Dental Provider Supplement
July 2026

AmeriHealth Caritas Pennsylvania

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Introduction

About AmeriHealth Caritas Pennsylvania – Who we are

AmeriHealth Caritas Pennsylvania, part of the AmeriHealth Caritas Family of Companies is headquartered in Harrisburg and serves Medical Assistance recipients in all counties of the Lehigh/Capital, Northeast, Northwest, and Soutwest Health Choices zones. We are committed to delivering quality care that enables our Members to live safe and healthy lives and to receive services in the community, preserve consumer choice, and be allowed to have active voices in the services they receive.

Our Mission

We Help People:

Get Care

Stay Well

Build Healthy Communities

Our Values

Our service is built on these values:

Advocacy

Care of the Poor

Compassion

Competence

Dignity

Diversity

Hospitality

Stewardship

Welcome to the AmeriHealth Caritas Pennsylvania (hereafter referred to as "the Plan") Dental Provider Network!

The information contained in this Dental Provider Supplement is in addition to the information contained in the Plan's Provider Manual and is intended to apply only to Dental Providers and to the Plan's Dental Program. This Dental Provider Supplement includes information on the Plan's Dental Program that may not be otherwise included in the Plan's Provider Manual.

Single point of contact

To ensure timely, accurate Provider reimbursement and high-quality services, this Plan assigns a dedicated Dental Account Executive. Dental Account Executives are responsible for building relationships with the office managers at each Provider location. This proven approach fosters teamwork and cooperation, which results in a shared focus on improving service, Member participation, and program results.

Support for Members

To further reduce costs for Providers while promoting satisfaction, the Plan offers support with appointment scheduling for Members. Providers may also refer Members with health-related concerns to the Plan to address any questions they may have. This highly successful program reduces administrative costs for dentists and routinely sends satisfied, eligible Members directly to Provider practice locations.

Consistent, transparent authorization determination logic

The Plan's trained Dental Program Team Members use clinical algorithms, which can be customized to ensure a consistent approach for making Utilization Management (UM) determinations. These algorithms are available to Providers through a Provider Services Website so dentists can follow the decision matrix and understand the logic behind UM decisions. In addition, the Plan fosters a sense of partnership by encouraging Providers to offer feedback about the algorithms. A consistent, well-understood approach to UM determinations promotes clarity and transparency for Providers, which in turn reduces Provider administrative costs.

Technology Tools

The Plan takes advantage of technology tools to increase speed and efficiency and keeps program administration and Provider participation costs as low as possible.

Provider Portal – **https://providers.dentaquest.com**. The Plan provides access to a website that contains the full complement of online Provider resources. The website features an online Provider inquiry tool for real-time eligibility, Claims status and authorization status. In addition, the Provider Portal provides helpful information such as required forms, Provider newsletter, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines and other information to assist Providers in working with the Plan.

The Provider Portal may be accessed at **https://providers.dentaquest.com**. The Plan's Provider Services website allows Network Providers direct access to multiple online services. Utilization of the online services offered through the Provider Portal lowers program administration and participation costs for Providers.

To access the site, enter a valid user ID and password. From your preferred internet browser, Providers and authorized office staff can log in for secured access anytime from anywhere, and handle a variety of day-to-day tasks.

Feedback

At the Plan, feedback from both Members and Providers is encouraged, logged, and acted upon when appropriate. To measure Provider and Member satisfaction, and to gather valuable feedback for its quality improvement initiatives, the Plan makes surveys available from its websites and through telephone calls. In addition, to help foster a sense of teamwork and cooperation, the Plan invites feedback from Providers about the UM algorithms by direct communication with the Plan's Dental Director which can be facilitated through your Account Executive.

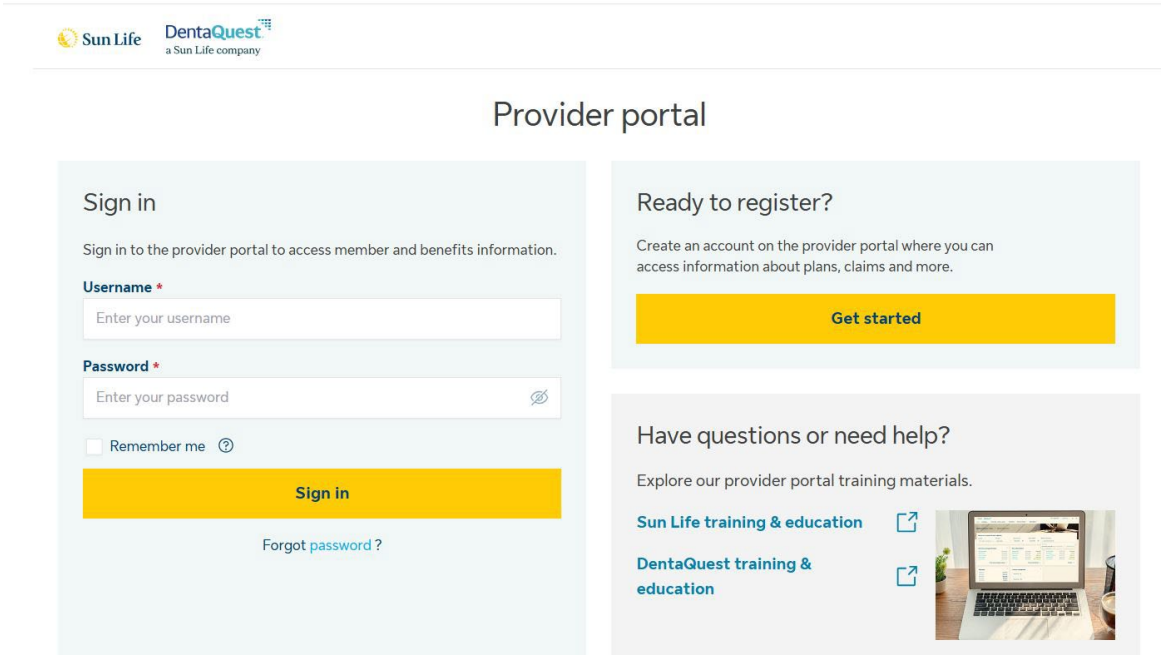
Provider Web Portal Registration and Introduction

TheDentaQuest's Provider Web Portal allows us to maintain our commitment to help you keep your office costs low, access information efficiently, get paid quicker and to submit Claims and Prior Authorization requests electronically along with the many other features listed here:

- Submit claims and authorizations
- Check member eligibility status (For additional information, please refer to the Accessing Member Eligibility Information section.)
- View up-to-date payment information
- Upload necessary documentation
- Review claims status
- Check benefits
- Message DentaQuest through secure messaging

To submit claims via the portal, simply log on to **www.dentaquest.com**. Once you have entered the website, click on "Providers". From there choose your State and press "View state page". You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. The Provider Portal also allows you to attach electronic files (such as X-rays in jpeg format, reports, and charts) to the claim.

If you have questions on submitting claims or accessing the portal, please contact Next Gen Provider Portal Support **1-888-308-2026** or via email at **nextgenportalsupportteam@greatdentalplans.com**.



Member Eligibility Verification Procedures and Services to Members

The Plan Member Identification Card

The Plan's Members are issued identification cards regularly. Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if Members have other health insurance.

The Plan Identification Card lists the following information:

- Member's Name
- Identification Number
- Member's Sex and Date of Birth
- State ID Number
- Lab Name
- Co-pays

To see the current Plan Identification Card template, please visit **www.amerihealthcaritaspa.com** → Members → Information for You → Your ID Cards.

Accessing Member Eligibilty Information

Enrolled Network Providers may access Member eligibility information through:

- PROMISe Provider Portal at **https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx**
- Pennsylvania Eligibility Verification System (EVS): **1-800-766-5387**, 24 hours/7 days a week
    - If a Member presents to a Provider's office and states he/she is a Medical Assistance recipient, but does not have a PA Electronic Benefits Transfer (EBT) ACCESS card, eligibility can still be obtained by using the Member's date of birth (DOB) and Social Security number (SS#) when the call is placed to EVS.
    - The plastic "Pennsylvania EBT ACCESS Card" has a magnetic strip designed for swiping through a point-of-sale (POS) device to access eligibility information through EVS.
- The Provider Portal **https://providers.dentaquest.com**
- DentaQuest's Interactive Voice Response (IVR) system eligibility line at: **1-855-343-7401**.
- The Plan's Member Services Department: AmeriHealth Caritas Pennsylvania: **1-888-991-7200**.

The eligibility information received from any of the above sources will be the same information. However, by utilizing the IVR or the website, you can get information 24 hours a day, 7 days a week.

Access to eligibility information via DentaQuest's Dental Providers website

Access to eligibility information via the Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering:

- The Member's Date of birth
- The expected date of service
- The Member's identification number or last name and first initial.

To access the eligibility information via DentaQuest's website, simply log on to the website at **www.dentaquest.com**. Once you have entered the website, click on "Providers". From there choose your 'State" and press "View state page". You will then be able to log in using your password and ID. First time users will have to register by utilizing:

- The Business's NPI or TIN
- State
- ZIP code

Once logged in, select "Eligibility look up" and enter the applicable information for each Member you are inquiring about. You can check on an unlimited number of patients and print off the summary of eligibility given by the system for your records. If you have questions, contact DentaQuest's Customer Service Department at **1-855-343-7401.**

Directions for using the DentaQuest IVR system to verify eligibility:

- Call the DentaQuest IVR system at **1-855-343-7401**.
- After the greeting, stay on the line for English or press 1 for Spanish.
- When prompted, press or say 2 for Eligibility.
- When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number. If you do not have this information, press or say 2.
- When prompted, enter your User ID (previously referred to as Location ID) and the last four digits of your Tax ID number.
- If the Member's ID has numbers and letters in it, press or say 1. When prompted, enter the Member ID. If the Member's ID has only numbers, press or say 2. When prompted, enter the Member ID.

Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another Member, get benefit information, get limited claim history on this Member, or get fax confirmation of this call. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat steps above for each Member.

Access to eligibility information via the Plan's Member Services Department

Call AmeriHealth Caritas Pennsylvania: **1-888-991-7200**.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or website, please contact the Plan's Member Services at **1-888-991-7200**.

Transportation Benefits for Certain Members

Members who need assistance with transportation should contact the Plan's Member Services at **1-888-991-7200.**

The Plan offers TTY service for hearing impaired Members at: **1-800-684-5505**.

Covered Benefits

Dental Benefits for Children under the age of 21

Children under the age of 21 are eligible to receive all Medically Necessary dental services. Members do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network.

Dental services that are covered for children under the age of 21 include, but are not limited to the following, when Medically Necessary:

- IV or Non-IV conscious sedation; nitrous oxide analgesia**
- Orthodontics (braces)* and **
- Initial and periodic oral examinations
- Periodontal services**
- Dental prophylaxis
- Fluoride Treatments
- Silver Diamine Fluoride
- Endodontics**
- Crowns**
- Sealants.
- Dentures**
- Dental surgical procedures**
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

**If braces were put on before the age of 21, AmeriHealth Caritas Pennsylvania will continue to cover services until treatment for braces is complete, or age 23, whichever comes first, as long as the patient remains dental eligible for Medical Assistance and is still a Member of AmeriHealth Caritas Pennsylvania. If the Member changes to another HealthChoices health plan, coverage will be provided by that HealthChoices health plan. If the Member loses dental eligibility, AmeriHealth Caritas Pennsylvania will pay for services through the month that the Member is eligible. If a Member loses eligibility during the course of treatment, you may charge the Member for the remaining term of the treatment after AmeriHealth Caritas Pennsylvania payments cease ONLY IF you obtained a written, signed agreement from the Member prior to the onset of treatment. For case specific clarification, please contact the AmeriHealth Caritas Pennsylvania Dental Director.*

*** Authorization is required and medical necessity must be demonstrated*

Dental Benefits for Adults age 21 and older

See benefit detail grid for procedure codes and eligibility criteria at:

www.amerihealthcaritaspa.com → Providers → Resources → Dental → Provider Resources → Dental Policies.

Members do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network.

The following dental services are covered for adult Members 21 years of age and older:

- IV or Non-IV conscious sedation *
- Initial and periodic oral evaluations**
- Periodontal services* and **
- Dental prophylaxis**
- Endodontics *and**
- Crowns* and **
- Dentures*and **
- Dental surgical procedures*
- Dental emergencies.
- X-rays.
- Extractions (tooth removals).
- Fillings

* Authorization is required and medical necessity must be demonstrated.

** Benefit Limit Exceptions may apply.

Please refer to the Benefit Limit Exception Process section of this manual for complete details. Please call DentaQuest Provider Services at **1-855-343-7401** with questions.

- These benefit limit exceptions do not apply if the Member is under age 21, or if the Member is 21 years of age or older and currently resides in a long-term care facility, or intermediate care facility. These Members are exempt from the benefit limitation exception process. However, all current prior authorization policies, parameters and criteria will remain in place. Determination of Member residency can be checked when verifying Member eligibility either by phone or through the Provider web-portal.

Adult Members may be eligible to receive the following services with an approved Benefit Limit Exception:

- Crowns and related services.
- Root canals and other endodontic services.
- Periodontal services.
- Additional cleanings and exams.
- Replacement dentures

Medically Necessary Dental Services for Members under 21 years of age

Such services require authorization and should be prior authorized (following the existing prior authorization process), whenever possible. Claims should be submitted with supporting documentation such as letters of medical necessity and documentation and/or images to substantiate the need for the services.

Missed Appointments

Enrolled Network Providers are not allowed to charge Members for missed appointments. Please refer to Medical Assistance Bulletin 99-10-14 in the Appendix of the Plan's Provider Manual.

The Plan offers the following suggestions to decrease the number of missed appointments.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment. If a Member exceeds your office policy for missed appointments and you choose to discontinue seeing the Member, please inform them to contact the Plan for a referral to a new dentist. Please refer to your Provider agreement with the Plan regarding your responsibilities in this regard.

Payment for Non-Covered Services

Network Providers shall hold Members or the Plan harmless for the payment of Non-Covered Services except as provided in this paragraph. Provider may bill a Member for Non-Covered Services, if the Provider first submits an authorization request for the service in question, then obtains an agreement in writing from the Member prior to rendering services that indicate:

- The non-covered services to be provided.
- The Plan will not pay for or be liable for said services.
- The Member will be financially liable for such services.

Please refer to the Dental Benefits Grid for a complete list of covered benefits.

Electronic Attachments

FastAttach™ - The Plan accepts dental radiographs electronically via FastAttach™ for Prior Authorization requests and Claims submissions. The Plan in conjunction with National Electronic Attachment, Inc. (NEA) allows Providers the opportunity to submit all Claims electronically, even those that require attachments. This program allows secure transmissions via the Internet lines for radiographs, periodontics charts, intraoral pictures, narratives and EOBs.

For more information, or to sign up for Fast Attach, go to **http://www.vynedental.com/fastattach/** or call NEA at: **1-463-218-9150**.

Prior Authorization, Retrospective Review, and Documentation Requirements

Procedures Requiring Prior Authorization

The Plan has specific dental utilization criteria as well as a Prior Authorization and Retrospective Review process to manage the utilization of services. Consequently, the Plan's operational focus is on assuring compliance with its dental utilization criteria.

Prior Authorizations will be honored for 180 days from the date they are issued. An approval does not guarantee payment. The Member must be eligible for services at the time the services are provided. Claims will be subject to benefit frequency limitations and standard of care guidelines. The Provider should verify eligibility at the time of service.

In order to timely process Prior Authorization requests, appropriate supporting documentation and a fully populated and most recently approved version of the Claim form must be submitted (paper or electronic). Lack of supporting documentation may result in denial of the authorization.

Prior Authorizations may be mailed to:
AmeriHealth Caritas Pennsylvania Health Plan– Prior Authorizations
c/o DentaQuest - Authorizations
P.O. Box 2906
Milwaukee, WI 53201-2906

The basis for granting or denying approval shall be whether the item or service is Medically Necessary. Medically Necessary is defined as follows:

A service, item, procedure, or level of care compensable under the MA program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Retrospective, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member's family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the Member. All such determinations must be made by qualified and trained practitioners.

Please refer to the Authorization Requirements and Benefits Grid in Policy 152.100 for a detailed list of services requiring Authorization at:

www.amerihealthcaritaspa.com → Providers → Resources → Dental → Provider Resources → Dental Policies.

Prior authorization for Hospital/Special Procedure Unit/Ambulatory Surgical Center/ outpatient admission for dental services is required by the Hospital/Special Procedure Unit/Ambulatory Surgical Center when utilizing a Plan participating facility. The dental services associated with the admission are governed by the authorization process. The Prior Authorization process should be followed listing all dental services that will be provided by the requesting dentist. The authorization request should designate the place of service to indicate that outpatient admission for dental services are planned to be performed. Please contact DentaQuest Provider Services (**1-855-343-7401**) with any questions.

Retrospective Review

Services that would normally require a Prior Authorization, but are performed in an emergency situation, will be subject to a Retrospective Review. Claims for Retrospective Review should be submitted to the same address utilized when submitting requests for Prior Authorization, accompanied by any required supporting documentation. Any Claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

Some services require only retrospective review due to the documentation requirement or inability to determine medical necessity pre-operatively. An example of such would be the removal of a benign odontogenic cyst or tumor (D7450/D7451). This procedure requires a pathology report describing the lesion (for determination purposes) and should only be submitted for retro authorization. Please refer to the "Medicaid Clinical Criteria for Prior Authorization of Routine and Emergency Treatment" section for a listing of all procedures and the authorization requirements

Benefit Limit Exception (BLE) Process (Adults age 21 and over)

You can request a benefit limit exception (BLE) for services to be provided to adults 21 and over before the services start or after they are finished. You can ask for a BLE up to 60 days after the dental services are finished. When submitting the BLE request, please limit your request to only those codes requiring BLE on the dated or undated claim form.

The Plan will consider benefit limit exceptions to the dental benefits when one of the following criteria is met:

- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member; or
- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the Member; or
- Granting a specific exception is a cost-effective alternative for the Plan; or
- Granting an exception is necessary in order to comply with federal law.

Please note that clinical criteria must still bemet for all approved BLEs.

The BLE Request Process:

You must send a completed Benefit Limit Exception Request Form AND an approved ADA Claim form by mail or electronically:

Mail:
AmeriHealth Caritas Pennsylvania Prior Authorizations
c/o DentaQuest - Authorizations
P.O. Box 2906
Milwaukee, WI 53201-2906

Include the following information:

- Member's name, address and ID number.
- The dental service that is needed (code(s) and description).
- The reason the exception is needed.
- Supporting diagnostic documentation required for the clinical authorization

- Supporting documentation from the Member's primary care or specialty care physician.
- Dentist's name and phone number.

If the dental BLE request identifies that the beneficiary has one of the conditions set forth below, as part of the dental BLE review process, the Plan will review the Member's Claim history to determine if the condition was previously identified on a Claim:

1. Diabetes.
2. Coronary Artery Disease or risk factors for the disease.
3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin).
4. Intellectual Disability.
5. Current Pregnancy including post-partum period.

If the condition was previously identified on a Medical Claim, the plan will not require supporting medical record documentation of the condition. If the condition was not previously identified on a Medical Claim, the plan will notify the dental Provider that supporting medical record documentation is needed to review the BLE request. The ADA claim, the supporting medical record documentation of the condition (from the Member's physician) if the condition was not previously identified by the Plan on a Medical Claim, and any additional information requested, must be submitted to the plan within 15 days of the date of the plan's request to the dental Provider. Upon receipt of the ADA claim, medical record documentation or additional information, the Plan will review the request for a dental BLE to confirm that one of the criteria for the granting of a BLE is met along with established clinical criteria. The dental Provider and Member will be informed of the Plan's determination by written Notice of Decision. If conditions for consideration of a BLE are met clinical criteria will be reviewed prior to a determination of an approval or denial of services.

You can obtain a Benefit Limit Exception Request Form on-line at: **https://providers.dentaquest.com** or **www.amerihealthcaritaspa.com** → Provider → Resources → Dental program or by calling DentaQuest Provider Services at: **1-855-343-7401**.

You can view our Dental Benefit Limitation Policy 152.101 at:

www.amerihealthcaritaspa.com → Providers → Resources → Dental → Provider Resources → Dental Policies.

Consistent with 55 Pa. Code 1101.31(f)(2)(viii), the Provider may not bill the Plan Member for payment for services rendered in excess of the dental benefit limits unless:

- The Provider informs the Member in writing before the service is rendered that the service requires a BLE and the Member is liable for the payment if the services associated with the request for a benefit limit exception are denied and;
- The Provider requests a benefit limit exception and the Plan denies the request.

Note: Please only include BLE eligible codes on requests for benefit limit exceptions. Refer to the Benefit Grid for BLE eligible codes.

The Exception Process

AmeriHealth Caritas Pennsylvania, under extraordinary circumstances, will consider payment for services for which the Medical Assistance Program has no established fees, or will expand the limits

for services or items that are listed on the Medical Assistance Program fee schedule (but ordinarily do not require a BLE form) through the appeals process. If a provider concludes that an additional or more frequent service, lack of service, or item would impair the Member's health, a benefited service will not suffice and feels the service meets standard of care criteria, the provider should include such information when requesting reconsideration.

Claims Submission Procedures

The Plan receives dental Claims in four possible formats. These formats include:

- Electronic Claims via DentaQuest's Provider Portal(https://providers.dentaquest.com)
- Electronic submission via clearinghouses.
- HIPAA Complaint 837D or 837P file
- Paper Claims via U.S. Postal Service or Fax **1-262-834-3589**

Electronic Claim Submission Utilizing DentaQuest's Provider Portal

Participating Providers may submit claims directly to DentaQuest by utilizing the Provider Portal. Submitting claims via the Provider Portal is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the portal, simply log on to **https://providers.dentaquest.com.** You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's:

- NPI or TIN
- State
- Zip Code

If you are experiencing difficulty logging in or for questions regarding DentaQuest's Provider Portal, contact DentaQuest's Provider Portal Support at **1-888-308-2026**. The Provider Portal allows you to attach electronic files (such as X-rays in jpeg format, reports, and charts) to the claim.

Electronic Claim Submission via Clearinghouse

Dentists may submit their Claims to the Plan via a clearinghouse such as DentalXChange.

You can contact your software vendor and make certain that they have the Plan listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted Claims are forwarded to the Plan.

The Plan's Payer ID is "CX014." DentalXChange will ensure that by utilizing this unique payer ID, Claims will be submitted successfully to the Plan.

For more information on DentalXChange, please refer to their website at:
http://www.dentalxchange.com

Electronic Claim Submission via HIPAA Compliant 837D or 837P File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA

compliant 837D or 837P file from the Provider's practice management system. Providers are advised to email **EDITeam@greatdentalplans.com** to inquire about this option for electronic claim submission.

Paper Claim Submissions

Claims must be submitted on the most current ADA claim form or other forms approved in advance by the Plan. Please reference the ADA Website for the most current Claim form and completion instructions. Forms are available through the American Dental Association at:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746

The Member's name, identification number, and date of birth must be listed on all Claims submitted. If the Member's identification number is missing or miscoded on the Claim form, the Member cannot be identified. This could result in the Claim being returned to the submitting Provider office, causing a delay in payment.

All information must be legible and contained within the appropriate boxes to allow for authorizations and claims to be scanned into our system for processing.

Please include contracted fees or UCR charges on all authorization requests and claims for all services to ensure at least your contracted fees are reimbursed. Our plan must reimburse the lesser of contracted fees and billed charges. If a claim is processed at a lower rate than those contracted due to an error with submitted charges, the claim must be voided and resubmitted for accurate reimbursement.

The Provider and office location information must be clearly identified on the Claim. To ensure proper Claim processing, the Claim form must include the following:

- Member name
- Member DOB
- Member ID #
- Provider name
- Tax ID #
- NPI
- Payee location
- Treating location

The date of service must be provided on the Claim form for each service line submitted.

Approved ADA dental codes as published in the Current Dental Terminology (CDT) book or as defined in this Manual must be used to define all services.

Providers must list all arches, quadrants, tooth numbers, and surfaces for dental codes that necessitate identification (i.e., fillings, scaling and root planning). Missing tooth and surface identification codes can result in the delay or denial of a Claim payment.

Affix the proper postage when mailing bulk documentation. The Plan does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

AmeriHealth Caritas Pennsylvania Health Plan– Claims
c/o DentaQuest - Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

Claims that have been previously paid, and need adjustment should be mailed to the following address:

AmeriHealth Caritas Pennsylvania Corrected Claims
c/o DentaQuest Corrected Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

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

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

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

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

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

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION (alll dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) | 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

SAMPLE

©2024 American Dental Association
J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

To reorder call 800.947.4746
or go online at ADAstore.org

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

COORDINATION OF BENEFITS (COB)

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

DIAGNOSIS CODING

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

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

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

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

The full list is available online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

PROVIDER SPECIALTY

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

Category / Description	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223X0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:
https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

SAMPLE

Timely Filing Limits

The Provider understands that failure to submit Claims (and any required documentation) within 180 days from the date of service may result in loss of reimbursement for services provided. Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB. Providers must submit a copy of the primary insurer's EOB. The Plan determines whether a Claim has been filed timely by comparing the date of service to the receipt date applied to the Claim when the Claim is received. If the span between these two dates exceeds the time limitation, the Claim is considered to have not been filed timely.

Coordination of Benefits (COB)

When the Plan is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the Claim. For electronic Claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds the Provider's contracted fee schedule with the Plan, the Plan will consider the Claim paid in full and no further payment will be made on the Claim. The Member may not be billed for any outstanding balance.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan (TPL does not affect the Member's Medicaid eligibility. Members can report TPL to AmeriHealth Caritas Pennsylvania Member Services at **1-888-991-7200**). COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. A Medicaid HMO, such as the Plan, is always the payer of last resort. This means that Claims must be submitted and processed by all other insurance carriers (the "Primary Insurers") before a Claim is submitted to the Plan. Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the Timely Filing Limits section above.

Reimbursement for Members with Third Party Resources

Medicare as a Third-Party Resource

For Medicare services that are covered by the Plan, the Plan will pay, up to the Plan's contracted rate, the lesser of:

- The difference between the Plan's contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment.

In any event, the total combined payment made by Medicare and the Plan, will not exceed the Plan's contracted rate.

Continuation of Care

The Plan provides continuing coverage of care for Members who are engaged in an ongoing course of treatment with a non-participating Practitioner or Provider to promote continuity of care. Please reach out to your Account Executive for non- orthodontic continuation of care.

The process for the continuation of orthodontic coverage can be found at **www.amerihealthcaritaspa.com** → Provider → Resources → Dental program. Please reach out to your AmeriHealth Caritas Pennsylvania Dental Account Executive for questions regarding this process.

Commercial Third-Party Resource

For services that have been rendered by a Network Provider, the Plan will pay, up to the Plan's contracted rate, the lesser of:

- The difference between the Plan's contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment.

In any event, the total combined payment made by the Primary Insurer and the Plan will not exceed the Plan's contracted rate.

Health Care Providers must comply with all applicable Plan referral and prior authorization requirements.

Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each dentist, the Plan performs an edit of all Claims upon receipt. This edit validates Member eligibility, procedure codes, and Provider identifying information. A Dental Reimbursement Analyst dedicated to the Plan's dental offices analyzes any Claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact the DentaQuest Provider Services Department at: **1-855-343-7401** with any questions you may have regarding Claim submission or your remittance.

Each Enrolled Network Provider office receives an "Explanation of Benefit" report with their remittance. This report includes Member information and an allowable fee by date of service for each service rendered during the period.

Dentist Appeal Procedures

Providers have the opportunity to request resolution of claim Disputes with DentaQuest at the following address:

AmeriHealth Caritas Pennsylvania – Appeals
c/o DentaQuest - Appeals
P.O. Box 2906
Milwaukee, WI 53201-2906

or request an Appeal on behalf of a Member for authorization/claim denilas through submission to the internal Plan department at the following address:

Member Appeals Department
Attention: Member Advocate
AmeriHealth Caritas Pennsylvania
200 Stevens Drive
Philadelphia, PA 19113-1570
Fax number: 1-215-937-5367

Submissions must be in writing and should be accompanied by any necessary additional documentation (and in the case of authorization appeals be accompanied by a signed Member consent form to file the appeal on the Member's behalf) within 60 days of the date of the explanation of benefit indicating Claim/Authorization denial.

Refer to the Provider Manual section on "Provider Dispute/Appeal Procedures" for complete and detailed information.

Health Insurance Portability and Accountability Act (HIPAA) and Fraud, Waste and Abuse

As a healthcare Provider, you are a "Covered Entity" under HIPAA, and you are therefore required to comply with the applicable provisions of HIPAA and its implementing regulations.

In regard to the Administrative Simplification Standards, you will note that the benefit tables included in this Dental Provider Manual reflect the most current coding standards recognized by the ADA. Effective the date of this manual, the Plan will require Providers to submit all Claims with the proper CDT codes listed in this manual. In addition, all paper Claims must be submitted on a current approved ADA Claim form.

Note: Copies of the Plan's HIPAA policies are available upon request by contacting: DentaQuest's Provider Service Department at: **1-855-343-7401**

For complete detailed information regarding the Plan's HIPAA policies refer to "Compliance with the HIPAA Privacy Regulations" section in the Provider Manual.

Fraud, Waste & Abuse

Under the HealthChoices program, the Plan receives state and federal funding for payment of services provided to our Members. In accepting Claims payment from the Plans, Health Care Providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud, Waste or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to **www.pacode.com/secure/data/055/partIIItoc.html** for more information regarding Fraud Waste or Abuse, including "Provider Prohibited Acts" that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

We are dedicated to eradicating Fraud, Waste and Abuse from our programs and cooperate in Fraud, Waste and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Section of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the HHS Office of Inspector General, as well as the Bureau of Program Integrity of DHS. As part of our responsibilities, the Payment Integrity department is responsible for identifying and recovering Claims overpayments. This department performs several operational activities to detect and prevent fraudulent, wasteful and/or abusive activities. We expect our dental partners to share this same commitment and conduct their businesses similarly, and report suspected noncompliance, Fraud, Waste or Abuse.

Examples of fraudulent/wasteful/abusive activities:

- Billing for services not rendered or not Medically Necessary.
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Prescribing items or referring services which are not Medically Necessary.
- Misrepresenting the services rendered.
- Submitting a Claim for Provider services on behalf of an individual that is unlicensed or has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.
- Failure to perform services required under a capitated contractual arrangement.

Reporting and Preventing Fraud, Waste and Abuse

If you, or any entity with which you contract to provide health care services on behalf of the Plan's beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact us by:

- Calling the toll-free AmeriHealth Caritas Pennsylvania Provider Compliance Hotline at: **1-866-833-9718**,
- E-mailing to **fraudtip@amerihealthcaritas.com**; or,
- Mailing a written statement to Special Investigations Unit:

AmeriHealth Caritas Pennsylvania
P.O. Box 7317
London, KY 40742

Below are examples of information that will assist us with an investigation:

- Contact Information (e.g., name of individual making the allegation, address, telephone number);
- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent, Wasteful or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected Fraud, Waste, and Abuse to the Pennsylvania Department of Human Services through one of the following methods:

Or

Phone:	**1-844-DHS-TIPS** or **1-844-347-8477**
Online:	**https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx**
Fax:	**1-717-214-1200, Attn: OMAP Provider**
Mail:	**Department of Human Services** **Office of Administration** **Bureau of Program Integrity** **P.O. Box 2675** **Harrisburg, PA 17105-2675**

Credentialing

Any Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is interested in participation with the Plan is invited to apply by submitting a credentialing application form for review by the Plan's Credentialing Committee. Providers who seek participation in the Plan's Network must be credentialed prior to participation in the network.

The Plan maintains and adheres to all applicable State and federal laws and regulations, DHS requirements, and accreditation requirements governing credentialing and re-credentialing functions. All applications reviewed by the Plan must satisfy these requirements, as they apply to dental services, in order to be admitted in the Plan's Provider Network.

The process to be credentialed as a Plan Network Provider is fast and easy. The Plan has entered into an agreement with the Council for Affordable Quality Healthcare (CAQH) to offer our Providers the Universal Provider Data repository that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, you provide credentialing information to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. The Plan's goal is to have all of its Network Providers enrolled with CAQH. There is no charge to Providers to submit applications and participate in CAQH. Please access the credentialing page on **http://www.amerihealthcaritaspa.com/Provider/services/credentialing/index.aspx** and follow the instructions to begin the application process for participation in the Plan's Provider Network.

Refer to the Plan's Provider Manual section on Credentialing and Re-credentialing Requirements for complete and detailed information.

Medical Recordkeeping

The Plan adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Likewise, the Plan expects that every office will provide quality dental services in a cost-effective manner in keeping with the standards of care in the community and dental profession nationwide.

The Plan's expectation is that every Network Provider will submit Claims for services in an accurate and ethical fashion reflecting the appropriate level and scope of services performed, and that Network Providers are compliant with these requirements.

The Plan will periodically conduct random chart audits in order to determine Network Providers' compliance with these conditions and expectation, as a component of the Plan's Quality Management Program. Network Providers are expected to supply, upon request, complete copies of Member dental records. The records are reviewed by the Plan's Dental Director, or his/her designee, such as a Registered Dental Hygienist, to determine the rate of compliance with medical recordkeeping requirements as well as the accuracy of the dental Claims submitted for payment. All dental services performed must be recorded in the patient record, which must be made available as required by your Participating Provider Agreement.

The first part of the audit will consist of the charts being reviewed for compliance with the stated record keeping requirements, utilizing a standardized audit tool. The charts are reviewed and a composite score is determined. Offices with scores above 90% are considered as passing the audit but a letter is sent to them so that they are aware of the areas that need improvement; offices that receive a score of 95% or greater are exempt from the audit the following year. Offices with scores less than 90% will have a corrective action letter sent and are re- reviewed for compliance within the next 120 days. Offices that do not cooperate with improving their scores are subject to disciplinary action in accordance with the Plan's Provider Sanctioning Policy as outlined in the Provider Manual.

The second portion of the audit consists of a billing reconciliation whereby the patient treatment notes and diagnostics are compared to the actual Claims submitted for payment by each dental office. The records are analyzed to determine if the patient record documents the performance of all the dental services that have been submitted for payment. Payment of any services not documented/diagnostics not present are recouped, and the records may be subject to additional review and follow-up by the Plan's Special Investigations Unit.

Results of both parts of the audit are entered into a tracking data base at the Plan and then reported back to each office in a summary of finding format.

The Plan recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using Teeth numbers 51 through 82 for permanent teeth and AS through TS for primary teeth. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 10 years after the end of the termination of the State of client contract.

Refer to the Quality Management, Credentialing and Utilization Management Section of the Provider Manual for more information.

Important Notice for Submitting Paper Authorizations and Claims

All Claims need to be submitted on a current approved ADA form.

All other forms will not be accepted and will result in a rejection of the Claim or Authorization request. Additionally, when making a correction to a previously submitted and paid Claim, please send it clearly marked to:

"Corrected Claims" on a current version of the ADA form to:

AmeriHealth Caritas Pennsylvania Corrected Claim
c/o DentaQuest – Corrected Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

Please contact DentaQuest's Provider Services at **1-855-343-7401** if you have questions. If you are in need of the current forms, please visit the ADA website at www.ada.org for ordering information.

Corrected Claims

Providers may make corrections to incorrectly submitted claims up to 365 days from the day of DentaQuest's receipt of the claim requiring correction.

- The corrected claim must clearly state the word "Corrected" in box 35 along with the claim number of the claim you are correcting.
- The corrected claim must contain clear and accurate corrections to the erroneous information. (A resubmission of identical claims data is not considered a corrected claim. The corrected claim must include additional or different information.)
- Do not resubmit all service lines on a corrected claim. Only resubmit for the service line requiring correction.
- If a claim is resubmitted for correction more than once, each must be submitted within 60 days of the adverse action on the previous submission.

DentaQuest will research the resubmission and adjudicate the corrected claim according to the resubmitted information. Once adjudicated, the corrected claim will appear on the Provider's Explanation of Benefits (EOB) with a corresponding Processing Policy outlining the reason for denial.

Corrected Claim Submission Guidelines

When Should I Submit a Corrected Claim?

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

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

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

What scenarios are subject to the Corrected Claim Process?

A corrected Claim should only be submitted if the original service(s) PAID based on incorrect information. Some examples of correction(s) that need to be made to a prior PAID Claim are:

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

How do I submit a Corrected Claim?

The Plan receives dental Corrected Claims in three possible formats. These formats include:

- Electronic Corrected Claims via DentaQuest's Provider Portal **https://providers.dentaquest.com**
- Electronic submission via clearinghouses.
- Paper Corrected Claims.

Electronic Claim Submission Utilizing DentaQuest's Provider Portal

- Enrolled providers may submit claims by clicking the "edit and resubmit" link in the original claim on the portal. To submit claims on the provider portal, log in using your user name and password at **https://providers.dentaquest.com.** If additional corrections are required after a corrected claim is submitted, the provider will need to submit the correction based on the most recently submitted corrected claim, not the original claim.

If you have questions on submitting Claims or accessing the Provider Portal, please contact DentaQuest's Provider Portal Support at **1-888-308-2026**

Electronic Claim Submission via Clearinghouse

Corrected claims via Clearinghouse File will be accepted when a specific set of criteria is met to ensure the original claim can be identified. In order for a submission to be considered a corrected claim, it must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element.
- Original claim in a paid status
- Original claim does not have previously resubmitted services, or a corrected claim already processed
- Original claim does not have associated service adjustments or refunds

Paper Claim Submissions

Corrected Claims must be submitted on the most current ADA claim form or other forms approved in advance by the Plan the Corrected Claims PO Box for proper processing and include the following:

- The ADA form must be clearly noted "Corrected Claim" across the top of the form
- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.

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

Attach supporting documentation and send documentation in the same package with the Corrected paper claim form.

- Submit to:

AmeriHealth Caritas Pennsylvania Corrected Claims
c/oDentaQuest – Corrected Cliams
PO Box 2906
Milwaukee, WI 53201-2906

What scenarios ARE NOT subject to the corrected Claim process?

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

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

Health Guidelines – Ages 0-20 Years

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling.

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special healthcare needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Refer to the most recent Pediatric Dental Periodicity Schedule by visiting **www.amerihealthcaritaspa.com** → Providers → Communications → DHS/Medical Assistance Bulletins.

AmeriHealth Caritas Pennsylvania Medicaid Clinical Criteria for Authorization of Routine and Emergency Treatment

A number of procedures require prior authorization before initiating treatment. When prior authorizing these procedures, please note the documentation requirements when sending in the information to the Plan. The criteria used by dental reviewers for determinations of authorizations requests are listed below. Treatment may be provided if a procedure needs to be initiated under an emergency condition to relieve a patient's pain and suffering. However, to receive reimbursement for the treatment, the Plan will require the same documentation be provided (with the Claim for payment) and the same criteria to be met in order to receive payment for the treatment.

Adults age 21 and older have benefit limitations. For information on the benefit limit exception criteria, please refer to Policy 152.101 at **www.amerihealthcaritaspa.com** → Providers → Resources → Dental → Provider Resources → Dental Policies.

or contact DentaQuest Provider Services at: 1-855-343-7401.

Dental Services Requiring Prior Authorization or Retrospective Review

Services that require prior authorization or retrospective review along with clinical criteria and documentation requirements can be found in Policy 152.100 at **www.amerihealthcaritaspa.com** → Providers → Resources → Dental → Provider Resources → Dental Policies.