

Dental Overview

2026 IHCP Works Annual Seminar



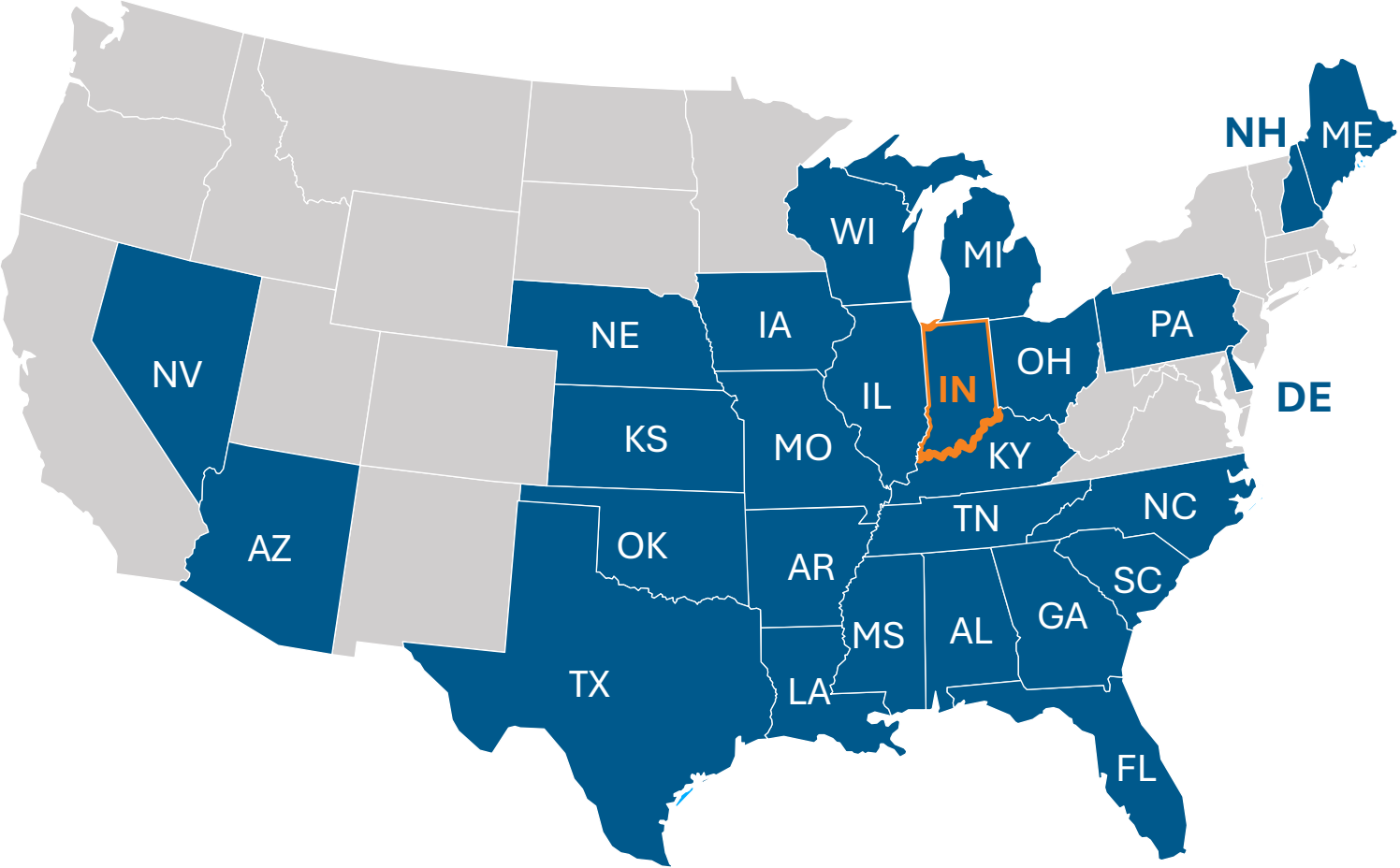
Centene Dental Services

Centene Dental Services, a division of Centene Corporation, partners with managed care organizations, health plans, and state governments to design and administer dental care programs that meet the needs of their members.

We are experienced in handling Medicaid, Marketplace, and Medicare benefits. As an organization supporting 4 million members in 27 states, we offer your practice an opportunity to bring new patients into your office.

Join our panel of over 78,000 dental professionals across the country.

Who We Serve



● Ambetter ● Medicaid ● Wellcare

Alabama	●	Mississippi	● ●
Arizona	● ●	Missouri	● ● ●
Arkansas	●	Nebraska	● ● ●
Delaware	● ● ●	Nevada	●
Florida	●	New Hampshire	●
Georgia	● ●	North Carolina	● ●
Illinois	● ● ●	Ohio	● ● ●
Indiana	● ●	Oklahoma	●
Iowa	●	Pennsylvania	● ●
Kansas	● ●	South Carolina	●
Kentucky	●	Tennessee	●
Louisiana	●	Texas	●
Maine	●	Wisconsin	●
Michigan	●		

Products Supported



MEDICAID

We support managed care
Medicaid plans in 12 states
3.3M Members Supported



MARKETPLACE

Our approach is based on the core
belief that quality healthcare is best
delivered locally
500K Members Supported



MEDICARE ADVANTAGE

We support WellCare MA plans
in DE, IL, ME, MO, NE, NC & OH
58K Members Supported



27 STATES

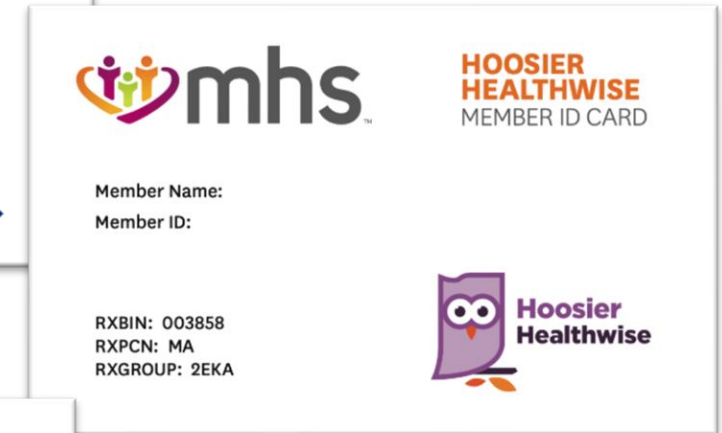


81K PROVIDERS

State Plan Information and ID Cards

- **MHS (Medicaid)**

- Hoosier Care Connect (All Ages)
- Hoosier Healthwise:
 - Package A (0 - 64)(Children and Adults)
 - Package C (CHIP) (Up to Age 19)
- Healthy Indiana Plan (HIP) (19 – 64)
 - HIP Basic
 - HIP Plus
 - HIP Maternity for Pregnant Women



Credentialing/Re-Credentialing

- When do I need to send my recredentialing documents?
 - Providers are recredentialed every 3 years
 - 30 calendar day turnaround time once a complete credentialing application is received
 - Required documents:
 - > Disclosure of Ownership (signed within the last 3 years)
 - > Council for Affordable Quality Healthcare Number or CAQH Application
 - > Signed Attestation Page (signed within the last 6 months)
 - > Attestation can be signed in CAQH
 - > Copy of the provider's Drug Enforcement Administration license
 - > Copy of the provider's Malpractice Insurance
 - > Copy of the provider's State License
 - > Type 1 and Type 2 National Provider Identifier Medicaid registration with Indiana Health Coverage Programs



Provider Web Portal

- centenedental.com/logon
- To register, request assistance through the *Provider Resources* page online:
Request Portal Access
 - Register as a Provider – See the provider's claims and authorizations for only one provider
 - Register as a Location – See the location's claims and authorizations for only one location
 - Register as a Payee – Access to ALL providers and locations associated with payee (tax ID #)
- Access on the Provider Web Portal (PWP)
 - Submit claims
 - Submit authorizations
 - Check member eligibility
 - Review Explanation of Benefits (if registered as a payee)



Centene Dental Benefits Website

Search Dental Codes

If your state is not listed, please refer to the Benefit Grid which you can also access on your [provider portal \(PWP\)](#). [To view details on different Medicare benefits, click Member Medicare Benefit Search Tool.](#)

Active Year Business * State Product Or CMS#

2025 Medicaid Indiana Hoosier Care Connect (HCC) Enter Contract ..

Q D7210

Search

Reset

Show 10 Records

Print

Click code number in results to see additional coverage details including age and/or frequency limitations.

State	Code	Product	Description	Covered	Prior Auth	PrePymt Review	Policy Name
IN	D7210	Hoosier Care Connect (HCC)	Surgical Removal Of Erupted Tooth	Yes	No	No	CP.DP.23 Surgical Extraction

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Enter the following to access the most current information:

- Active year
- Line of business
- State
- Product or plan name

Review the **Blue** hyperlinks for more information:

- Code link will provide information on frequency limits
- Policy name will provide a description of our clinical policies

Verifying Member Eligibility (1 of 2)

Providers are responsible for confirming member eligibility the day of the scheduled appointment. This can be done two ways:

1. Contact your dedicated Provider Customer Service number: Monday through Friday, 8 a.m. to 5 p.m. Eastern time to speak to a Representative or use the Interactive Voice Response (IVR) system for automated member eligibility verification 7 days a week, 24 hours a day.
 - **Medicaid: 855-609-5157**
 - **Ambetter:**
 - > **Premier: 855-609-5157**
 - > **Solutions: 877-236-1340**
2. Visit the Provider Web Portal

The screenshot shows a web portal interface for verifying patient eligibility. At the top is a purple navigation bar with links: Home, Claims, Authorizations, Patient Management, Entity Management, Documents, Reports, Setup, and Contact Us. The main heading is 'Verify Patient Eligibility / Start Claim'. Below this are several input fields: 'Location' (a dropdown menu showing 'Despicable Teeth (Bear, DE, 19701)'), 'Provider' (a dropdown menu showing 'Dru Gru'), and 'Date of Service' (an empty text box). A red arrow points from the 'Date of Service' field to a pink callout box on the right that says 'Verify member benefits & eligibility.' Below these fields are two radio button options: 'Subscriber ID and date of birth' (which is selected) and 'Last name and date of birth'. Under the selected option are 'Subscriber ID' and 'Date of Birth' text boxes. At the bottom are two buttons: a green 'Reset' button and a purple 'Verify Eligibility' button.

Verifying Member Eligibility (2 of 2)

- “Date of Service” field should be the current date; however, providers can verify patients up to 30 days in the past.
- If they search before that date, they will receive an error stating Date of Service cannot be before a specific date.
- If the member has two plans through Centene Dental Services, both plans will show, and you will be asked which plan you would like to verify eligibility for.

The screenshot shows a web form titled "Verify Patient Eligibility / Start Claim" with a red error message at the top: "Certain data entered is not valid. Hover over red arrows for explanations." The form contains the following fields and options:

- Location:** A dropdown menu with "Despicable Teeth (Bear, DE, 19701)" selected.
- Provider:** A dropdown menu with "Dru Gru" selected.
- Date of Service:** A text input field containing "04/01/2018". A red arrow points to this field, and a black tooltip message states: "Date of Service cannot be before 04/16/2018".
- Subscriber ID and date of birth:** A radio button is selected for this option.
- Subscriber ID:** A text input field containing "*****".
- Date of Birth:** A text input field containing "04/22/2023".
- Last name and date of birth:** An unselected radio button option.
- Buttons:** A green "RESET" button and a purple "VERIFY ELIGIBILITY" button are at the bottom.

Claims

Claims Submissions:

- Provider Web Portal
- Electronically through a Clearinghouse
(Payor ID is: 46278)
- Paper Claim:
 - Must be submitted on current [American Dental Association claim form](#)
 - Cannot be handwritten
 - Mail to:
 - **Centene Dental - Claims IN**
P.O. Box 20847
Tampa, FL 33622-0847

Turnaround Times: Medicaid

- Timely Filing:
 - Medicaid - Claims must be submitted within 90 calendar days from DOS.
 - Ambetter - Claims must be submitted within 180 calendar days from DOS.
- When filing to Centene Dental Services as secondary payor, timely filing is 365 calendar days from date on primary insurance explanation of payment (EOP).

Coordination of Benefits

- If the member has a primary insurance plan, Medicaid is always the secondary payor.
- Providers must first submit the claim to the primary insurance and include a full EOB when submitting to Medicaid for secondary payment consideration.
- Secondary Claims can be submitted via a clearinghouse, our Provider Web Portal, or via a current ADA paper claim

Frequently Asked Claims Questions (1 of 4)

Can I enter primary EOB information on the Provider Web Portal?

- Enter in the required claim information
- Select Yes for the Other Coverage
- Type in the primary dental information
 - EOB Present will automatically populate to Yes

Services

Code	Description	Surfaces					Oral Cavity	DiagPtr				EPSDT	Qty	Auth Number	Service Date	Billed Amt
		Tooth	1	2	3	4		5	1	2	3					
1 D0120	Periodic Oral Evaluation - Established Patient												1		02/05/2024	50.00
2 D1110	Prophylaxis - Adult												1		02/05/2024	75.00
3																
4																
5																
6																
7																
8																
9																
10																

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

Office Reference Number Referral Number

Other Fees \$ 11.00
Total Billed \$ 136.00

Other Coverage

Other Coverage 1? Yes ☒ No ☐

Other Coverage

Other Coverage 1? Yes ☒ No ☐

First Name

Last Name

Date Paid

Subscriber ID

Policy Group

Claim Filing Indicator

Insurance Plan

Relationship ☒ Self ☐ Spouse ☐ Dependent ☐ Other ☐

EOB Present? Yes ☒ No ☐

Claims Help and Information (2 of 4)

Primary Insurance (continued)

- After entering in the primary insurance information, proceed to coordination of benefits. The following fields must be populated:
 - Collected Amount – The amount paid by the primary insurance
 - Allowed Amount – The amount allowed for the procedure code per the primary insurance
 - Deductible Amount, Coinsurance Amount – Any patient responsibility amount that is not designated as deductible should be entered in the coinsurance column - The fields highlighted in red should have a 0.00 entered.
 - Remark Code – PR1 for deductible and PR2 for coinsurance
 - Attach the EOB to the claim

Other Coverage

Other Coverage 1? ☒ Yes ☐ No

First NameJane

Last NameDoe

Date Paid02/11/2024

Subscriber ID

Policy Group

Claim Filing Indicator

Insurance Plandelta dental

RelationshipSelf ☒ Spouse ☐ Dependent ☐ Other ☐

EOB Present? ☒ Yes ☐ No

	Code	Tooth	Cavity	Collected Amount	Allowed Amount	Deduct Amount	Co-Ins Amount	Copay Amount	Non-Std Pt. Resp	Remark Code	Paid Date
1	D0120			15.00	15.00	10.00	0.00			PR1	02/12/2024
2	D1110			50.00	50.00		15.00			PR2	02/12/2024
3											
4											
5											
6											
7											
8											
9											
10											

Other Coverage 2? ☐ Yes ☒ No

Attached Documents (0)

Attach Document(s)

Maximum file size: 13.4 Megabytes.
Allowed file types: doc, docx, gif, jpg, jpeg, odt, pdf, png, tif, txt, xls, xlsx, zip

Claims Help and Information (3 of 4)

Can I fax or email claims?

- No, all claims must be submitted via:
 - Clearinghouse (EDI)
 - Mailed on a current ADA form (original form only, no copies)
 - Provider Web Portal

Do I have to mail a corrected claim?

- No, corrected claims can be mailed or submitted through our [Provider Web Portal](#).
- Include all the original codes and original information.
- If mailing in, Write “Corrected Claim – original claim #” and indicate what you are correcting in box 35
- Mail corrected claims to:
 - **Centene Dental Corrected Claims IN**
P.O. Box 20847
Tampa, FL 33622-0847



Claims Help and Information^(4 of 4)

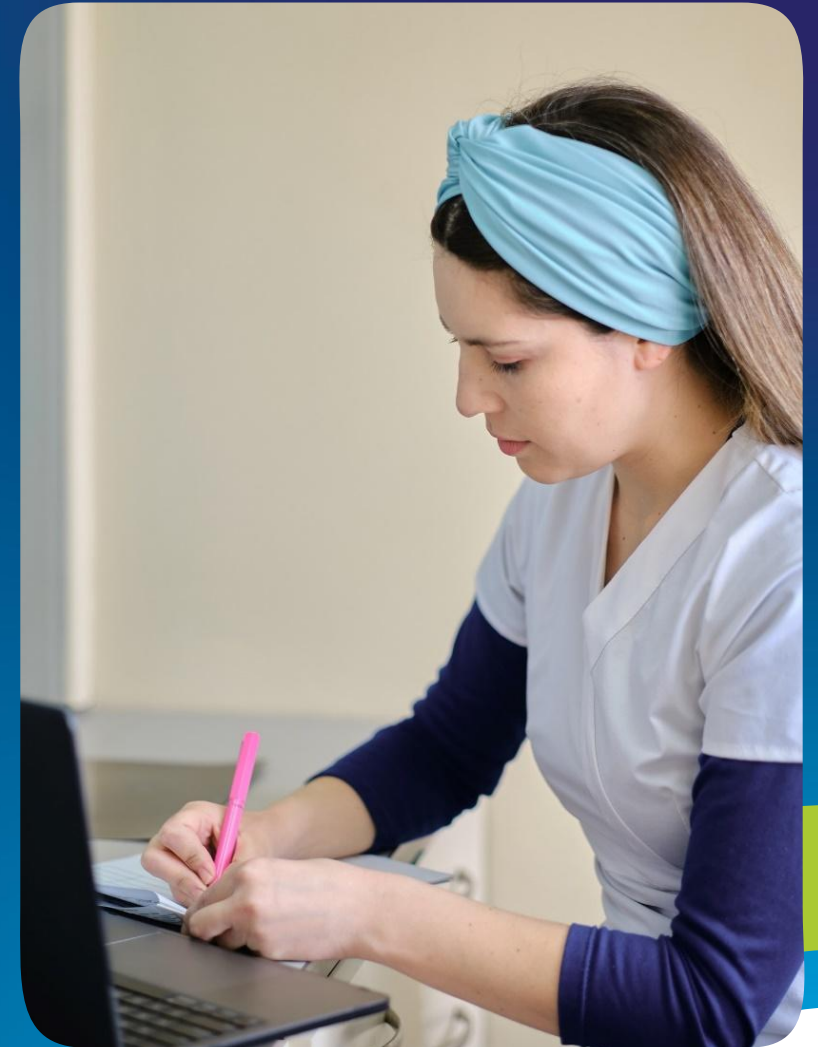
Appeals – Grievances (Medicaid)

- Auth Appeals:
 - Timely Filing: 60 Calendar Days after the denial
 - Determination: 30 Calendar Days
- Claim Appeals:
 - Timely Filing: 60 Calendar Days after the denial
 - Determination: 30 Calendar Days
- Reference our Provider Resources Page for Plan Specifics



Authorizations

- Authorizations can be submitted three ways:
 - Provider Web Portal
 - Electronic via clearinghouse
 - Via paper predetermination
 - > Must be submitted on a current ADA Claim Form
 - > Cannot be handwritten
 - Authorizations can be mailed to:
Centene Dental
Authorizations IN
P.O. Box 20847
Tampa, FL, 33622-0847
- Authorizations will be determined within 5 business days.
- Authorizations are valid for 180 calendar days from the date of approval.



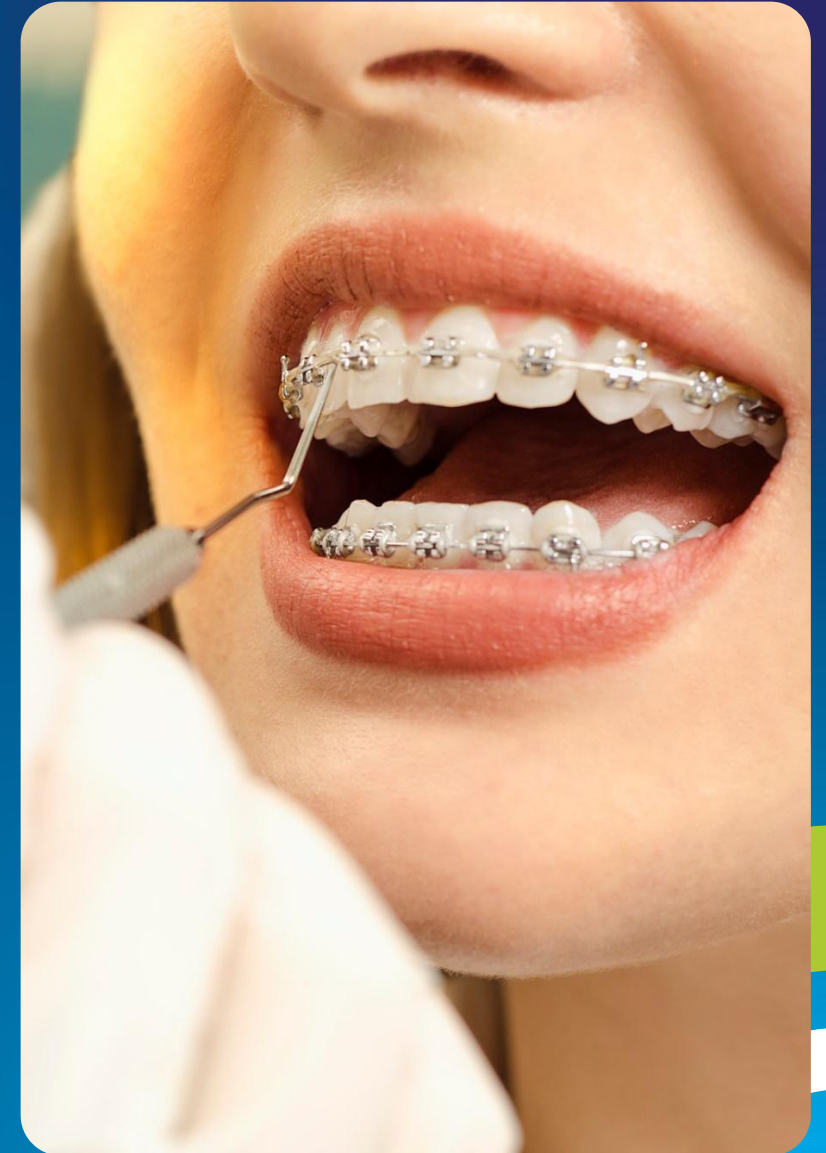
Authorizations Continued

What do I need to submit for outpatient hospital/ASC dental visits?

- Prior Authorization should be submitted using normal submission routes
 - All planned dental codes for facility treatment should be included
 - Authorization should also include the following code to indicate outpatient facility usage:
 - > D9420: hospital or ambulatory surgical center call
- Supporting Clinical Documentation: Films, Chart Notes, Treatment Plan
- Narrative of Medical Necessity
 - Why should services be performed in an outpatient setting?
- Outpatient Medical Prior Authorization Form for MHS is required for in-network facilities; authorization approval by Centene Dental Services will submit for in-network facility authorization. To obtain the most recent listing of facilities in your area:
 - Visit MHS website: ([Locate a facility](#))
 - Call MHS Provider Services: 877-647-4848

Orthodontic Treatment

- Orthodontic services are a covered benefit for members under the age of 21 only when medically necessary to treat a handicapping malocclusion. (Excluding HIP Basic, HIP Plus Plans)
- Prior Authorization is required for approval of orthodontic services:
 - Panoramic Film
 - Cephalogram
 - Intraoral Photos
 - Handicapping Labio-Lingual Deviation (HLD) Form
- Completed IHCP Medical Prior Authorization Form, frontal and lateral digital photographs of the face and occlusion, panoramic film and lateral cephalometric film; Treatment plan.



Orthodontic Continuity of Care



- Submit a prior authorization request with:
- Prior health plan's approved authorization
- Original provider's ledger of services reimbursed, with remits/EOBs
- Narrative of remaining treatment, reason for transfer, and prior treating office contact
- Case fee requested to complete treatment
- If the prior authorization is unavailable, also submit:
- Panoramic or cephalometric x-ray
- Other state-mandated scoring tool
- Photos
- Centene Dental Services determines remaining covered treatment and sends the provider written notice of the decision.

Electronic Funds Transfer (EFT)

Centene Dental Services offer claims payment and remittance delivery through Zelis® Payment Network's ePayment Center or Zelis ACH+.

ePayment Center:

- No-cost ACH payments
- Secure portal to access remittance data

Zelis ACH+:

- Low-cost premium payment experience
- Remittance data for 550+ payers in one place with a single login

For more information visit centenedental.com/getpaid.



Fraud, Waste and Abuse.

Centene Dental Services takes the detection, investigation, and prosecution of fraud, waste and abuse very seriously and performs ongoing claims audits that may result in taking actions against those providers who, individually or as a practice, commit fraud, waste and/or abuse.

Fraud: When someone knowingly and intentionally executes or attempts to execute a scheme to obtain money or property of any healthcare benefit program

Waste: Providing services that are not medically necessary

Abuse: When healthcare providers or suppliers perform actions that directly or indirectly result in unnecessary cost to the healthcare benefit program

Cultural Competency

What is Cultural Competency?

Cultural competency is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective, which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused, and family oriented.

Provider Cultural Competency Responsibilities:

Providers must assure that cultural differences between the Provider and Covered Person do not present barriers to access and quality dental care. Provider must be able to demonstrate the ability to provide quality dental care across a variety of cultures.



Contact us:



- Provider Relations email: DentalProviderRelations@Centene.com
- Provider Customer Service: Monday through Friday, 8 a.m. to 5 p.m. Eastern time to speak to a Representative or use the Interactive Voice Response (IVR) system for automated member eligibility verification 7 days a week, 24 hours a day.
 - **Medicaid:** 855-609-5157
 - **Ambetter:**
 - > Premier: 855-609-5157
 - > Solutions: 877-236-1340
- Credentialing Department: DentalCredentialing@Centene.com
- Network Department: DentalNetwork@Centene.com
- Centene Dental Fraud Waste and Abuse Hotline: 866-685-8664 (7 days a week, 24 hours a day)
 - Email: EBOSIU@Centene.com
- Appeals and Grievances:
 - Appeals Email: DentalHWAppeals@Centene.com
 - Grievances Email: Dentalgrievances@Centene.Com

Questions?

