

Clear Filters Search

- The “Authorization Search” functionality allows a search for a single authorization by authorization number or for batches of authorizations using various criteria.
- Searches can be made for “open,” “processed” or “all” authorizations.
- Batches of authorizations can be searched for using a variety of criteria:
 - Date span – search by tentative date of service span or date entered span
 - Member – search by using a member’s name and member ID to review all authorizations submitted for a specific member
 - Provider or location – search for all authorizations associated with a specific provider or location under a dental group

Manage Roster

1. On the “Patient Management” tab, you will find the “Location Roster” and “My Roster” tab.
2. Select patient name on the roster list.
3. Rosters can be created by day in order to manage a daily patient schedule.

Patient Management ?

Select Location **Mock Dentistry (Tampa, FL, 33622)**

Mock Dentistry
12345 Mock Ln
Tampa, FL 33622

Location Roster (3 Patients)

Roster Search

Last Name ^	First Name ⇅	DOB ⇅	
+ BICUSPID	LAUREN	11/06/2002	x
+ JAW	JOHN	10/02/2001	x
+ MOLAR	LISA	01/12/1997	x

+ Add Patient Print Roster

My Roster (0 Patient)

Patient Calendar

Provider Mock Mock

September 2016 Today

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28	29	30	31	1	2	3
4	5	6	7	8	9	10
11	12	13 1 Patients	14	15 1 Patients	16 3 Patients	17
18	19	20	21	22	23	24

Claim Entry & Submission

Enter claims on the Provider Web Portal. Provide applicable narratives and attach required documentation.

1. Click the "Claims" tab on the upper navigation bar. Then select "Submit Claim."
2. Enter member's ID and date of birth, and then choose location and provider from the drop-down menu.
3. Click "Verify Eligibility" to check patient coverage. The field will turn green if the patient is covered; and red if not covered.
4. Click "View Patient Service History" to review member's treatment history and confirm the service is appropriate and within limitations and guidelines.
5. Under "Other Coverage" tab Check "EOB Present," if applicable.
6. Use the check boxes inside the "Ancillary Claim Information" box to notate service details such as orthodontic treatment or

Claim Entry ⌵ ⌶

Patient Eligibility and Provider Information
⌵

Data Entry | Roster

Patient Information

Subscriber ID:

First Name:

Last Name:

Date of Birth:

Date of Service:

Provider Information

Location:

Provider:

Provider Specialty:

Place of Service:

Verify Eligibility

✓ John Jaw is eligible for services on 09/25/2016 from at Mock Dentistry (Tampa, FL, 33622).
[View Patient Service History](#)

Diagnosis Codes ⌵

Ancillary Information ⌵

Missing Teeth ⌵

Services ⌵

	Code	Description	Tooth	Surfaces					Oral Cavity	DiagPtr				EPSDT	Qty	Auth Number	Service Date	Billed Amt
				1	2	3	4	5		1	2	3	4					
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		

[Clear Selected Service](#) | [Clear All Services](#)

Office Reference Number:

Referral Number:

Other Fees: \$

\$

Total Billed: \$

Other Coverage ⌵

Attached Documents (0) ⌵

Remarks ⌵

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accident- related.

7. Enter procedures rendered for each line using CDT Codes, including tooth/surface/area information as required, date of service, quantity, authorization number, if applicable, and billed rate. (At this time, **no** ICD-9 or ICD-10 codes are required.)
8. Click the “Remarks” tab to add any additional narratives, such as NEA numbers or other pertinent details.
9. Click “Attachments” tab to attach x-rays or other documents that are required for payment.
10. If an EOB is present and primary payment information needs to be entered; be sure the “EOB Present” box on the top of the screen is checked to enter COB details.

Services ▼

Other Coverage ▲

Other Coverage? No Yes

Coverage Type Dental Medical

Member Name

Date of Birth

Gender

Policy Group

Insurance Plan

Subscriber ID

Relationship Self Spouse Dependent Other

EOB Present? Yes No

	Code	Tooth	Cavity	COB Info	COB Amount	Collected Amount	Allowed Amount	Deduct Amount	Co-Ins Amount	Copay Amount	Remark Code	Paid Date	Claim Status
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
...													

Attached Documents (0) ▼

Remarks ▼

Clear All
View Estimate
Submit Claim

Pre-Claim Estimate – Remaining Dental Benefit Amount

An important feature is the pre-claim estimate pop-up window, available on the claim entry tab. Once all fields have been entered, as above, click on the “View Estimate” button.

A pre-claim estimate pop-up window will show the reimbursement amount a provider can expect to receive for the reported CDT codes.

Preclaim Estimate

This preclaim estimate is not a guarantee of benefits

Patient Name: **JAW, JOHN**
 Subscriber/Member: 564392984 / 00
 DOB: 10/02/2001

Provider Name: **Mock Mock** Preclaim ID: **44708**
 Provider/Loc ID: 10530 / 6762
 Plan: Dental Health & Wellness, Inc. - Florida
 Product: FL - MMA/CW Medicaid Benefit Level: In Network

ITEM	DOS	CODE	POS	QTY	BILLED	ALLOWED	PAY %	PAYABLE	COPAY	COINS	DEDUCT	PATIENT	NET	
					AMOUNT	QTY		AMOUNT	AMOUNT	AMOUNT	AMOUNT	PAY	AMOUNT	
1	09/15/16	D1110 00	11	1	\$75.00	1	\$26.75	100.00 %	\$26.75	\$0.00	\$0.00	\$0.00	\$0.00	\$26.75
					\$75.00		\$26.75		\$26.75	\$0.00	\$0.00	\$0.00	\$0.00	\$26.75

Claims Status

Track the status of claims currently in process and review payment records for past claims.

- The claim status functionality allows a provider to search for a single claim by claim encounter ID number or for batches of claims.
- Searches can be for all, “received” or “in process” or “processed” claims. This allows a provider to track claims currently in the payment process, or to view paid claim records.
- Batches of claims can be searched using a variety of criteria:
 - Date span – search by tentative date of service span or date entered span
 - Member – search by using a member’s name and member ID to review all authorizations submitted for a specific member
 - Provider or location – search for all authorizations associated with a specific provider or location under a dental group

The screenshot shows a web portal interface for searching claims. At the top is a navigation bar with links: Home, Claims, Authorizations, Patient Management, Documents, Reports, Setup, and Contact Us. On the right of the navigation bar is a user profile icon and a 'Log Out' link. Below the navigation bar is a 'Claim Search' section with an information icon. The search criteria are organized into three sections:

- Claim Information:** Includes a 'Claim Status' dropdown menu (set to 'All') with a link 'What does the claim status mean?'. Below this are input fields for 'Encounter ID', 'Service Date From' and 'To', 'Entered Date From' and 'To', and 'Paid Date From' and 'To'.
- Member Information:** Includes input fields for 'First Name', 'Last Name', and 'Subscriber ID'. The 'Insurer' is set to 'Dental Health & Wellness, Inc. - Flc'.
- Provider Information:** Includes a 'Location' dropdown menu (set to 'Mock Dentistry (Tampa, FL, 336...') and a 'Provider' dropdown menu (set to 'Mock Mock').

At the bottom of the search criteria section are two buttons: 'Clear Filters' and 'Search'. Below the search criteria is a table header with the following columns: Encounter ID, Patient Name, DOB, Provider Name, Date of Service, Date Paid, and Claim Status. Below the table header is the text 'Enter search criteria'.

Electronic Funds Transfer

The Provider Web Portal displays remittance statements electronically. EFTs (Electronic Fund Transfer) offer direct deposit into a bank account more quickly than payments made by check. To set up EFT, complete an EFT form (found in your contracting packet) or in the Provider Manual and send with a copy of a voided check for verification to providerrelations@envolvehealth.com or fax to 844-847-9807. Allow four to six weeks for your EFT application to take effect, as the banks must verify all information is accurate.

To view online remittances, go to the “Documents” tab, then select “My Documents” and choose the applicable remittance statement date.

The screenshot displays the Provider Web Portal interface. At the top is a purple navigation bar with links: Home, Claims, Authorizations, Patient Management, Documents, Reports, Setup, and Contact Us. On the right of the bar is a user profile icon and a 'Log Out' link.

The main content area is split into two columns. The left column is titled 'Verify Patient Eligibility / Start Claim' and contains a form with the following fields:

- Location: A dropdown menu showing 'Mock Dentistry (Tampa, FL, 33622)'.
- Provider: A dropdown menu showing 'Mock Mock'.
- Date of Service: An empty text input field.
- Subscriber ID and date of birth: A radio button selected, with sub-fields for 'Subscriber ID' and 'Date of birth', both empty text input fields.
- Last name and date of birth: A radio button unselected.
- Buttons: 'Reset' (green) and 'Verify Eligibility' (purple).

The right column is titled 'Information Center' and contains three sections:

- Claims:** A table showing 'Received' (0), 'In Process' (2), and 'Processed (last 30 days)' (0). Below the table is a green 'Claims Dashboard' button.
- Authorizations:** A table showing 'Pending' (4) and 'Determined (last 30 days)' (2). Below the table is a green 'Authorization Search' button.
- Payments:** The word 'Payments' is circled in blue. Below it are two tabs: 'Recent' (selected) and 'Historical'. Below the tabs is a message box with a warning icon and the text 'No payment record.'
- Schedules:** A partially visible section at the bottom.

Documents

A copy of the Envolve Dental Provider Manual can be found under the “Insurer Documents” tab.

The screenshot shows the 'Documents' section of the provider web portal. On the left, there are three tabs: 'My Documents', 'Insurer Documents' (circled in blue), and 'Network Documents'. The main content area displays a table of documents for the selected insurer, 'Dental Health & Wellness, Inc. - Florida'. The table has three columns: 'Document Description', 'Document Type', and 'Date'. Below the table, it indicates '4 Records Returned'.

Document Description ^	Document Type ⇅	Date ⇅
Ambetter Provider Manual v3 2016	Other	3/31/2016 5:33 PM
EFT Form	Other	8/19/2016 7:55 AM
FL Provider Manual	Other	8/19/2016 7:56 AM
Provider Web Portal Enhancements/New Features	Other	8/19/2016 2:23 PM

Frequency and Ratios Reports

To support utilization management functions, the Provider Web Portal allows providers to review clinical profiling data relative to peers. Go to the “Reports” tab, and select the “Frequency Report” or “Ratio Report” tab to view provider-specific comparisons.

The screenshot displays the Provider Web Portal interface. At the top, a purple navigation bar contains links for Home, Claims, Authorizations, Patient Management, Documents, Reports, Setup, and Contact Us. The 'Reports' dropdown menu is open, showing options for Frequency Report, Ratio Report, and View Primary Care Assignments. On the right side of the navigation bar, there is a user profile icon and a Log Out link.

The main content area is divided into two sections. On the left, the 'Verify Patient Eligibility / Start Claim' form is visible. It includes a 'Location' dropdown menu set to 'Mock Dentistry (Tampa, FL, 33622)', a 'Provider' dropdown menu set to 'Mock Mock', and a 'Date of Service' input field. Below these are two radio button options: 'Subscriber ID and date of birth' (selected) and 'Last name and date of birth'. The 'Subscriber ID and date of birth' option has 'Subscriber ID' and 'Date of birth' input fields. At the bottom of the form are 'Reset' and 'Verify Eligibility' buttons.

On the right side, the 'Information Center' section displays a 'Claims' dashboard with a table showing 'Received' (0), 'In Process' (2), and 'Processed (last 30 days)' (0). Below this is a 'Claims Dashboard' button. The 'Authorizations' section shows a table with 'Pending' (3) and 'Determined (last 30 days)' (2), along with an 'Authorization Search' button. The 'Payments' section has 'Recent' and 'Historical' tabs, with a message box indicating 'No payment record.' The 'Schedules' section has 'Fee' and 'Authorization' tabs.

If you have questions about the Envolve Dental Provider Web Portal, please contact Provider Services at 1-855-609-5157 for assistance.

Envolve Dental Provider Manual

We welcome your input for future editions: providerrelations@envolvehealth.com
