2021

Envolve Dental, Inc.

Ambetter Provider Manual

AR, AZ, FL, GA, IL, IN, KS, MI, MO, MS, NV, NH, NC, OH, PA, SC, TN, TX

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Contents

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

Claims – submit & view status

Clinical guidelines

Referral directories

Electronic remittance advice

Electronic Funds Transfer

Up-to-date Provider Manual

Access the Provider Web Portal by clicking this link:

https://pwp.envolvedental.com

Key Contacts

The following chart includes several important telephone and fax numbers available to your office. When calling Envolve Dental, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number

REFERENCE	CONTACT
Provider Web Portal	https://pwp.envolvedental.com
Provider Customer Service	**Arizona** 833-605-6272 **Arkansas** 855-609-5155 **Florida** 855-934-9809 **Georgia** 844-464-5632 **Illinois** 855-934-9811 **Indiana** 844-621-4579 **Kansas** 855-434-9245 **Michigan** (833) 317-0439 **Mississippi** 855-934-9810 **Missouri** 855-434-9240 **Nevada** (844) 695-0358 **New Hampshire** (844) 258-4615 **North Carolina** (833) 482-2947 **Ohio** 844-621-4581 **Pennsylvania** 833-605-6275 **South Carolina** 833-605-6320 **Tennessee** (833) 662-1996 **Texas** 833-260-3625

Ambetter Member Services **(includes translation assistance)**	**Arizona** 888-926-5057 **Arkansas** 877-617-0390 **Florida** 877-687-1169 **Georgia** 877-687-1180 **Illinois** 855-745-5507 **Indiana** 877-687-1182 **Kansas** 844-518-9505 **Michigan** 833-993-2426 **Mississippi** 877-687-1187	**Missouri** 855-650-3789 **Nevada** 866-263-8134 **New Hampshire** 844-265-1278 **North Carolina** 833-863-1310 **Ohio** 877-687-1189 **Pennsylvania** 833-510-4727 **South Carolina** 833-270-5443 **Tennessee** 833-709-4735 **Texas** 877-687-1196
Credentialing	**Please call Provider Customer Service for your health plan**	
Fraud & Abuse	**800-345-1642**	

Paper Claim Address, Appeals and Corrected Claim Address	**Arizona** Envolve Dental Claims PO Box 20132 Tampa, FL 33622-0132 **Arkansas** Envolve Dental Claims PO Box 26632 Tampa, FL 33623-6632 **Florida** Envolve Dental Claims PO Box 20654 Tampa, FL 33622-0654 **Georgia** Envolve Dental Claims PO Box 22085 Tampa, FL 33622-2085 **Illinois** Envolve Dental Claims: PO Box 22377 Tampa, FL 33622-2377 **Indiana** Envolve Dental Claims PO Box 20847 Tampa FL 33622-0847 **Kansas** Envolve Dental Claims PO Box 25857 Tampa, FL 33622-5857 **Michigan** Envolve Dental Claims PO Box 20062 Tampa FL 33622-0062 **Mississippi** Envolve Dental Claims PO Box 25255 Tampa, FL 33622-5255	**Missouri** Envolve Dental Claims PO Box 20262 Tampa, FL 33622-0262 **Nevada** Envolve Dental Claims PO Box 26564 Tampa FL 33622-6564 **New Hampshire** Envolve Dental Claims PO Box 20062 Tampa FL 33622-0062 **North Carolina** Envolve Dental Claims PO Box 20654 Tampa, FL 33622-0654 **Ohio** Envolve Dental Claims PO Box 22687 Tampa, FL 33622-2687 **Pennsylvania** Envolve Dental Claims PO Box 26631 Tampa, FL 33623-6631 **South Carolina** Envolve DentalClaims PO Box 26632 Tampa, FL 33623-6632 **Tennessee** P Envolve Dental Claims O Box 20654 Tampa, FL 33622-0654 **Texas** Envolve Dental Claims PO Box 26564 Tampa FL 33622-6564

Summary

Quick Reference Guide

Member Eligibility

Providers may access primary eligibility through one of the following. You must provide your NPI number to access member details.

- Provider Web Portal: https://pwp.envolvedental.com
- Call Provider Customer Service for the automated member eligibility IVR system to reach our automated member eligibility-verification system 24 hours a day.

Claims Submission

The timely filing requirement for Ambetter is 180 calendar days from the date of service. Turnaround time is 30 calendar days from the date of the original submission. Submit claims in one of the following formats:

- Envolve Dental Provider Web Portal at https://pwp.envolvedental.com
- Electronic claim submission through selected clearinghouses: Payer ID 46278
- Alternate pre-arranged HIPAA-compliant electronic submissions
- Paper claims must be submitted on a 2012 or later ADA claim forms and mailed to the market-specific address.

Corrected Claim Submission

Providers who receive a claim denial and need to submit a corrected claim must send a paper claim on a 2012 or later ADA form including ALL codes originally submitted, plus the corrected code with supporting documentation, within 180 calendar days from the date of notification or denial to the market-specific appeals and corrected claim address.

Provider Claim Disputes

Claim payment disputes must be filed within 180 calendar days from the date of notification of payment or denial. Disputes will be resolved within 30 calendar days via a remittance statement. If unsatisfied with result, providers can submit an appeal to Envolve Dental.

To request a reconsideration of a claims denial, a provider may:

- Call Provider Customer Service for information
- Write to the market-specific appeals address.

Provider Inquiries and Grievances

To make an inquiry or grievance, email your concern to providerrelations@envolvehealth.com or call Provider Customer Service.

Quick Reference Guide

Member Appeals

Members must submit appeals within 180 calendar days of receiving an adverse Notice of Action by calling Ambetter:

Arizona:	888-926-5057
Arkansas:	877-617-0390
Florida:	877-687-1169
Georgia:	877-687-1180
Illinois:	855-745-5507
Indiana:	877-687-1182
Kansas:	844-518-9505
Michigan:	833-993-2426
Mississippi:	877-687-1187
Missouri:	855-650-3789
Nevada:	866-263-8134
New Hampshire:	844-265-1278
North Carolina:	833-863-1310
Ohio:	877-687-1189
Pennsylvania:	833-510-4727
South Carolina:	833-270-5443
Tennessee:	833-709-4735
Texas:	877-687-1196

Members who are not satisfied with the Ambetter appeal decision may request an External Review in accordance with their state Department of Insurance requirements. State Fair Hearing requests are not available to Ambetter members.

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. is a wholly owned subsidiary of Envolve Benefit Options, Inc. and Centene Corporation, Inc., a Fortune 100 company with more than 30 years' experience in Medicaid managed care programs. With the advent of the Health Insurance Marketplace, Centene developed marketplace products to meet the needs of additional people who previously were uninsured. Envolve Dental has partnered with Ambetter health plans in Arizona, Arkansas, Florida, Georgia, Illinois, Indiana, Kansas, Michigan, Mississippi, Missouri, Nevada, New Hampshire, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee and Texas to administer the dental benefit for eligible members in 2021.

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 Customer Service at providerrelations@envolvehealth.com or call us at your state-specific Provider Customer Service number.

Envolve Dental retains the right to modify items in this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Envolve Dental as proprietary and confidential.

Provider Contracting and Credentialing

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:

- Email Envolve Dental at dentalnetwork@envolvehealth.com with your specific requests.
- Call the state-specific number below for a contracting packet.

Provider Customer Service

Arizona **833-605-6272**	**Kansas** 855-434-9245	**North Carolina** (833) 482-2947
Arkansas 855-609-5155	**Michigan** (833) 317-0439	**Ohio** **844-621-4581**
Florida 855-934-9809	**Mississippi** 855-934-9810	**Pennsylvania** 833-605-6275
Georgia 844-464-5632	**Missouri** 855-434-9240	**South Carolina** 833-270-5443
Illinois 855-934-9811	**Nevada** (844) 695-0358	**Tennessee** (833) 662-1996
Indiana 844-621-4579	**New Hampshire** (844) 258-4615	**Texas** **877-687-1196**

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, call Provider Customer Service.

Credentialing

The purpose of the credentialing and re-credentialing process is to help make certain that Envolve Dental maintains a high-quality healthcare delivery system. The credentialing and re-credentialing process helps achieve this aim by validating the professional competency and conduct of our providers. This includes the verification of licensure, board certification and education, and disclosure of ownership or control interests, as well as identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Base.

If a practitioner/provider already participates with Envolve Dental in the Medicaid product, the practitioner/provider will NOT be separately credentialed for the Ambetter product.

For more information on credentialing, please email dentalcredentialing@envolvehealth.com.

Re-credentialing

To comply with accreditation standards, Envolve Dental confirms provider re-credentialing at least every 36 months from the date of the initial credentialing. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all providers, primary care providers, specialists and ancillary providers/facilities previously credentialed to practice within the Envolve Dental network.

In between credentialing cycles, Envolve Dental conducts ongoing monitoring activities on all network providers. This includes ongoing monitoring of the appropriate state licensing agencies to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps make certain that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Envolve Dental reviews monthly reports released by the Office of Inspector General and other sources to identify network providers who have been newly sanctioned or excluded from participation in federal and state programs.

A provider's agreement may be terminated at any time if Envolve Dental's Credentialing Committee determines that the provider no longer meets the credentialing requirements.

Electronic Funds Transfer (EFT)

Envolve Dental makes Electronic Funds Transfer (EFT) available to providers for claims payments that are faster than paper checks sent via US Mail. If you are currently enrolled in EFT with Envolve Dental, you do not need a new form to receive EFT payments for Ambetter claims.

To begin receiving electronic payments, complete an EFT form (found on the Provider Web Portal) and submit it via email, with a voided check, to providerrelations@EnvolveHealth.com. The EFT form can also be mailed physically 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.

Provider Rights & Responsibilities

Consistent with Ambetter policies, Envolve Dental applies the following rights and responsibilities to all network providers. [1]

Provider Rights

Providers have the right to:

- Be treated by Ambetter members, Envolve Dental staff, and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have their patients, who are Ambetter members, act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.
- Make a complaint or file an appeal against Ambetter, Envolve Dental, and/or a member.
- File a grievance on behalf of a member, with the member's consent.
- Have access to information about Ambetter and Envolve Dental quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
- Contact Provider Customer Service with any questions, comments, or problems.
- Collaborate with other health care professionals who are involved in the care of members.
- Not be excluded, penalized, or terminated from participating with Ambetter or Envolve Dental for having developed or accumulated a substantial number of patients in Ambetter with high cost medical conditions.
- Collect member copays, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers are responsible for:

- Making covered services available on a timely basis, based on medical appropriateness.
- 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, pre-existing mental or physical disability/condition, religion, limited language proficiency, marital status, arrest record, conviction record, or military involvement.
- Maintaining the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Giving to members a notice that clearly explains their privacy rights and responsibilities as they relate to the provider's practice and scope of service.

[1] *Ambetter 2018 Provider Handbook*

- Providing members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allowing members to request restriction on the use and disclosure of their personal health information.
- Providing members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- Providing clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.
- Telling a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- Allowing a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respecting members' advance directives and include these documents in their medical record.
- Allowing members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- Allowing members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
- Following all state and federal laws and regulations related to patient care and rights.
- Participating in Ambetter and Envolve Dental data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Reviewing clinical practice guidelines distributed by Ambetter.
- Complying with the Envolve Dental Ambetter Medical Management program as outlined herein.
- Disclosing overpayments or improper payments to Envolve Dental.
- Providing members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtaining and reporting to Envolve Dental information regarding other insurance coverage the member has or may have.
- Giving Envolve Dental timely, written notice if provider is leaving/closing a practice.
- Contacting Envolve Dental to verify member eligibility and benefits, if appropriate.
- Inviting member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
- Providing members with information regarding office location, hours of operation, accessibility, and translation services.
- Objecting to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
- Providing hours of operation to Ambetter members which are no less than those offered to other commercial members.

Member Rights & Responsibilities

Consistent with Ambetter policies, Envolve Dental applies these rights and responsibilities to all members. [2]

Member Rights

Members have the right to:

- View medical records.
- Be informed of changes within the Ambetter or Envolve Dental networks.
- Information about Ambetter and its health plans.
- A current list of Ambetter and Envolve Dental providers.
- Select a dental provider from within the Envolve Dental network.
- Talk to a provider about new uses of technology; members can also ask Ambetter for information on our quality plan, how members use the plan and how we review new technology view medical records.
- Receive considerate, respectful care at all times.
- Receive assistance in a prompt, courteous and responsible manner.
- Be treated with dignity when receiving care.
- Be free from harassment by the health plan or the plan's providers if there are any business disagreements between the plan and provider.
- Select a health plan or switch health plans, within the Health Insurance Marketplace (HIM) guidelines, without any threats or harassment.
- Receive and have privacy respected.
- Access treatment or services that is medically necessary regardless of age, race, creed, sex, sexual preference, national origin or religion.
- Access medically necessary, emergency services 24 hours a day and seven (7) days a week.
- Seek a second medical opinion from a participating provider at no cost to the member.
- Receive information in a different format in compliance with the Americans with Disabilities Act if the member has a disability.

Member Responsibilities

Members are responsible for:

- Participating in their healthcare by giving accurate and complete information about present conditions.
- Following the provider's treatment plan and asking questions to fully understand it.
- Presenting the Ambetter ID card when obtaining services and informing the plan if the card is lost or stolen.
- Going to the emergency room only when the health condition is an emergency.
- Making and keeping appointments and notifying the provider prior to an appointment if unable to attend.
- Treating all staff, providers, and other members with respect and dignity.

[2] *Ambetter 2018 Member Handbook*

- Keeping current all personal information with providers, the Ambetter plan, and the Health Insurance Marketplace, including address, name, and telephone number.
- Informing healthcare providers about other insurances in effect.
- Reporting to appropriate channels possible fraud and abuse by another member or provider.
- Paying for charges when Ambetter rules are not followed, and co-pay amounts at the time of service.

Eligibility & Member Services

Member Identification Card

Ambetter members are issued ID cards that should be checked and verified at each visit. Each Ambetter plan issues identification cards to members, 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.

Eligibility Verification

Ambetter plans follow all Health Insurance Marketplace regulations. Open enrollment is November 1 through December 15 annually. If an individual or family has a qualifying event outside of the open enrollment period, eligibility may be available to enroll in Ambetter mid-year. Continued coverage depends on the member paying premiums on time to the Ambetter plan.

Ambetter and Envolve Dental eligibility data are 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 calling Provider Customer Service. Callers need to supply the provider NPI or tax identification number and the following member information to check eligibility:

Member Details

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

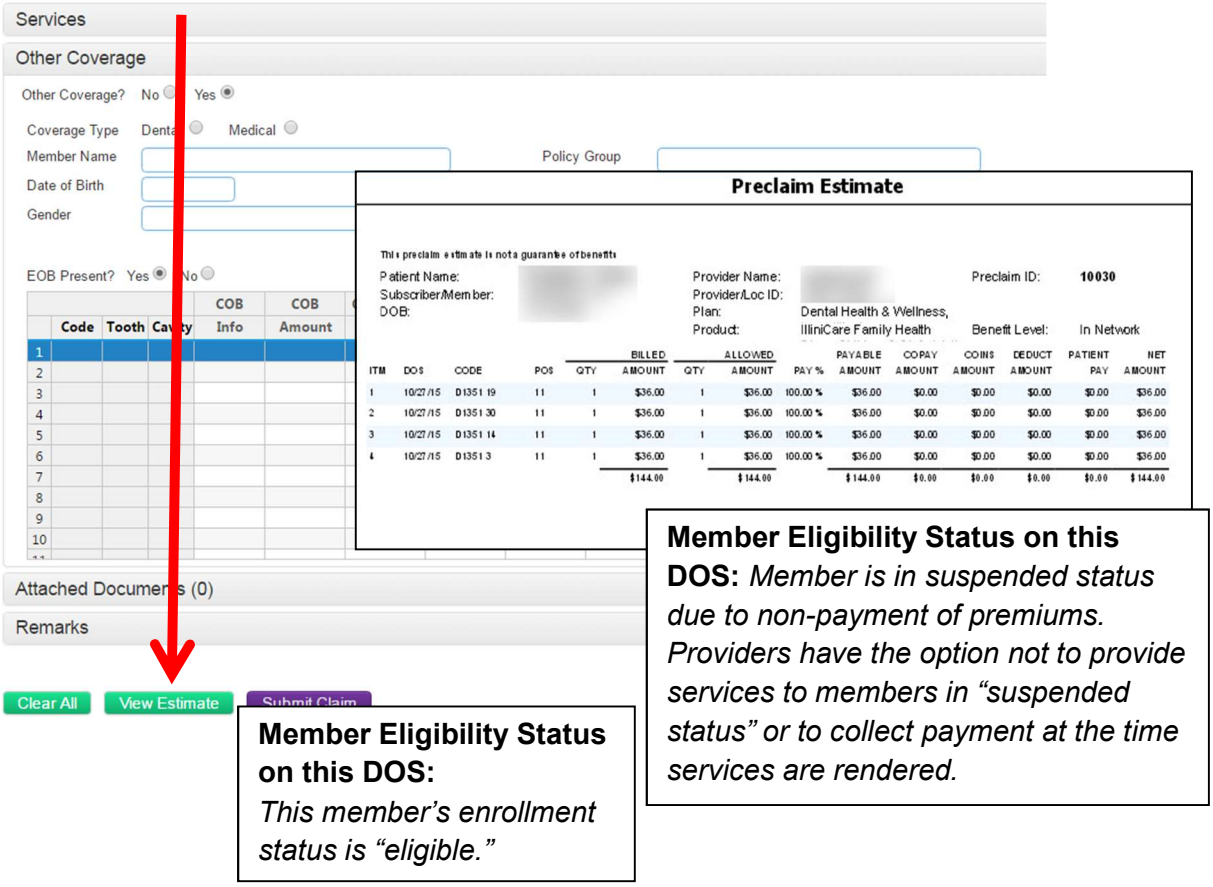
With this information ready, verify eligibility on the Provider Web Portal or via telephone to Provider Customer Service.

According to Health Insurance Marketplace regulations, a member's Ambetter eligibility status can be "Enrolled" (the same as "Eligible") or "Suspended." Members can enter into a "suspended" status when premium payments are not made in a subsequent month. The status change date occurs according to the member's eligibility for federal health insurance subsidies (advance premium tax credits, or "APTC").

- For members with APTC, suspended status begins on the first day of the *second* month of premium payment delinquency.
- All other members (without APTC), suspended status begins on the first day of the *first* month of premium payment delinquency.

APTC participation and "Suspended" does not appear on the Envolve Dental Provider Web Portal main eligibility screen. To accommodate providing accurate eligibility verification that includes "suspended" status, Envolve Dental has developed a secondary option, as follows.

1. **Log on** to the Provider Web Portal.
2. On the Claim Entry screen, enter the member's ID, date of birth, and other required information, including the CDT codes for the service date.
3. Click **View Estimate** button. Refer to screenshot below.



A pop-up screen appears showing the pre-claim estimate amount. In the Payment Note section of the pre-claim estimate, a note will show eligible or suspended enrollment status.

Providers can choose not to deliver services to members in suspended status or to collect payment at the time services are rendered.

Provider Options for Treating Members in Suspended Status

When a member's eligibility is suspended, providers may communicate one of the following to the member:

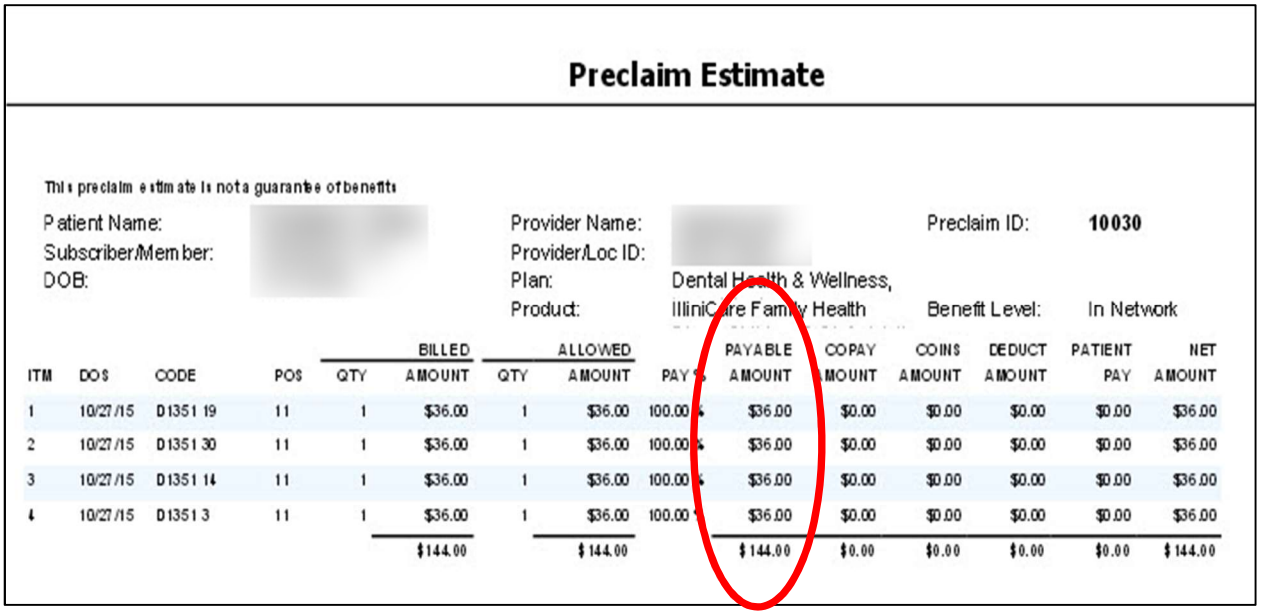
- Services may not be delivered due to member being in suspended status.
- Deliver services and collect payment from the member. However, a claim must still be submitted to Envolve Dental.

If a provider chooses to treat a member in suspended status, claims will be pended up to two months (as long as premium payment is delinquent). At the end of two months, Envolve Dental will complete one of the following:

- Release payments to the provider if the member has paid premiums in full. Providers must reconcile reimbursement with the member directly for payments made by the member at the point of service.
- Release a remittance with a 27 code (expenses incurred after the coverage terminated). If not done so previously, provider can bill the member in full for services rendered during suspended status.

Checking Dental Spending Status

The pre-claim estimate pop-up window also shows if a member has a portion remaining of the $1,000 annual dental benefit limit. If the member has remaining dollars, the "payable amount" will reflect the amount the provider can expect for reimbursement if those services are rendered. If the member has spent the $1,000 annual maximum, the payable amount will be $0.



Preclaim Estimate

This preclaim estimate is not a guarantee of benefits

Patient Name:
Subscriber/Member:
DOB:

Provider Name:
Provider/Loc ID:
Plan: Dental Health & Wellness,
Product: IlliniCare Family Health

Preclaim ID: 10030
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	NET AMOUNT
1	10/27/15	D1351 19	11	1	$36.00	1	$36.00	100.00%	$36.00	$0.00	$0.00	$0.00	$0.00	$36.00
2	10/27/15	D1351 30	11	1	$36.00	1	$36.00	100.00%	$36.00	$0.00	$0.00	$0.00	$0.00	$36.00
3	10/27/15	D1351 14	11	1	$36.00	1	$36.00	100.00%	$36.00	$0.00	$0.00	$0.00	$0.00	$36.00
4	10/27/15	D1351 3	11	1	$36.00	1	$36.00	100.00%	$36.00	$0.00	$0.00	$0.00	$0.00	$36.00
					$144.00		$144.00		$144.00	$0.00	$0.00	$0.00	$0.00	$144.00

Claims being adjudicated will not appear in the pre-claim estimate calculation.

Transportation Assistance

Transportation assistance is not a covered benefit in the Ambetter plans.

Member Translation/Interpreter and Hearing Impaired Services

Members requiring language assistance should contact Ambetter Member Services. Interpreter services are available for many different languages, and there is no cost to members. Sign language and assistance for members who are blind or visually impaired are also available.

Arizona 888-926-5057	**Kansas** 844-518-9505	**North Carolina** 833-863-1310
Arkansas 877-617-0390	**Michigan** 833-993-2426	**Ohio** 877-941-9236
Florida 877-687-1169	**Mississippi** 877-687-1187	**Pennsylvania** 833-510-4727
Georgia 877-687-1180	**Missouri** 855-650-3789	**South Carolina** 833-270-5443
Illinois 855-745-5507	**Nevada** 866-263-8134	**Tennessee** 833-709-4735
Indiana 800-743-3333	**New Hampshire** 844-265-1278	**Texas** 877-687-1196

Appointment Availability Standards

Appointment availability standards are set by Ambetter plans 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.

Type of Appointment	Scheduling Time Frame
Routine dental care (for example, a cleaning)	21 calendar days
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.	Twenty-four (24) 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 30 minutes 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. Ambetter requires call-back times to be no more than 30 minutes.

Referrals to Specialists

Envolve Dental does not require general 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 to ensure payment is possible for covered benefits. Participating network specialists can be found on the Ambetter "Find a Provider" page for each state. Prior to making a referral to a specialist, discuss with the member if the recommended specialist services are covered or non-covered benefits according to Appendix A. 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

The Ambetter member manual includes instructions for members to cancel in advance if unable to keep an appointment. 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 repeatedly misses appointments. Be sure to keep a record of occurrences in the member's record, and refer the member to Ambetter Member Services to identify a new dental provider.
- Your office's missed appointment and dismissal policies for Ambetter members cannot be stricter than your private or other commercial patient policies.
- Providers are not allowed to charge Ambetter 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, Ambetter, and the Department of Health & Human 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.
- 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 may bill a member *only* under the following circumstances:

- In all states in 2021, members are responsible for a 50% coinsurance for the cost of comprehensive services from in-network providers. *In Arkansas, Mississippi and Texas only*, Ambetter members may also choose to receive comprehensive dental services from out-of-network providers at 50% coinsurance as described in the benefit grids. For all other states, services by non-network providers are not reimbursable. Comprehensive services are defined in Appendix A.
- The member has received $1,000 in dental services in the coverage year. Any amounts above $1,000 are billable to the member.
- The member is in suspended status. (See section on "Provider Options for Treating Members.")
- The member agrees to receive and personally pay for *non-covered* dental services. In such cases, 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 and Ambetter for payment of non-covered services. An example form is posted on the Provider Web Portal.

Cultural Competency

Cultural Competency is the measure of a person or organization's willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families.

In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender and/or ethnic groups and accommodating the patient's culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Envolve Dental is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of Ambetter's Cultural Competency Program, providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members' primary language, race and/or ethnicity as it relates to the members' health or illness

- Office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order assist the member in accurately identifying their race or ethnicity
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on health care
- Office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area
- An appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.
- Ambetter considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:
    - Denying a member a covered service or availability of a facility
    - Providing an Ambetter member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

Americans with Disabilities Act (ADA)

Ambetter strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

The term "disability" means, with respect to an individual:

- A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- A record of such an impairment; or
- Being regarded as having such an impairment.

An individual meets any one of these three tests, he or she is considered to be an individual with a disability for purposes of coverage under the ADA.

General Requirements

General prohibitions against discrimination.

- No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability:
    - Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
    - Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
    - Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
    - Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
    - Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
    - Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;
    - Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Ambetter, or opportunity enjoyed by others receiving the aid, benefit, or service.
- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
    - That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
    - That have the purpose or effect of defeating or
    - substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
    - That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.
- A public entity may not, in determining the site or location of a facility, make selections:
    - That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

    - That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
    - Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
    - A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
        - Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
        - Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
    - A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

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 below.

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.
Protect against threats or disclosures	Potential threats or disclosures to e-PHI that are *reasonably anticipated* must be identified and protected.	All email correspondence that includes patient name and personal health details must be sent via a secure email service. *Providers should never initiate to Envolve Dental an email that is not encrypted and contains patient details.* Envolve Dental can initiate a secure, encrypted email to providers who can then reply while maintaining the security of the email. Call Provider Customer Service for details.

HIPAA Definitions and Applications		
Security Rule Requirement	Definition	Application Example
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 and Review

The Envolve Dental Utilization Management program is designed to ensure members receive access to the right dental care at the right place and right time.

Envolve Dental seeks to optimize a member's oral health status and access to quality dental care, while at the same time actively managing cost trends. The program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

The treating dental provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The dental provider, in consultation with Envolve Dental's Dental Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established criteria.

Envolve Dental Affirmative Statement

Envolve Dental does not reward practitioners, providers, or employees who perform utilization reviews for issuing denials of coverage or care. UM's decision-making is based only on appropriateness of care, service, and existence of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. Utilization denials are based on lack of medical necessity or lack of covered benefit.

Envolve Dental has utilization and claims management systems in place in order to identify, track, and monitor the care provided and to ensure appropriate care is provided to the members.

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. Generalist 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.

Medical Necessity

The fact that a dental provider may prescribe, authorize, or direct a service does not itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a member or provider within 30 days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Envolve Dental clinical staff. Determinations will be made utilizing guidelines based care, appropriate UM policies, and by applying clinical judgment and experience. Dental policies are developed through periodic review of generally accepted standards of dental practice and updated at least on an annual basis.

Medically necessary services are generally accepted oral healthcare practices provided in light of conditions present at the time of treatment. These include services which are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate, and cost-effective setting give the nature of the diagnosis and severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the "Grievance Process" section of the provider manual. All such determinations must be made by qualified and trained dental care providers.

Prior Authorization

As noted in Appendix A of this manual, the 2021 Ambetter dental benefits do not require authorization prior to the service.

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Envolve Dental considers all 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 refer to the clinical criteria section in the benefit grid appendix that substantiates the criteria. Providers should measure intended services to the clinical criteria before treatment begins to assure appropriateness of care.

Fraud, Waste and Abuse

Envolve Dental is dedicated to upholding integrity in the healthcare system. Most individuals working in government-supported insurance products 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, waste and abuse. The Centers for Medicare and Medicaid 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:

- The insurer 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 ID card.

Waste: Providing medically unnecessary services.

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;
- Misusing codes on a claim, such as upcoding or unbundling codes.

The primary difference between fraud and abuse is intention.

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

Fraud, Waste and Abuse Hotlines

Envolve Dental Hotline: 800-345-1642

Fraud, Waste, and Abuse Hotline for all Ambetter health plans: 866-685-866

Claims and Billing

General Billing Guidelines

Dental providers contract directly with Envolve Dental for payment of covered services.

It is important that providers ensure Envolve Dental has accurate billing information on file. Envolve Dental will return claims when billing information does not match the information that is currently in our files. Claims missing the required information will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered "clean" and therefore cannot be entered into the system.

We recommend that providers notify Envolve Dental in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's Tax Identification Number (TIN) and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit under the member's contract on the date of service
- Referral processes were followed

Payment for service is contingent upon compliance with referral policies and procedures and eligibility at the time of service as well as the billing guidelines outlined in this manual.

Encounters vs Claims

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. Encounters should be submitted using the following requirements:

- Submit one encounter claim for each unique member visit.
- Submit codes for every procedure performed on the encounter claim to ensure member utilization data is complete.
- Ensure every code includes corresponding tooth numbers, quads, arches, and any other required identifiers.
- Include all documentation requirements for each code.

A claim is a request for reimbursement, either electronically or by paper, for any dental service. A claim must be filed on the proper form, such as a 2012 or later ADA claim form. A claim will be paid or denied with an explanation for the denial.

Clean Claims

A clean claim means a claim received by Envolve Dental for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Envolve Dental.

If Envolve Dental requires additional clean claim elements or changes to clean claim elements or attachments, or if Envolve Dental has an address or telephone number change, Envolve Dental will notify providers in writing, via fax, email, Provider Web Portal bulletin, or mail, at least 60 days in advance of the change.

Non-Clean Claims

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Claims Submission Information

Providers may submit claims electronically or via U.S. mail. Please have all required information ready to insert into the electronic fields or the paper form prior to initiating submission. Do NOT highlight any items on your submission. Electronic attachment options for X-rays, charts, photos and other items are available as described below.

Electronic Claims Submission via Provider Web Portal or Electronic Clearinghouse

Network providers are encouraged to submit claims and encounters electronically through our Provider Web Portal or selected electronic clearinghouses. Providers who bill electronically are responsible for filing claims within the same filing deadlines as the provider's filing paper claims.

Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Provider Web Portal

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 this manual to ensure you include all required information before submitting.

To access the 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 Customer Service or send us an email at: providerrelations@envolvehealth.com.

Electronic Clearinghouse and Attachments

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).

For all clearinghouses, use Envolve Dental payor identification number 46278 for all clearinghouses. 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 NEA system, **complete** the following steps:

1. Navigate to www.nea-fast.com.
2. Install the software.
3. Follow the prompts to scan required documents.
4. Transmit documents to NEA's secure repository.
5. Select Envolve Dental as the payor (ID #46278).
6. Receive an NEA unique tracking number.
7. Include the NEA tracking number in the remarks section of claims submissions to Envolve Dental.

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 800-782-5150.

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.

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 your state-specific Provider Relations.

Paper Claims

The following information must be included on the 2012 or later ADA claim form for timely claims processing:

- Member name
- Member ID number
- Member date of birth

- Provider name
- Provider location and service setting
- Billing location
- NPI and 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 your market-specific address.

Postage due mail will be returned to sender.

Claims Imaging Requirements

Envolve Dental uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct PO Box number
- Do submit all claims in a 9" x 12", or larger envelope
- Do type all fields completely and correctly
- Do use black or blue ink only
- Do submit on a proper form, such as the 2012 or later ADA claim form

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax

Provider Corrected Claims

Providers who receive a claim denial due to incorrect or missing information can submit a "corrected claim" on a 2012 or later ADA claim form within 180 days. Claims are "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 or an incorrect code. To submit a corrected claim, providers must mail the corrected claim as follows:

- Complete the 2012 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" typed on the top of the form, with the original claim number.
- Corrections must be indicated on the 2012 or later 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 your market-specific address.

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

Claims Adjudication, Editing, and Payments

Envolve Dental adjudicates all claims at least 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.

Claims will be adjudicated (finalized as paid or denied) within 30 calendar days from the date of the original submission or electronic claim receipt.

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 clean claims are paid within 10 days of submission. Payments are made to the provider's Electronic Funds Transfer (EFT) account or to a check printer that delivers the paper check and remittance statement by US mail. Please 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.

Call Provider Customer Service with questions about claims and remittances.

Member Co-pays and Co-insurance

All States

In 2021, members enrolled in Ambetter have no co-pays. Basic services have no co-insurance. Comprehensive services require a 50% co-insurance payment. Providers are not permitted to charge members any amount for covered services except the plan-defined co-insurance amount. Covered basic and comprehensive services are listed in Appendix A.

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 Provider Customer Service 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 180 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 the 2012 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 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.
- **Endodontic therapy:** All diagnostic tests, evaluations, radiographs and post-operative treatment are included in the fee.
- **Denture-related services:** All complete and partial 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. Only coinsurance payments mandated by Ambetter are billable to the member.
- **Missed appointment billing:** Providers are not allowed to charge members for missed appointments.

Coordination of Benefits (COB)

Claim submissions for Ambetter members who have benefits with another insurer must be coordinated. 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 180 days of the date of service.
- 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.

Claim Denials

Claims submitted correctly but were denied can be submitted as a "dispute" when submitted to Envolve Dental within 180 days of the Explanation of Payment, 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 a completed 2012 or later ADA claim form and write "Dispute" on

the top of the form. Be sure to include your name, NPI, contact details, and all supporting documentation to:

Arizona
Envolve Dental Appeals
PO Box 20132
Tampa, FL 33622-0132

Arkansas
Envolve Dental Appeals
PO Box 26632
Tampa, FL 33623-6632

Florida
Envolve Dental Appeals
PO Box 20654
Tampa, FL 33622-0654

Georgia
Envolve Dental Appeals
PO Box 22085
Tampa, FL 33622-2085

Illinois
Envolve Dental Appeals:
PO Box 22377
Tampa, FL 33622-2377

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

Kansas
Envolve Dental Appeals
PO Box 25857
Tampa, FL 33622-5857

Michigan
Envolve Dental Appeals
PO Box 20062
Tampa FL 33622-0062

Mississippi
Envolve Dental Appeals
PO Box 25255
Tampa, FL 33622-5255

Missouri
Envolve Dental Appeals
PO Box 20262
Tampa, FL 33622-0262

Nevada
Envolve Dental Appeals
PO Box 26564
Tampa, FL 33622-6564

New Hampshire
Envolve Dental Appeals
PO Box 20062
Tampa FL 33622-0062

North Carolina
Envolve Dental Appeals
PO Box 20654
Tampa FL 33622-0654

Ohio
Envolve Dental Appeals
PO Box 22687
Tampa, FL 33622-2687

Pennsylvania
Envolve Dental Appeals
PO Box 26631
Tampa, FL 33623-6631

South Carolina
Envolve Dental Appeals
PO Box 26632
Tampa, FL 33623-6632

Tennessee
Envolve Dental Appeals
PO Box 20654
Tampa FL 33622-0654

Texas
Envolve Dental Appeals
PO Box 26564
Tampa, FL 33622-6564

Quality Management

Mission Statement

The Quality Improvement Program provides an effective, system-wide, measurable plan for monitoring, evaluating and improving the quality of care and services in a cost-effective and efficient manner for our members.

Vision Statement

The vision of our Quality Improvement Program is to improve the quality of care and services provided to our members and to therefore improve the oral health of our community, one member at a time, which contributes to the improved overall health of individuals. To this end, our aim is to produce better oral health outcomes at lower costs for our members while enhancing the patient experience and lowering the total cost of care.

Purpose of the Quality Improvement Program

Envolve Dental is committed to the provision of a well-designed and well-implemented Quality Improvement Program. This describes the Quality Improvement process as it relates to the coordination, safe delivery, and evaluation of high quality, cost-effective routine and medical dental care required by payors for their covered members. Envolve Dental continuously strives to maintain a quality dental care program that assures patients' access to routine and medical dental care services while ensuring the continuity of care that patients receive and utilizes provider oversight in assuring the quality and appropriateness of these services. This is measured through routine medical record reviews, potential quality of care reviews, grievance reviews and member/provider surveys. This collective information is tracked and analyzed to identify opportunities for improvement.

The Quality Improvement Program utilizes a systematic approach to quality using reliable and qualitative methods of monitoring, analysis, evaluation and improvement in the delivery of high quality dental services to all members, including those with special needs. This proven approach to quality improvement provides a continuous cycle for assessing the quality of care and service among Envolve Dental's initiatives of all routine and medical dental care services provided. Additionally, the Quality Improvement Program serves to assure the timely identification, assessment and resolution of known or suspected deficiencies in the quality of care or services received by members and to prevent their reoccurrence by continuous monitoring, evaluation and improvement of the routine and medical dental care services provided.

In order to fulfill its responsibility to members, the community, key stakeholders and regulatory/accreditation agencies, Envolve Dental's Board of Directors (BOD) has adopted the

following Quality Improvement Program Description. The Program Description is reviewed and approved at least annually by the Quality Improvement Committee (QIC) and BOD.

Scope

Envolve Dental's Quality Improvement Program extends to all internal departments and business partners in the recognition that teamwork, collaboration and sharing of activities and outcomes are critical for successful quality improvement. Departmental leaders are charged with developing and overseeing quality improvement activities aimed at optimal care, services and organizational efficiency within their respective departments as well as coordinating interdepartmental quality improvement activities when applicable. This is accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative services. Envolve Dental's Quality Improvement Program consists of components to monitor, analyze, and evaluate contract/industry standards and processes to improve the following:

- Continuity and coordination of care
- Member and provider complaint/grievance system
    - Member and provider satisfaction
- Quality management
- Timeliness and clinical appropriateness of care
    - Provider appointment accessibility/availability
    - Available member scheduling for urgent care within 24 hours
    - Available member scheduling for routine/preventative dental appointments within 30 days of request, unless member requested otherwise
    - Available member scheduling of non-urgent/sick appointments within 14 days, unless member requests otherwise
- Provider network adequacy and capacity
    - Network performance
- Patient safety
- Credentialing and re-credentialing of practitioners and providers
    - Compliance with state, federal, and professional standards and guidelines. Providers should be able to produce documentation of compliance at the request of Envolve Dental.
- Utilization management, including under and over-utilization
- Denials and administrative reviews

A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program may include, but are not limited to:

- Measuring, monitoring, trending and analyzing the quality of patient care delivery against performance goals and/or recognized benchmarks

- Fostering continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement
- Evaluating the effectiveness of implemented changes to the Quality Program
- Reducing or minimizing opportunities for adverse impacts to members
- Improving efficiency, cost effectiveness, value and productivity in the delivery of services
- Evaluating the delivery of appropriate dental care according to professionally recognized standards
- Evaluating that written policies and procedures are established and maintained the ensure that quality dental care is provided to the members
- Quality Improvement Projects

Goals and Objectives of the Quality Improvement Program

Quality Improvement goals include but are not limited to the following:

- Provide and build quality into all aspects of Envolve Dental's organizational structure and processes and continuously strive for improvement in the delivery of care and patient safety to all members
- Provide a formal process for the continuous and systematic monitoring, evaluation, intervention for improvement, and reassessment of the adequacy and appropriateness of clinical and administrative services provided by Envolve Dental to members, practitioners, and other internal and external customers
- Develop appropriate quality guidelines and standards for implementation by the QI Committee and subcommittees, departments, and personnel involved in quality issues including providers and their staff
- Plan services will meet industry-accepted standards of performance
- Facilitate culturally sensitive and linguistically appropriate services
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across organization functional areas
- Continuously assess the overall effectiveness of the guidelines and standards in all levels of service and care with appropriate measurements
- Take corrective action when quality guidelines and standards are not followed or met
- Make best efforts to adapt and modify guidelines and standards, at least annually, in accordance with the most recent state and federal regulations (including HIPAA) and the most up-to-date clinical/medical studies and practice guidelines
- Support a high level of satisfaction as it pertains to the services provided by Envolve Dental to members, providers and clients

Quality Improvement objectives include but are not limited to the following:

- To establish and maintain a health system that promotes continuous quality improvement, which includes fostering long-term relationships with our provider network that are built

on trust and collaboration to ensure consistent improvements in the quality and cost effectiveness of care and services delivered to members

- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time
- To allocate personnel and resources necessary to:
- Support the Quality Improvement Program, including data analysis and reporting
- Meet the educational needs of providers and staff relevant to quality improvement efforts
- To seek input and work with providers and community resources to improve quality of care
- To oversee peer review procedures that will address deviations in medical management and healthcare practices and devise action plans to improve services
- Maintain National Committee for Quality Assurance (NCQA) accreditation
- Monitor for compliance with regulatory and NCQA requirements
- Monitor marketing practices

All information related to the Quality Improvement process is considered confidential. All Quality Improvement data and information, inclusive of but not limited to, minutes, reports, letters, correspondence and reviews, are housed in a designated, secured area. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

Complaint and Grievance Process

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 the Ambetter plan's member grievances and appeals protocol and leads the Ambetter plan's dental provider appeals process. Table 2 summarizes the definitions and actions for each, and a more detailed narrative follows.

Distinguishing Grievances and Appeals		
	Providers	**Members**
Grievances/ Complaints	A verbal, mailed, or emailed expression of dissatisfaction with a policy, procedure, administrative function, or proposed Action*, submitted to Envolve Dental. Must be filed within 30 days of the incident. Can be filed on the member's behalf when the member appoints the provider to be his/her representative.	Any expression of dissatisfaction about any matter *other than an action*.* Can be filed verbally or in writing to Ambetter. Contact should be made as soon as possible after the incident. Members should follow up calls in writing to support the grievance.
Appeal	A request for denied claim review, submitted in writing to Envolve Dental. For claims, first submit a claim dispute within 180 days. If the result is unfavorable, then an appeal can be filed.	A request for "Notice of Adverse Action"* review, submitted verbally or in writing to Ambetter.
State Fair Hearing Appeal	Not available through the Health Insurance Marketplace.	Not available through the Health Insurance Marketplace.
State Insurance Department	Not available through the Health Insurance Marketplace.	Members may request an independent external review for appeals not resolved to the member's satisfaction.
*An "action" or "Notice of Adverse Action" occurs when a provider receives a denied claim or prior authorization is denied.		

Provider Complaint and Appeal Procedures

Differences may develop between Envolve Dental and a network dentist concerning 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.

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. Providers have 30 calendar days from the date of the incident to file a complaint/grievance.

An *appeal* is the mechanism for providers to request a reconsideration of actions by Envolve Dental, such as a denial of a claim dispute or if the provider is aggrieved by any rule, policy or decision made by Envolve Dental. Verbal appeals must be followed up with a written appeal. Envolve Dental will confirm receipt of the appeal within 10 business days, and will indicate if any additional information is required to consider the appeal request.

Call or write with complaints or appeals to:

Arizona
Envolve Dental Appeals
PO Box 20132
Tampa, FL 33622-0132

Arkansas
Envolve Dental Appeals
PO Box 26632
Tampa, FL 33623-6632

Florida
Envolve Dental Appeals
PO Box 20654
Tampa, FL 33622-0654

Georgia
Envolve Dental Appeals
PO Box 22085
Tampa, FL 33622-2085

Illinois
Envolve Dental Appeals:
PO Box 22377
Tampa, FL 33622-2377

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

Kansas
Envolve Dental Appeals
PO Box 25857
Tampa, FL 33622-5857

Michigan
Envolve Dental Appeals
PO Box 20062
Tampa FL 33622-0062

Mississippi
Envolve Dental Appeals
PO Box 25255
Tampa, FL 33622-5255

Missouri
Envolve Dental Appeals
PO Box 20262
Tampa, FL 33622-0262

Nevada
Envolve Dental Appeals
PO Box 26564
Tampa, FL 33622-6564

New Hampshire
Envolve Dental Appeals
PO Box 20062
Tampa FL 33622-0062
Tampa, FL 33622-2687

North Carolina
Envolve Dental Appeals
PO Box 20654
Tampa FL 33622-0654

Ohio
Envolve Dental Appeals
PO Box 22687

Pennsylvania
Envolve Dental Appeals
PO Box 26631
Tampa, FL 33623-6631

South Carolina
Envolve Dental Appeals
PO Box 26632
Tampa, FL 33623-6632

Tennessee
Envolve Dental Appeals
PO Box 20654
Tampa FL 33622-0654

Texas
Envolve Dental Appeals
PO Box 26564
Tampa, FL 33622-6564

Envolve Dental will resolve each appeal and provide written notification of the decision within 30 calendar days of receiving the appeal. The written decision will include:

- The Envolve Dental decision

- The date of the decision
- For appeal decisions not in favor of the member, information about pursuing an external review.

For claim disputes, Envolve Dental will notify providers within 30 days of the result when the denial is upheld, or via EOP if the denial is overturned. Providers who are not satisfied with the Envolve Dental decision have the option to pursue a complaint with Ambetter's Appeals and Grievance Departement.

Member Grievance and Appeal Procedures

Member Grievances

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

Members or their designated representatives should file a grievance with Ambetter about their dental or medical care as soon as possible after the event causing dissatisfaction occurred. Envolve Dental will support Ambetter's Grievances and Appeal Coordinator with information gathering that can assist in formulating a response to the member.

Member grievances should be directed to:

Arizona 888-926-5057	**Kansas** 844-518-9505	**North Carolina** 833-863-1310
Arkansas 877-617-0390	**Michigan** 833-993-2426	**Ohio** 877-941-9236
Florida 877-687-1169	**Mississippi** 877-687-1187	**Pennsylvania** 833-510-4727
Georgia 877-687-1180	**Missouri** 855-650-3789	**South Carolina** 833-270-5443
Illinois 855-745-5507	**Nevada** 866-263-8134	**Tennessee** 833-709-4735
Indiana 800-743-3333	**New Hampshire** 844-265-1278	**Texas** 877-687-1196

Appeals

Instructions on how to file an appeal are included on the letter a member receives containing the decision. Members can also contact their Ambetter health plan's Member Services department for assistance.

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, standard appeal resolution time limits apply.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires. Within 72 hours of receiving the request (one business day in Mississippi), 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. Expedited determinations will not exceed 72 hours from the date of receipt. Envolve Dental will follow up verbal determinations with a written notice to the requesting provider within three calendar days.

Benefit Summary

Benefit Descriptions

Plan Eligibility

Ambetter offers dental benefits through Envolve Dental providers for people age 19 and over who are eligible for and enrolled in a plan with dental add-on coverage. All members with the dental add-on product have benefits classified as "Basic" (Class 1), "Comprehensive" (Class 2) or "Comprehensive" (Class 3) benefits, which includes crowns and dentures.

Dental Benefits

Ambetter provides "basic" dental services with no member co-pays or co-insurance: periodic exams, teeth cleaning, fluoride treatment, radiographs, and palliative (emergency) treatment of dental pain (minor procedure). In addition, the following "comprehensive" services are covered with a 50% co-insurance per service: limited tooth restorations and endodontic services, extractions, periodontal scaling and root planing, and denture adjustments and repairs. Providers can bill members for co-insurance amounts on the date of service.

Members have a $1,000 benefit limit for all dental services per calendar year. Specific covered codes are listed 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.

Appendix A: Ambetter Covered Dental Benefits

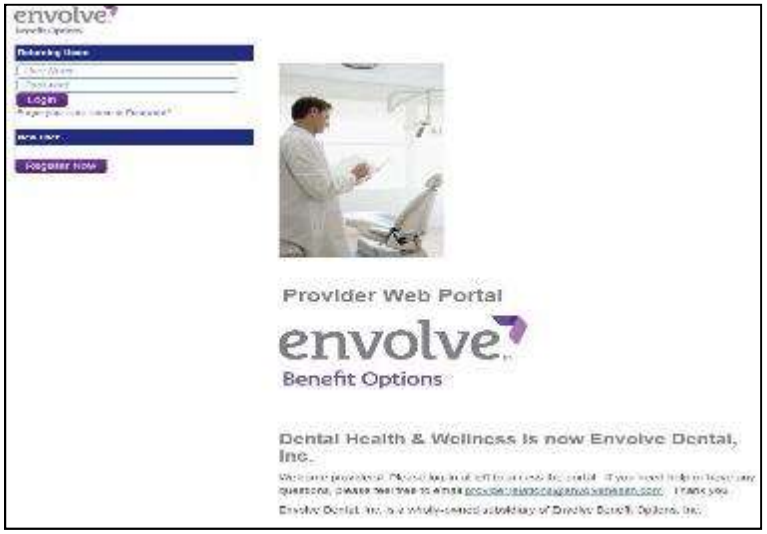
Ambetter Dental Benefits

For the most current covered dental benefit codes and details, including clinical criteria, please refer to the Appendix A, 2021 Ambetter Covered Dental Benefits, posted separately on the Provider Web Portal.

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:

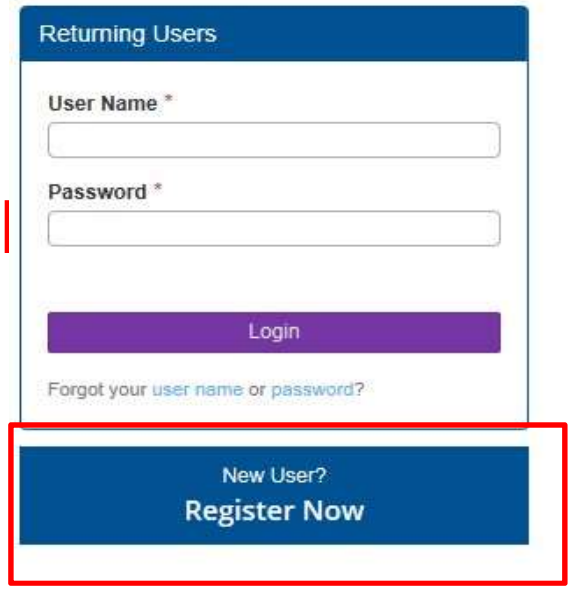
- Verify member eligibility
- Check patient treatment history
- Set up office appointment schedules, automatically verifying eligibility and prepopulating claim forms for online submission
- Submit claims and authorizations by simply entering procedure codes, relevant tooth numbers, etc.
- Send electronic 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

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 Customer Service to obtain a unique Payee ID Number. Provider Customer Service will verify your identity to ensure registration is completed and accessed only by an authorized user.

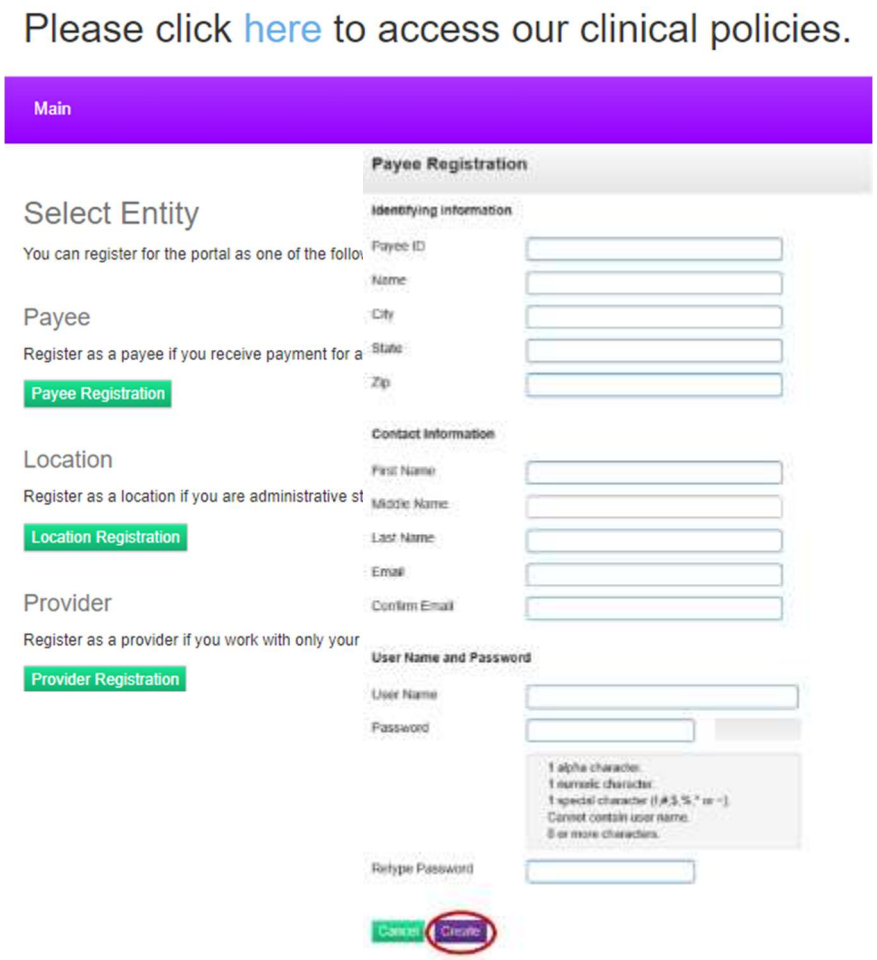
To register, complete the following steps:

1. Visit the Provider Web Portal (PWP) at: https://pwp.envolvedental.com.
2. Click **Register Now.**
3. Call Provider Customer Service Monday through Friday, 8:00 a.m. to 5:00 p.m. local-time to obtain your Payee ID Number.



4. On the **User Registration** pop-up screen, select **Payee Registration**.
5. Add the Payee ID number from Provider Customer Service.
6. Verify spelling/punctuation of Name, City, State and Zip.
7. Fill in details in every field. Remember your user name and password for future use.
8. Click **Submit**.

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



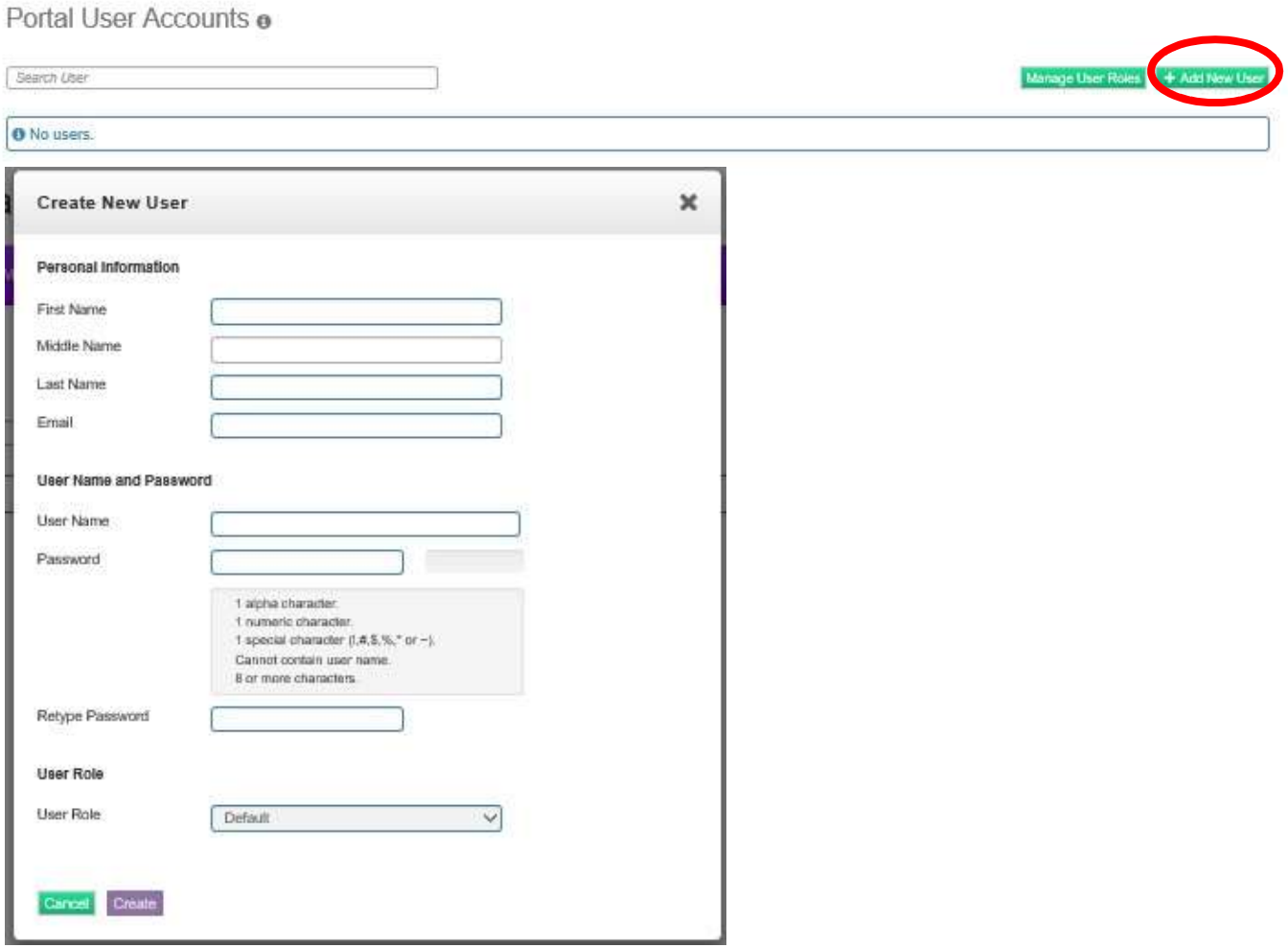
Subaccounts

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, complete the following:

1. Log in to your Payee account.
2. From the Setup tab, click **Portal User Accounts**.
3. Select **Add New User**.
4. Complete all fields and click **Create**.
5. Select **Manage User Roles** to create/edit portal features for additional user roles.



User Account Security

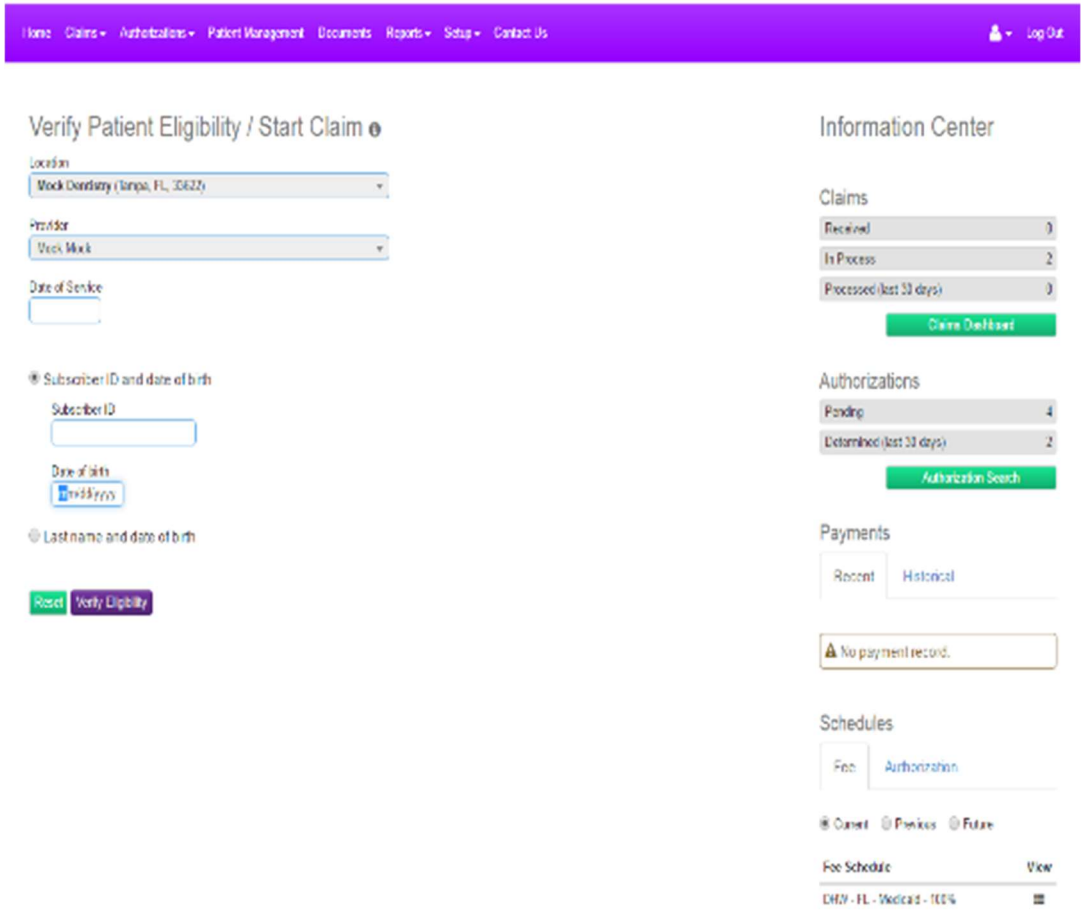
Master accounts can be manually locked and unlocked by a Provider Customer Service Representative. If a master account is locked accidentally—for example, if the master account user enters an invalid password too many times, or if the password expires—the master account holder must call Provider Customer Service 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. Provider Customer Service cannot unlock subaccounts.

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.



Eligibility Verification

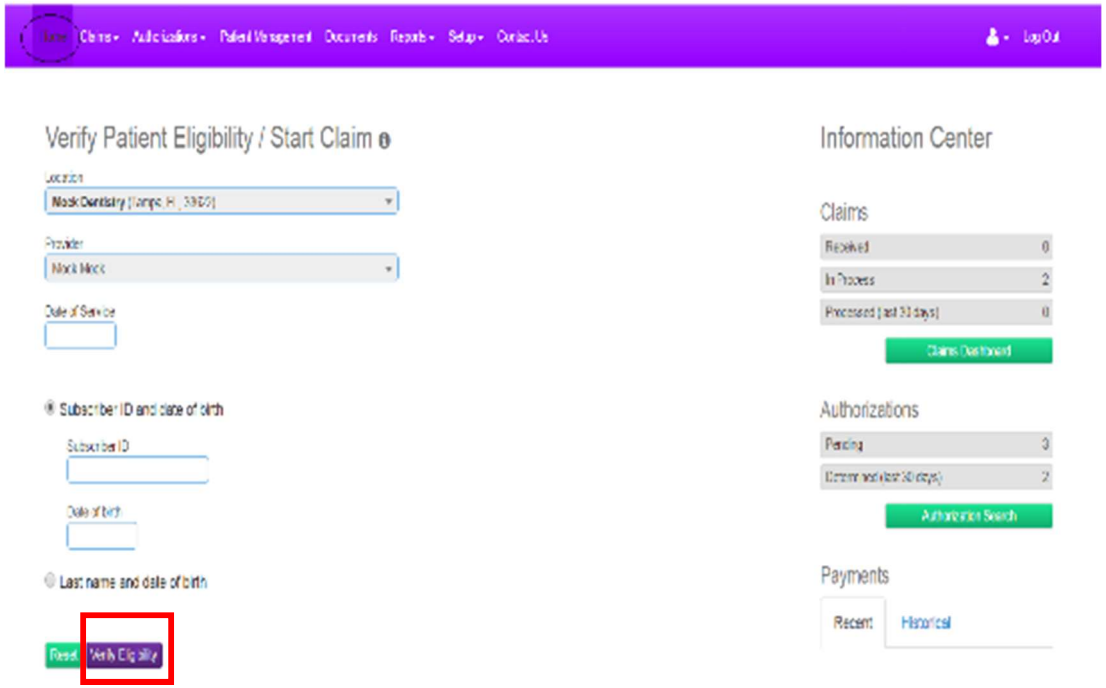
Complete the following to confirm a patient's benefit coverage and eligibility for service on a specific date:

1. Click the **Home** tab.

2. From the Verify Patient Eligibility drop-downs, select the 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.

NOTE: When verifying 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 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

Lawrence Bicuspid

1 Floss Way
Tampa FL 33603

Provider Information

Mock Mock
Mock Dentistry
12345 Mock Ln
Tampa, FL 33622

Insurer Information

Dental Health & Wellness, Inc. - Florida
FL - MMA/CW Medicaid

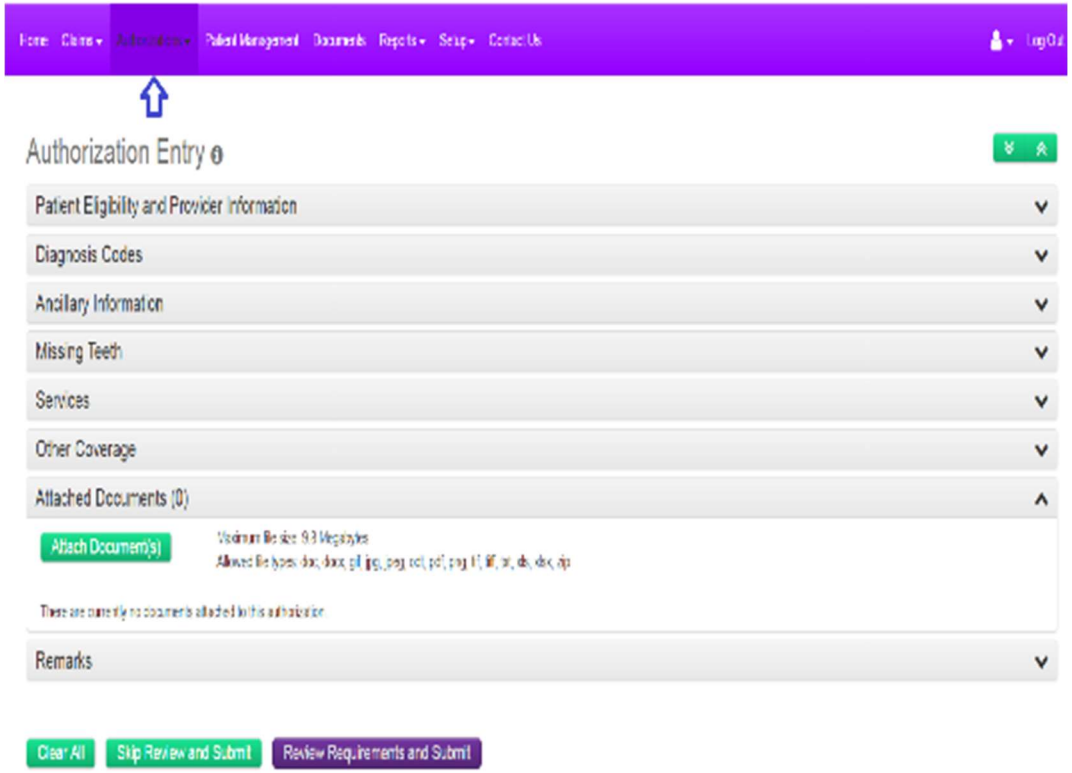
Eligibility Details

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

Authorization Entry & Submission

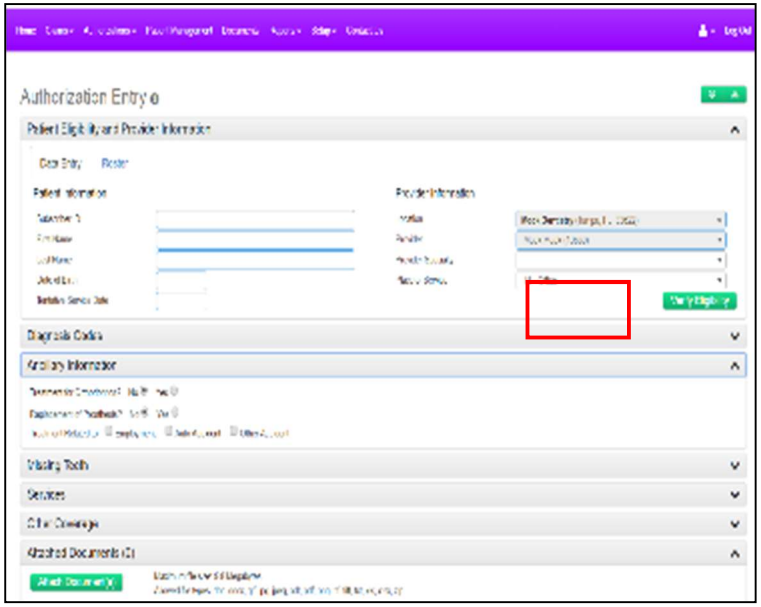
Use the Authorization tab for the following:

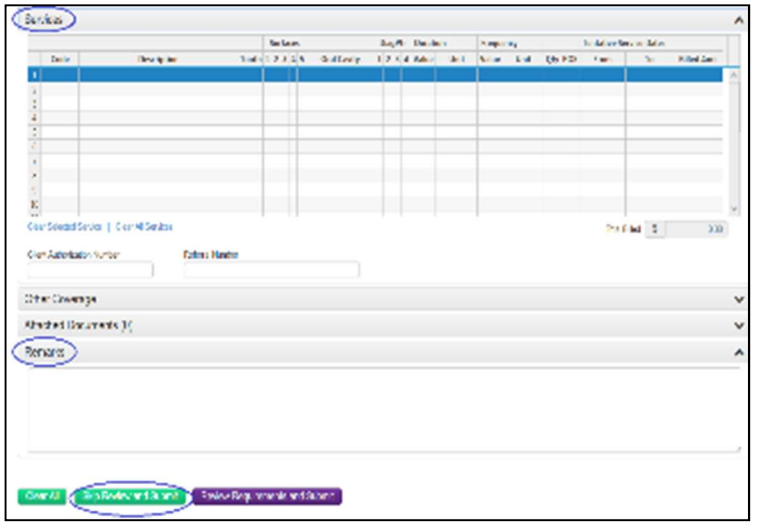
- Submit authorization requests via the Provider Web Portal.
- Track authorization review status and determinations, as well as historical records for all authorizations processed.
- Provide applicable narratives and attach any required documentation using the Authorization Entry functionality.



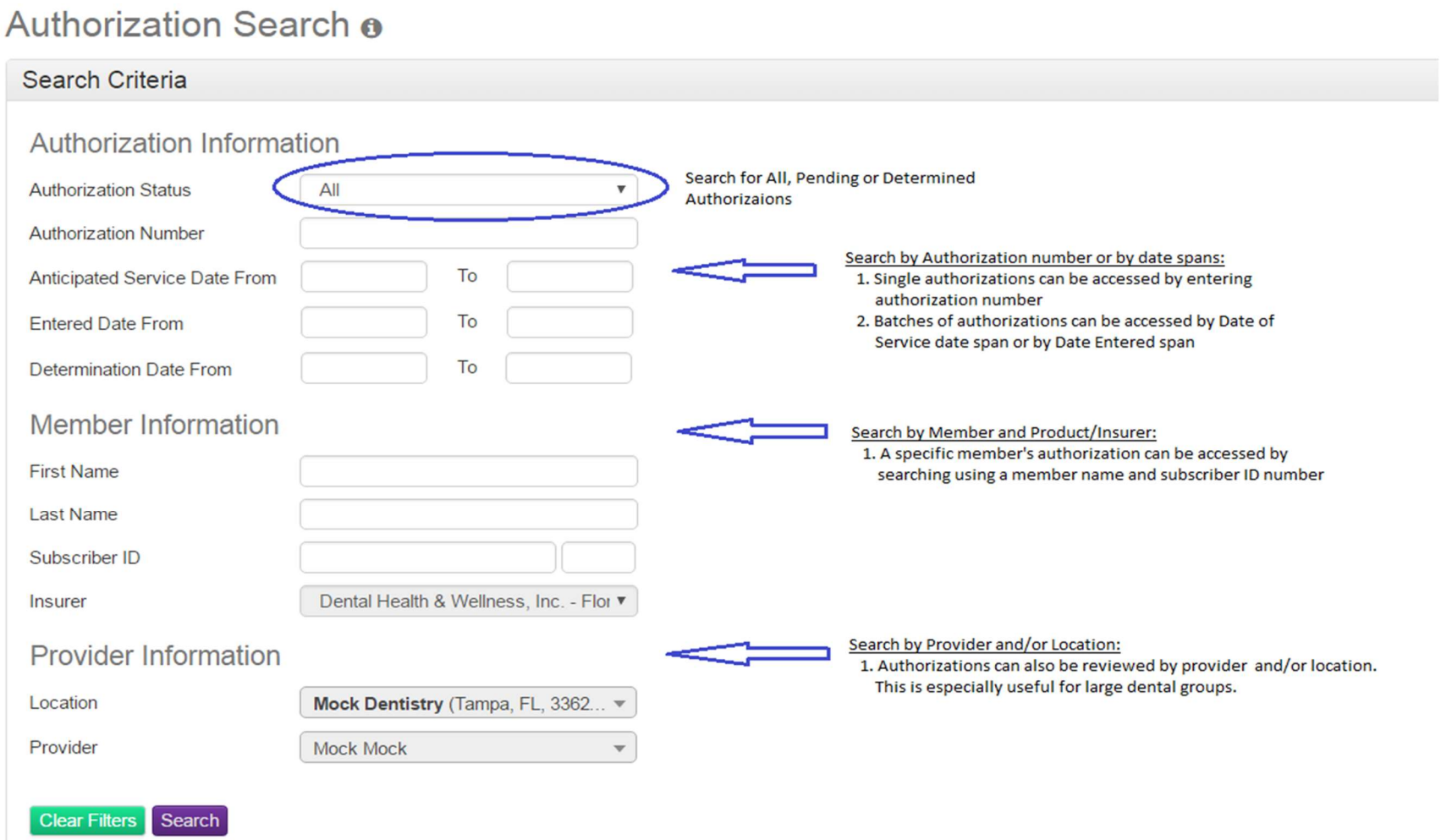
To submit an authorization, complete the following steps:

1. Click the Authorizations tab.
2. From the Data Entry tab, enter member ID and date of birth.
3. Select the location and provider from the drop-down menus.
4. Click **Verify eligibility** to confirm member's coverage.
5. Use the check boxes inside the "Ancillary Authorization Information drop-down menu to notate service details, e.g., orthodontic treatment, accident-related, etc.
6. On the **Services** drop-down, enter specific procedures by line, including tooth/surface/area information as required, projected date of service, quantity, and the billed rate.
7. Click on the **Remarks** drop-down to add additional narratives, including an NEA number for attachment identification or other pertinent details.
8. After submission data is entered, click the **Skip Review and Submit** button.
9. A pop-up window will open confirming that you want to submit the authorization.





Authorization Status

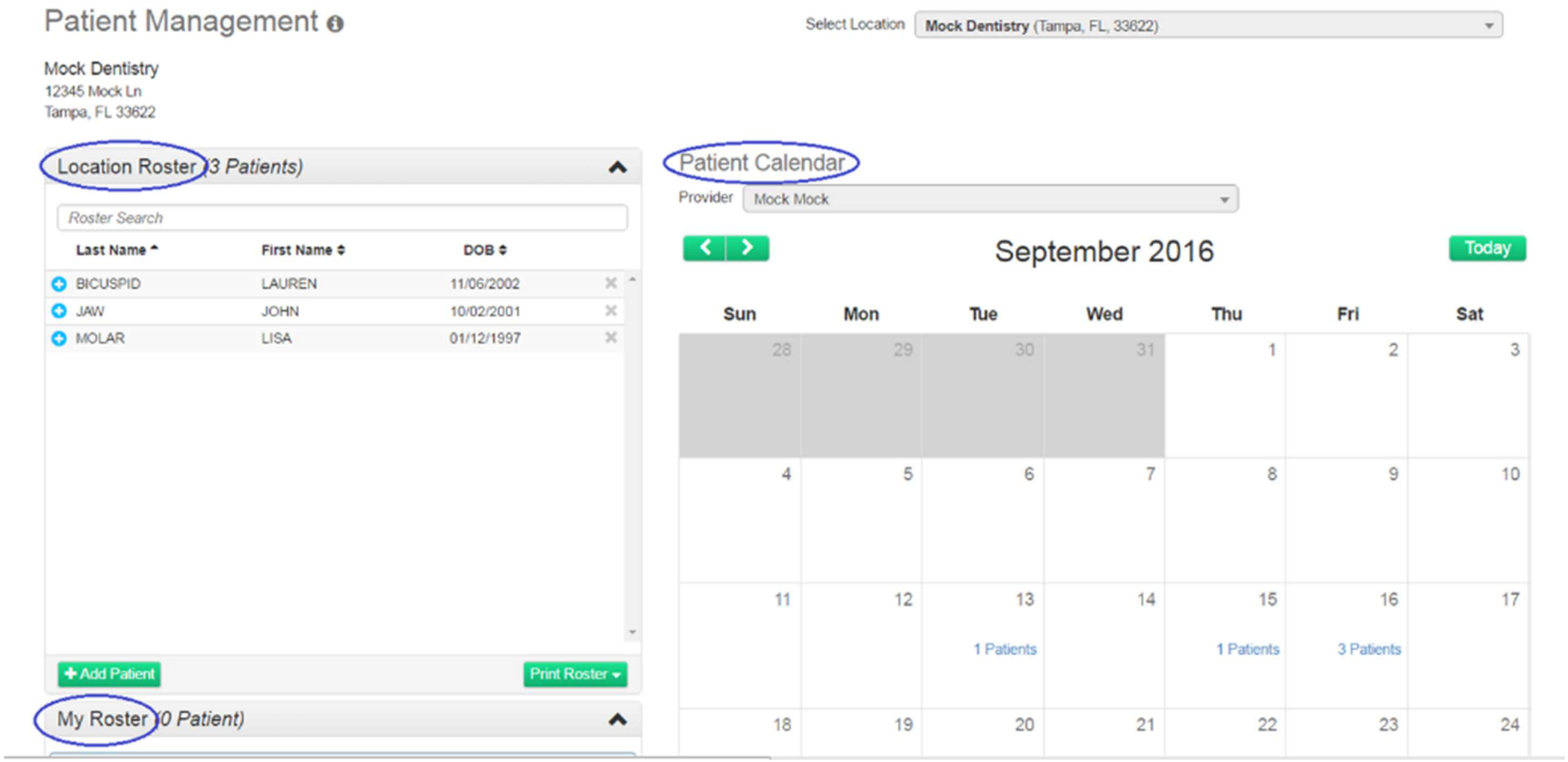


- Searches can be made for **open**, **processed**, or **all** authorizations.
- Batches of authorizations can be searched for using a variety of criteria:
    - Date span – search by tentative date of service span or date entered span
    - Member – search by using a member's name and member ID to review 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

To manage roster, complete the following:

1. Open the **Patient Management** tab.
2. From the Location Roster and My Roster drop-down, select patient name.
3. Rosters can be created by day in order to manage a daily patient schedule.

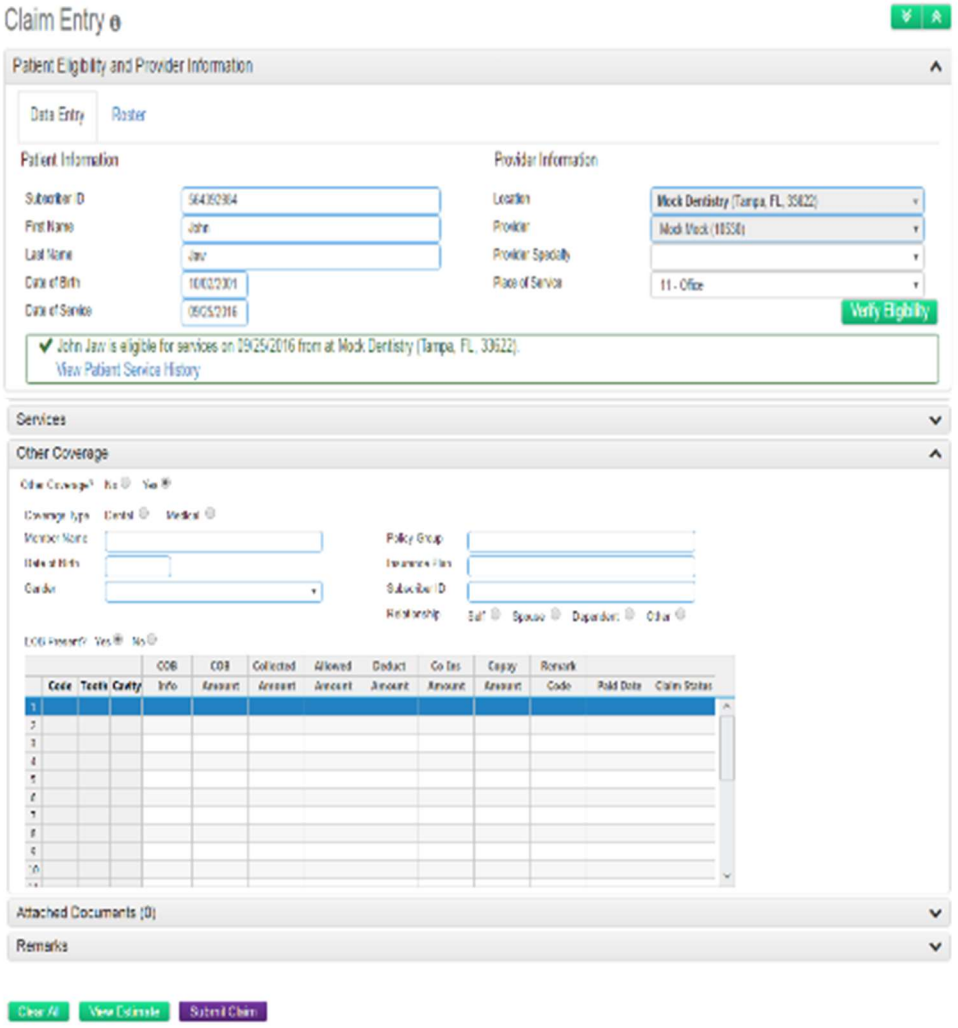


Claim Entry & Submission

To enter and submit claims, complete the following:

NOTE: Provide applicable narratives and attach required documentation.

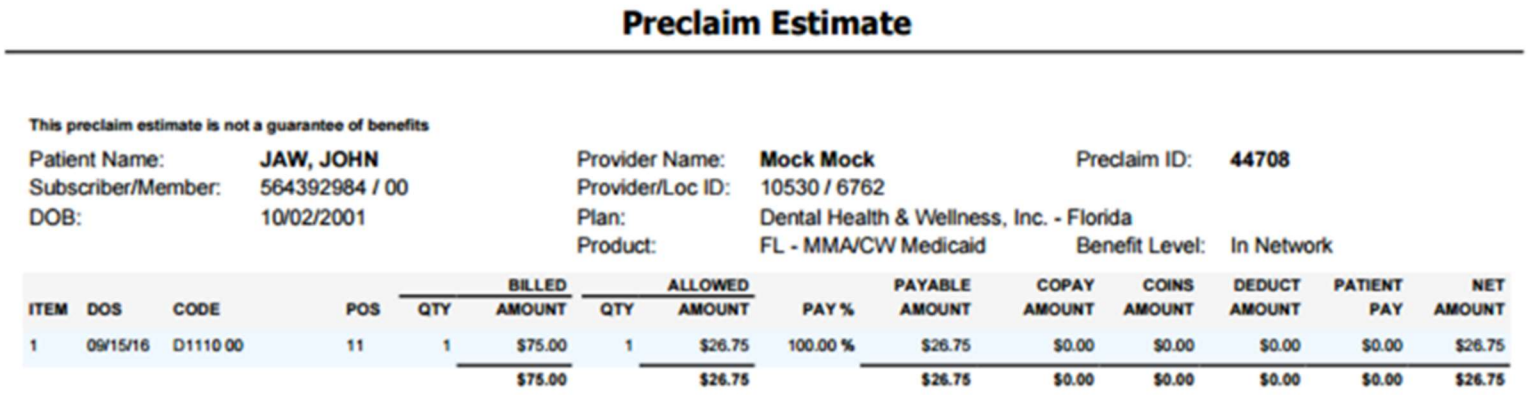
1. Click the **Claims** tab on the upper navigation bar and select **Submit Claim**.
2. Enter member's ID, date of birth, location and provider from the drop-down menu.
3. Click **Verify Eligibility** to check patient coverage. The field will turn green if the patient is covered and red if not covered.
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.
   a. 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.
6. Use the check boxes inside the "Ancillary Claim Information" box to notate service details such as orthodontic treatment or 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** drop-down to add any additional narratives, such as NEA numbers or other pertinent details.
9. Click the **Attachments** drop-down to attach x-rays or other documents that are required for payment.



Pre-Claim Estimate – Remaining Dental Benefit Amount

An important feature is the pre-claim estimate pop-up window, available on the claim entry tab. After all fields above have been entered, 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

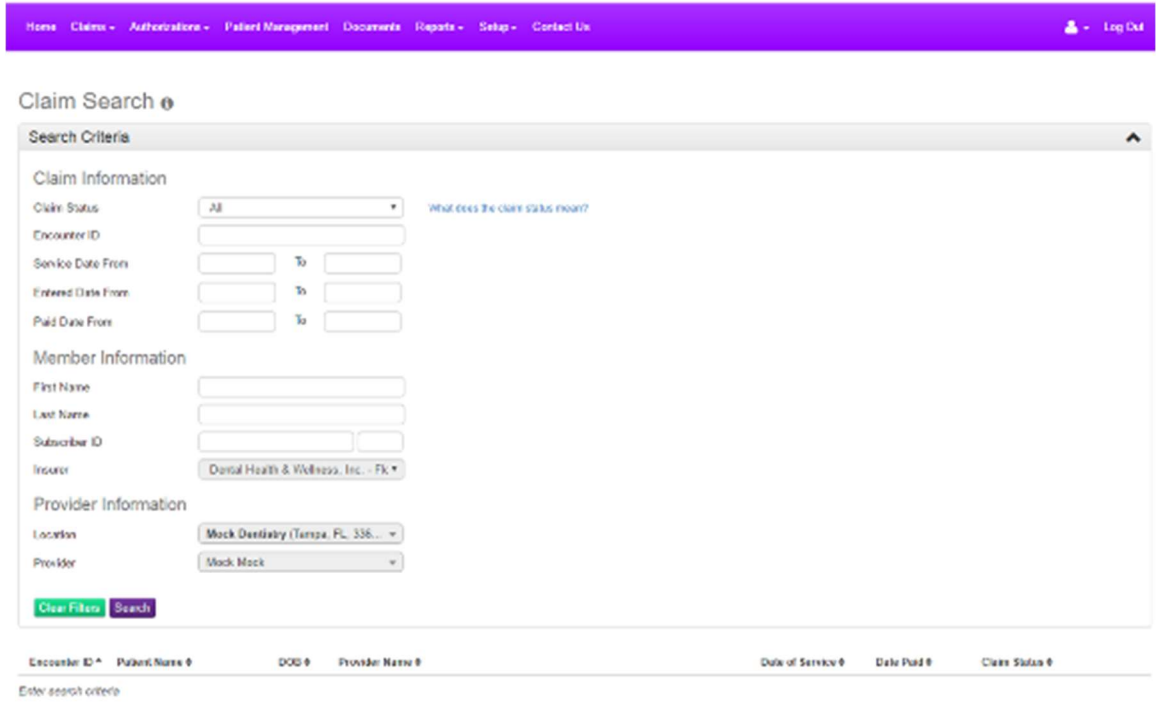
Patient Name:	**JAW, JOHN**	Provider Name:	**Mock Mock**	Preclaim ID:	**44708**
Subscriber/Member:	564392984 / 00	Provider/Loc ID:	10530 / 6762		
DOB:	10/02/2001	Plan:	Dental Health & Wellness, Inc. - Florida		
		Product:	FL - MMA/CW Medicaid	Benefit Level:	In Network

					BILLED		ALLOWED		PAYABLE	COPAY	COINS	DEDUCT	PATIENT	NET
ITEM	DOS	CODE	POS	QTY	AMOUNT	QTY	AMOUNT	PAY %	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.

- From the Claim Search screen, 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, 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

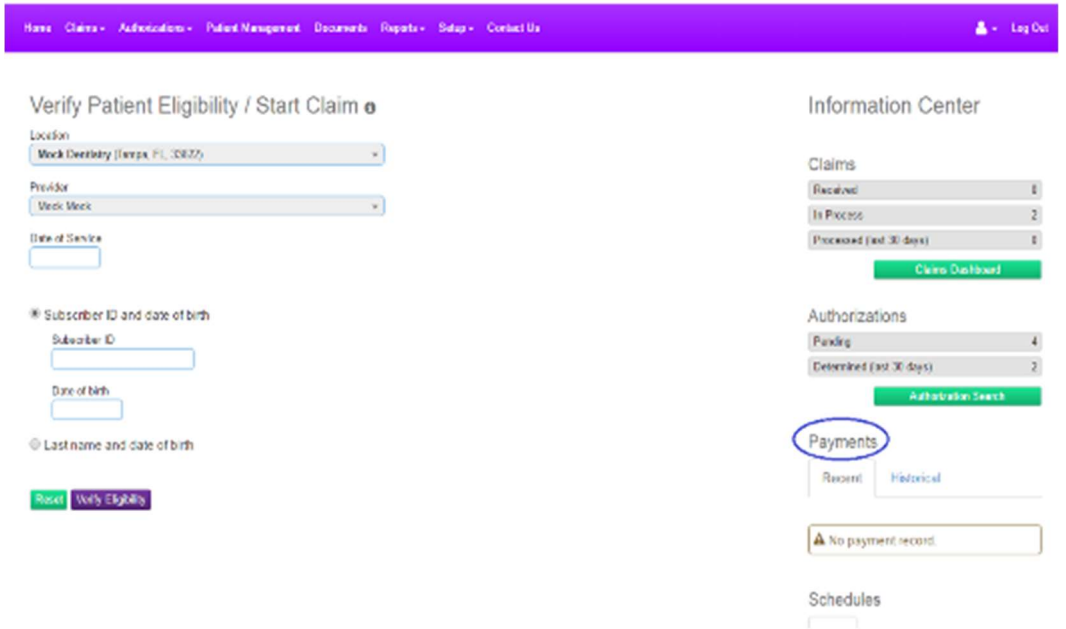


Electronic Funds Transfer

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 on the Provider Web Portal) 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.

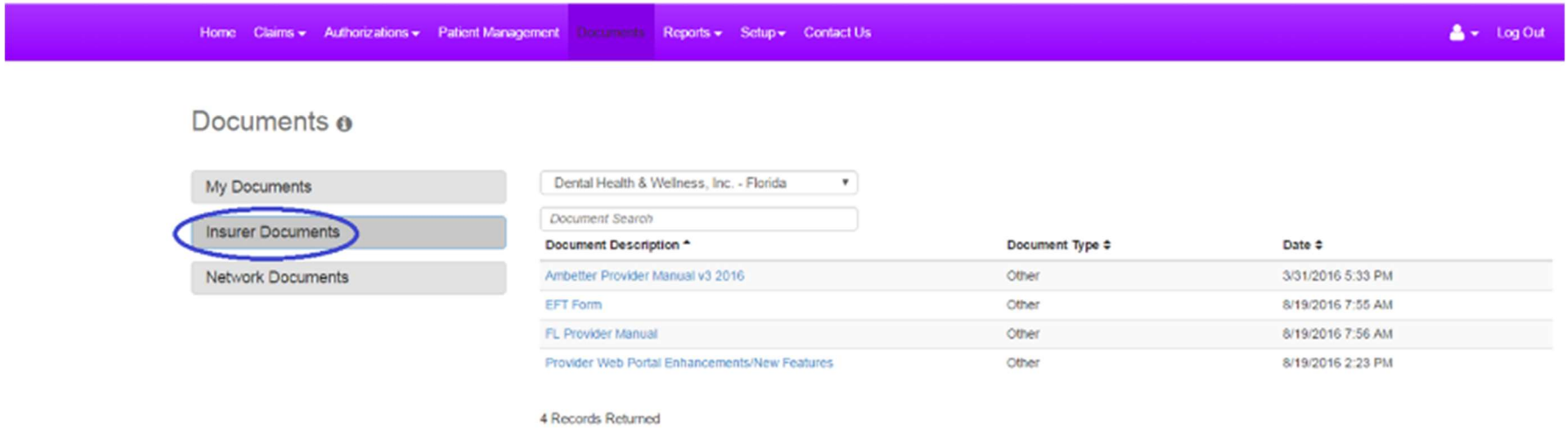
To view online remittances, complete the following:

1. Open the **Documents** tab.
2. Select **My Documents**.
3. Select the applicable remittance statement date.



Documents

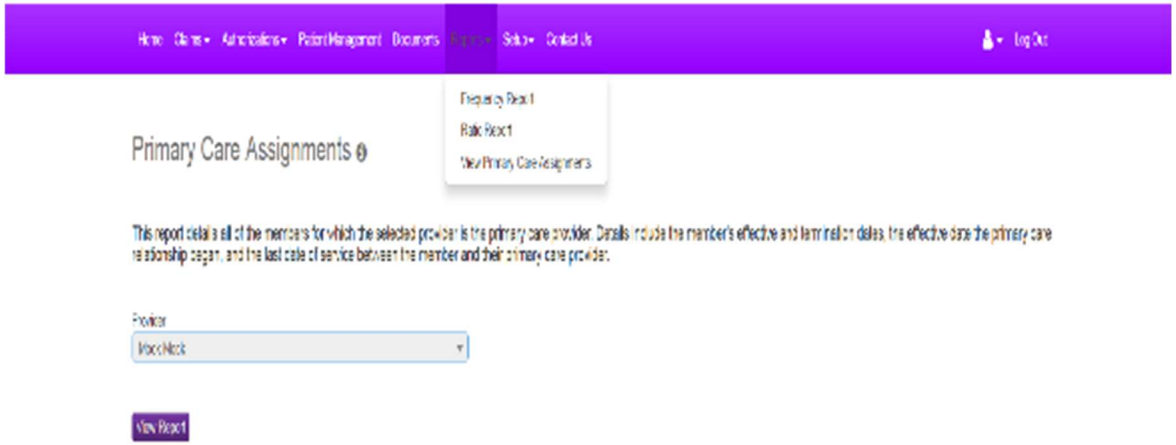
From the **Insurer Documents** tab, view a copy of the Envolve Dental Provider Manual.



Primary Care Provider Assignments

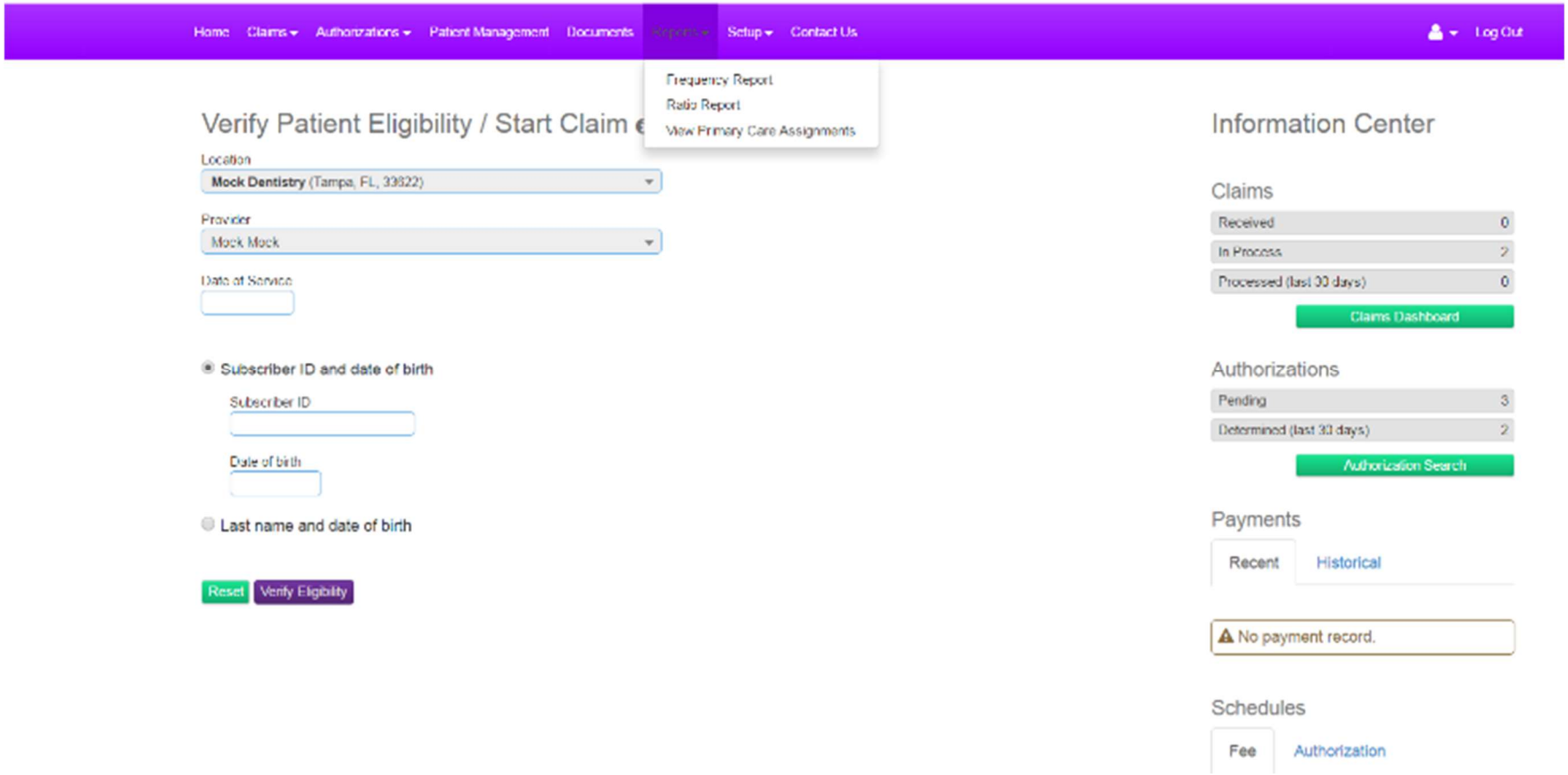
Some health plans require membership assignments to a Primary Care Provider/Dentist.

1. From the **Reports** tab, select **View Primary Care Assignments**.
2. From the drop-down menu, select the provider name.
3 . Click the **View Report** button. A roster of all members assigned to that provider is displayed in a report format.



Frequency and Ratios Reports

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



If you have questions about the Envolve Dental Provider Web Portal, contact Provider Customer Service for assistance.

Envolve Dental Ambetter Provider Manual