



PATHWAYS TO
ORAL HEALTH

**New Era, New
Opportunities:
Making Medicaid
Work for You**

New Era, New Opportunities Webinar Series

August 19: Medicaid Dental: New Rates, Better Coverage

August 26: Your Practice, Your Way: Managing Your Patient Mix

September 2: Get to Know Your MCOs

September 9: Enrollment & Credentialing


September 16: Filing Medicaid Claims

September 23: Do Well by Doing Good: Medicaid Opportunities

September 30: My Dental Care Passport



Logistics

- Please use the Q&A box to ask questions throughout today's webinar
 - If you have any questions or run into any technical problems, please use the Chat, and the staff will help you
 - You also can email info@oralhealthkansas.org if you have any problems during the webinar
 - There will be a total of 3.5 dental CEs available for participating in this webinar series
 - If you need CEs, please put your name and email address in the Chat
 - CE certificates will be sent at the end of the webinar series
- 

PATHWAYS TO ORAL HEALTH

— A PROJECT OF ORAL HEALTH KANSAS —

- Support for dental professionals in being successful Medicaid providers
- Education programs for dental professionals and people with disabilities
- Communication tools to break down barriers



Join us in making dental care more accessible and equitable for all.



New Era, New Opportunities Webinar Series



*This project is funded by the Kansas Department of Health and Environment –
Division of Health Care Finance (KDHE-DHCF) and ARPA.*

Today's agenda

- SkyGen (On behalf of Healthy Blue)
- Centene (Representing Sunflower)
- United Healthcare Community Plan
- Resources





Healthy Blue

<https://www.healthybluekansas.com/provider/state-federal>



<https://www.sunflowerhealthplan.com/providers.html>



UnitedHealthcare[®] Community Plan

<https://www.uhcdental.com/>



Healthy Blue Kansas
Oral Health Kansas Webinar
09/16/2025

member identification card

Medicaid



Medicare



Dual (D-SNP)



SKYGEN - Dental Hub

SKYGEN Dental Hub: <https://app.dentalhub.com/app/login>

- Is a secure online service that offers quick, easy-to-use self- service tools for providers and their office staff. The portal is available 24 hours a day, 7 days a week from any computer with internet access. Utilizing the portal speeds up processing time, helps lower administrative time and costs, and allows providers to perform a wide variety of daily administrative tasks such as but not limited to:
 - Checking member eligibility, benefits, and history
 - Submitting authorizations and claims
 - Searching authorizations and claims
 - Viewing insurer documents, provider notices, and remittances
- For help utilizing the SKYGEN Dental Hub, registering, or training visit: <https://www.dentalhub.com/webinars>
- For support with the SKYGEN Dental Hub Team: Phone #: 1-855-609-5156.

checking Eligibility

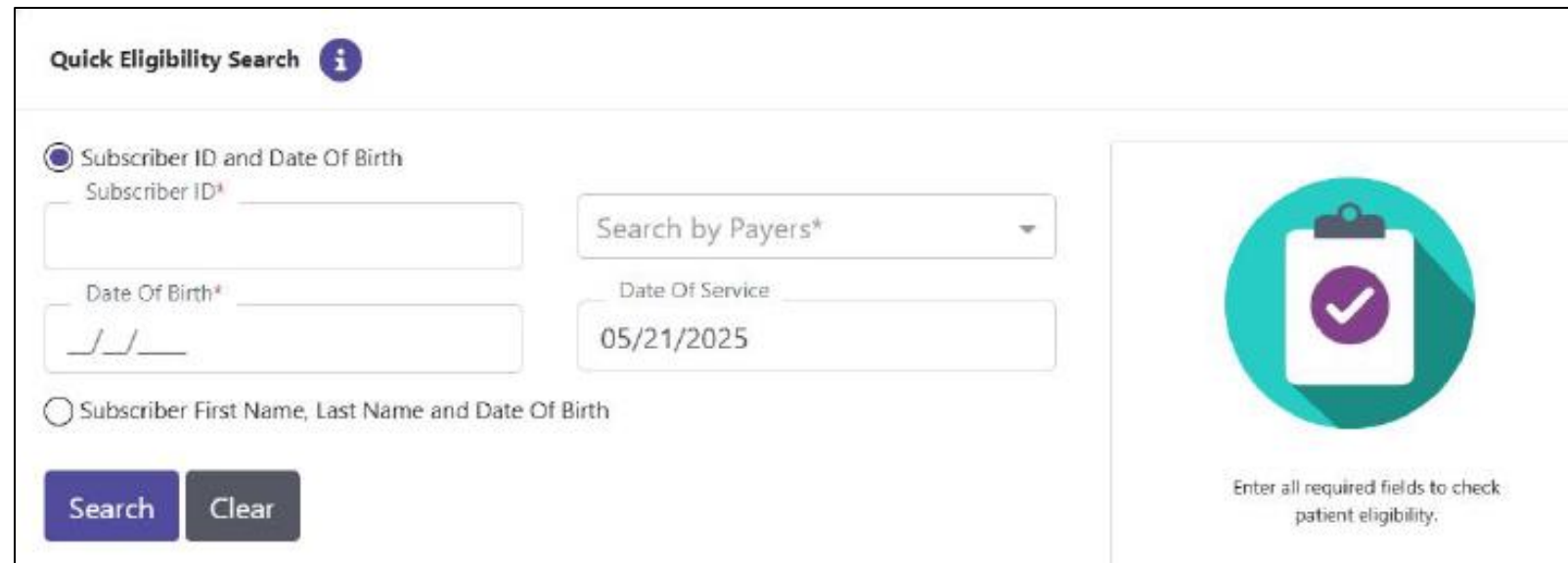
Providers can verify Member eligibility several ways:

- Visit SKYGEN Dental Hub at: <https://app.dentalhub.com/app/login>
- Provider Services Contact Center for assistance at 855-434-9237

Dental Hub:

A Quick Eligibility Search indicates whether the patient is eligible on the given date of service.
Log onto the Dental Hub then:

1. Subscriber ID
2. Date of birth
3. Select Healthy Blue payer
4. Date of service
5. Click search



The screenshot shows the 'Quick Eligibility Search' interface. It features two radio button options for search criteria. The first option, 'Subscriber ID and Date Of Birth', is selected and includes input fields for 'Subscriber ID*' and 'Date Of Birth*' (with a date picker showing //). The second option is 'Subscriber First Name, Last Name and Date Of Birth'. To the right of the first option is a 'Search by Payers*' dropdown menu. Below the dropdown is a 'Date Of Service' input field showing '05/21/2025'. At the bottom are 'Search' and 'Clear' buttons. On the right side of the form is a large teal circle containing a white clipboard icon with a purple checkmark. Below this icon is the text: 'Enter all required fields to check patient eligibility.'

checking Eligibility

Full Eligibility & History Search gives you access to benefit information and service history plus quick links to the treatment plan calculator, start a claim, and submit authorization with that patient's information prefilled.

Step 1: Patient & Insurance

The screenshot shows the 'Eligibility & History' application with the 'Patient & Insurance' tab selected. The form contains fields for Patient Information and Insurance details.

Patient Information	
Subscriber ID or Medicaid ID	<input type="text"/>
First Name	<input type="text"/>
Last Name	<input type="text"/>
Date of Birth	<input type="text"/>
Procedure Date	<input type="text"/>
Patient's Relationship to Subscriber	<input type="text"/>
Plan	<input type="text"/>

Buttons: Search, Back, Continue

Step 2: Practitioner & Location

The screenshot shows the 'Eligibility & History' application with the 'Practitioner & Location' tab selected. The form contains fields for Practitioner and Location information.

Selected Patient	
AJ MARTIN	
Date of Birth	04/11/1976
Member ID	467054321
Age	49
Gender	Male
Preferred Language	English
Special Communication Needs	

Treating Practitioner & Location	
Northwest Dental	
8001 North Fort Washington Road Fox Point, WI 53217	

Primary Care Practitioner & Location	
Northwest Dental	
8001 North Fort Washington Road Fox Point, WI 53217	

Buttons: Back, Continue

Step 3: Eligibility Check Results

The screenshot shows the 'Eligibility & History' application with the 'Eligibility Check Results' tab selected. The form displays the results of the eligibility check.

Selected Patient	
AJ MARTIN	
Date of Birth	04/11/1976
Member ID	467054321
Age	49
Gender	Male
Preferred Language	English
Special Communication Needs	

Treating Practitioner & Location	
Northwest Dental	
8001 North Fort Washington Road Fox Point, WI 53217	

Primary Care Practitioner & Location	
Northwest Dental	
8001 North Fort Washington Road Fox Point, WI 53217	

Buttons: Back, Return to Eligibility & History

checking Eligibility

Eligibility status is displayed with three distinct indicators:

✓ **Member Eligible as of 01/01/2025**

Green means go! A green eligibility response means the patient is eligible for benefits on the date of service you entered – and that the Payer is showing both the Treating Practitioner and Location as being in network.

✓ **Member Eligible as of 01/01/2025**

Orange means proceed with caution. The patient is eligible for benefits on the date of service you entered. However, the Payer is showing the Treating Practitioner or Location – or the combination of the two – as being out of network.

Not Eligible as of 01/01/2025

Red means stop! This patient does not appear to be eligible for benefits on the date of service you entered. This could be because either: (1) the patient could not be found in the Payer's system; or (2) the patient was found but is not eligible on that date of service.

Key Addresses

Payer ID:

- SCION

Authorizations/Retro Authorizations:

- Healthy Blue Kansas Authorizations PO BOX 1236 Milwaukee, WI 53201

Claims:

- Healthy Blue Kansas Claims PO BOX 359 Milwaukee, WI 53201

Corrected Claims:

- Healthy Blue Kansas Corrected Claims PO BOX 541 1236 Milwaukee, WI 53201

Auth Appeals:

- Healthy Blue Kansas Authorizations Appeals PO BOX 62429 Virginia Beach, VA 23466

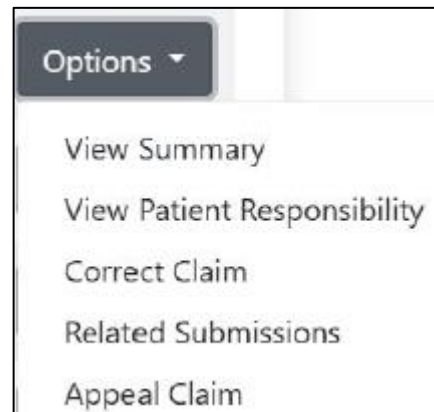
Claim Appeals:

- Healthy Blue Claim Appeals PO BOX 61599 Virginia Beach, VA 23466

Plus - Submitting a Corrected Claim

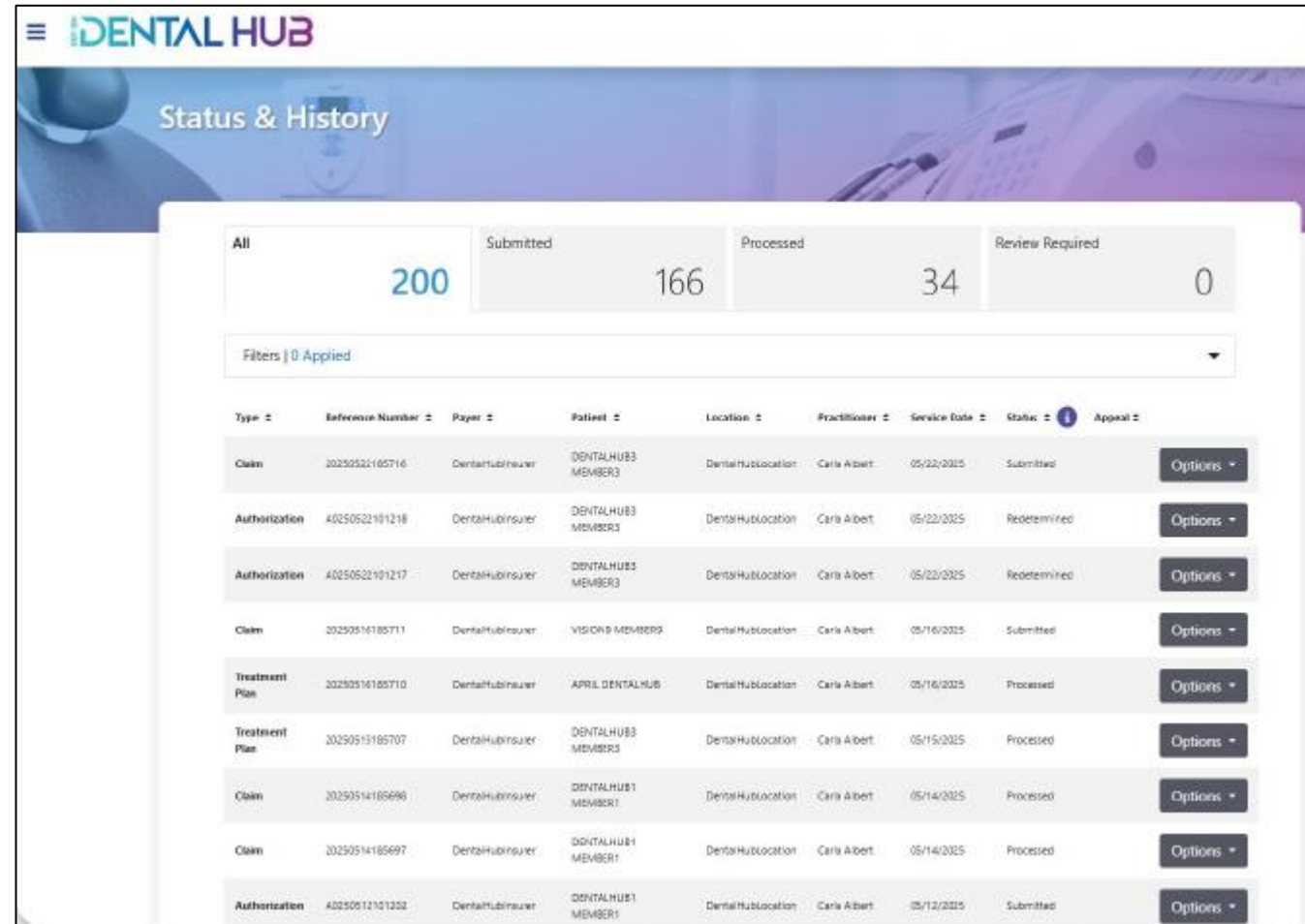
Submitting a Corrected Claim via the Dental Hub

1. Navigate to the appropriate page:
 - Status & History page (for Dental Hub claims)
 - Claim Search page (for non-Dental Hub claims)
2. Locate your claim and select "Correct Claim" from the Options menu



After Correction: All corrected claims appear on the Status & History page after submission.

Status & History

A screenshot of the 'DENTAL HUB' 'Status & History' page. The page has a header with the 'DENTAL HUB' logo and a background image of a dental office. Below the header, there's a summary section with four boxes: 'All' (200), 'Submitted' (166), 'Processed' (34), and 'Review Required' (0). Below this is a 'Filters | 0 Applied' dropdown. The main part of the page is a table with columns: Type, Reference Number, Payer, Patient, Location, Practitioner, Service Date, Status, and Appeal. The table contains 10 rows of data, each with an 'Options' button to its right.

Type	Reference Number	Payer	Patient	Location	Practitioner	Service Date	Status	Appeal
Claim	20250521105716	DentalHubInsurer	DENTALHUB3 MEMBER3	DentalHubLocation	Carla Albert	05/22/2025	Submitted	Options
Authorization	40250522101218	DentalHubInsurer	DENTALHUB3 MEMBER3	DentalHubLocation	Carla Albert	05/22/2025	Redetermined	Options
Authorization	40250522101217	DentalHubInsurer	DENTALHUB3 MEMBER3	DentalHubLocation	Carla Albert	05/22/2025	Redetermined	Options
Claim	20250516185711	DentalHubInsurer	VISORP MEMBER3	DentalHubLocation	Carla Albert	05/16/2025	Submitted	Options
Treatment Plan	20250516185710	DentalHubInsurer	APRIL DENTALHUB	DentalHubLocation	Carla Albert	05/16/2025	Processed	Options
Treatment Plan	20250515185707	DentalHubInsurer	DENTALHUB3 MEMBER3	DentalHubLocation	Carla Albert	05/15/2025	Processed	Options
Claim	20250514185698	DentalHubInsurer	DENTALHUB1 MEMBER1	DentalHubLocation	Carla Albert	05/14/2025	Processed	Options
Claim	20250514185697	DentalHubInsurer	DENTALHUB1 MEMBER1	DentalHubLocation	Carla Albert	05/14/2025	Processed	Options
Authorization	40250512101202	DentalHubInsurer	DENTALHUB1 MEMBER1	DentalHubLocation	Carla Albert	05/12/2025	Submitted	Options

submitting a corrected claim - clearinghouse

Corrected claims via Clearinghouse file 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.
- Corrected claim must have a data match to original claim on at least three of the four items: Enrollee ID, Provider ID, Location ID, and/or Tax ID.

submitting a corrected claim - mail

Submitting A Corrected Claim via Paper

- Identify the claim as **Corrected** by writing “**Corrected**” across the top of a paper claim form.
- In the remarks field (Box 35) of the ADA Claim form you must 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 the corrections to the claim form.
- Attach supporting documentation and send documentation in the same package with the paper claim form.
- Send paper forms and documents to:

Healthy Blue Kansas Corrected Claims
PO Box 541
Milwaukee, WI 53201

Timely filing

Claims Timely Filing:	180 days from date of service
Claims Timely Filing With Primary insurance:	180 days from primary processed date of EOB
Corrected Claim Timely Filing:	365 days from date of service
Claim Appeals Timely Filing:	60 days of denial date (plus 3 days for mailing time)

Payments options

I. Zelis Electronic Options (Please note fees may apply*)

Zelis ACH - ACH is the most efficient way to maximize payments for your practice, facility, or health system by directly depositing electronic payments into your bank account. ACH payment delivery is CAQH CORE®- certified, which ensures compliance with ACA standards and HIPAA requirements. Once enrolled, your funds are automatically deposited into your bank account. ACH only allows funds to be directly deposited into your account; it does not allow funds to be recouped from your account.

Zelis Virtual Card - Zelis has partnered with MasterCard (through Optum Financial) to provide card-based payments. By utilizing the Zelis Virtual Card, office staff simply enters the virtual card information into the card terminal to receive payments for the claim(s) submitted. Card numbers and Explanations of Payment can either be download from the Zelis Payments secure web portal or delivered by fax.

- *Fees may apply for all providers who receive payments from Zelis. The fee depends on a variety of factors. For additional information, questions or to enroll, please follow the steps below.

Zelis Enrollment:

- Providers who are already enrolled with Zelis do not need to make any changes and will automatically be paid through Zelis.
- To enroll, please contact the Zelis Provider Enrollment Department at (855) 496-1571 for complete details.

To change your enrollment status:

- To change your enrollment status (including disenrollment from Zelis); please contact the Zelis Client Service Department at (877) 828-8770.

II. SKYGEN E-Payment Center Option (no-fee)

- For Providers seeking an alternative payment solution, SKYGEN is excited to introduce a new electronic payment (E-Payment) platform to accelerate and add efficiency to our claims payment process.
- By enrolling, providers have the ability to receive a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the E-Payment Center enrollment portal.
- Enrollment instructions and a detailed question and answer guide are available for download at <https://skygen.epayment.center/Registration>.
- Follow the instructions to obtain a registration code. A customer service representative will review your registration and a link will be sent to your email once confirmed.
- For more information, please call (855) 774-4392 or email help@epayment.center.

III. Paper Check Option (no-fee)

Paper Checks - Providers who chose not to enroll with Zelis – or – prefer to receive paper checks can still access their Remittance Reports online.

- Providers will need to send an email message to SKYGEN Customer Services to request electronic remittances: providerservices@skygenusa.com.
- Remittance Reports will be available online through the Dental Hub.

key contacts

- Dental Hub: <https://app.dentalhub.com/app/login>
- Dental Hub Support: 855-609-5156
 - Provider Manual & Fee Schedule are posted on the Dental Hub
- Provider Call Center: 855-434-9237
 - Call for general questions, benefits, claim & authorization status questions
- Contracting: 800-508-6965, www.skygenusaproviders.com, enter code: (KS)
 - Call for adding a new location or new provider, TIN change, address change
- Credentialing: 855-812-9211, providercap.skygenusasystems.com/cap
 - Call for credentialing and re-credentialing questions
- Zelis: Enrollment: 855-496-1571 Client Service: 877-828-8770
- ePayment Center: 855-774-4392 or Email: help@epayment.center
- Provider Relations: Email: providerservices@skygenusa.com



Thank You

CONNECT WITH US

SKYGENUSA.com

Visit our online **Knowledge Center** to access helpful tips and industry best practices to succeed in the future of benefit management.

JOIN THE CONVERSATION



Sunflower Health Plan

Eric Rholes, Provider Relations Specialist II

John Dane, DDS

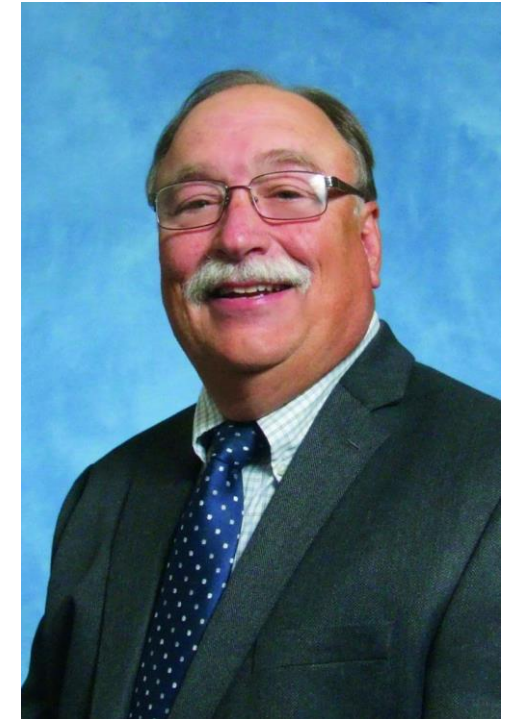
Sunflower Health Plan

Dr. John Dane serves as Sunflower Health Plan's Dental Manager.

In the role, Dr. Dane oversees all Sunflower Health Plan oral health activities and contractual requirements and serves as a liaison to the State.

He retired from his position as Missouri State Dental Director in 2021.

He is currently a member of the American Society for Geriatric Dentistry and the Academy of Dentistry for the Persons with Disabilities.





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, Health Insurance 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.

State Plan Information and ID Cards

- **Sunflower Health Plan/KanCare**
(Medicaid Plan)
 - **Children Title 19** Age: 0-20
 - **Children Title 21 CHIP** Age: 0-18
 - **Adults Title 19** Age: 21+



The ID card features the Sunflower Health Plan and KanCare logos at the top. To the right of the logos, it lists pharmacy information: RXBIN: 003858, RXPCN: MA, and RXGROUP: 2ELA. Below the logos, there are fields for NAME, #, PCP Name, PCP Phone, Effective Date, and DOB. A copay of \$0 is indicated. A disclaimer at the bottom states: 'If you have an emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your PCP or Sunflower's 24/7 nurse line at 877-644-4623 (TTY 711)'. The address 8325 Lenexa Drive, Suite 410, Lenexa, KS 66214 and the website www.SunflowerHealthPlan.com are also listed.

Pharmacy:
RXBIN: 003858
RXPCN: MA
RXGROUP: 2ELA

NAME:
#:
PCP Name:
PCP Phone:
Effective Date:
DOB:
Copay: \$0

If you have an emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your PCP or Sunflower's 24/7 nurse line at 877-644-4623 (TTY 711).

8325 Lenexa Drive, Suite 410, Lenexa, KS 66214
www.SunflowerHealthPlan.com

IMPORTANT CONTACT INFORMATION

Members:

Customer Service: 877-644-4623
(TTY 711)
Transportation: 877-917-8162
Vision: 877-644-4623
Dental: 877-644-4623
Behavioral Health: 877-644-4623
Pharmacy: 877-644-4623

Medical Correspondence/ Non-Claims:

Sunflower Health Plan
PO Box 4070
Farmington, MO 63640-3833

Provider Claims information via the web: www.SunflowerHealthPlan.com

Providers:

Provider Services & IVR Eligibility Inquiry
- Prior Auth: 877-644-4623
Pharmacists Only: 833-750-4447

**EDI/EFT/ERA please visit
For Providers at
www.SunflowerHealthPlan.com**

Behavioral Correspondence/ Non-Claims:

Sunflower Health Plan
PO Box 6400
Farmington, MO 63640-3807

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 EOBs (if registered as a payee)



Provider Web Portal

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#

2024

Medicaid

Kansas

Title 19 Adults (Age 21+)

Enter Contract ..

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
KS	D7210	Title 19 Adults (Age 21+)	Surgical Removal Of Erupted Tooth	Yes	No	Yes	CP.DP.23 Surgical Extraction

1 - 1 of 1

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Enter the following to access the most current information:

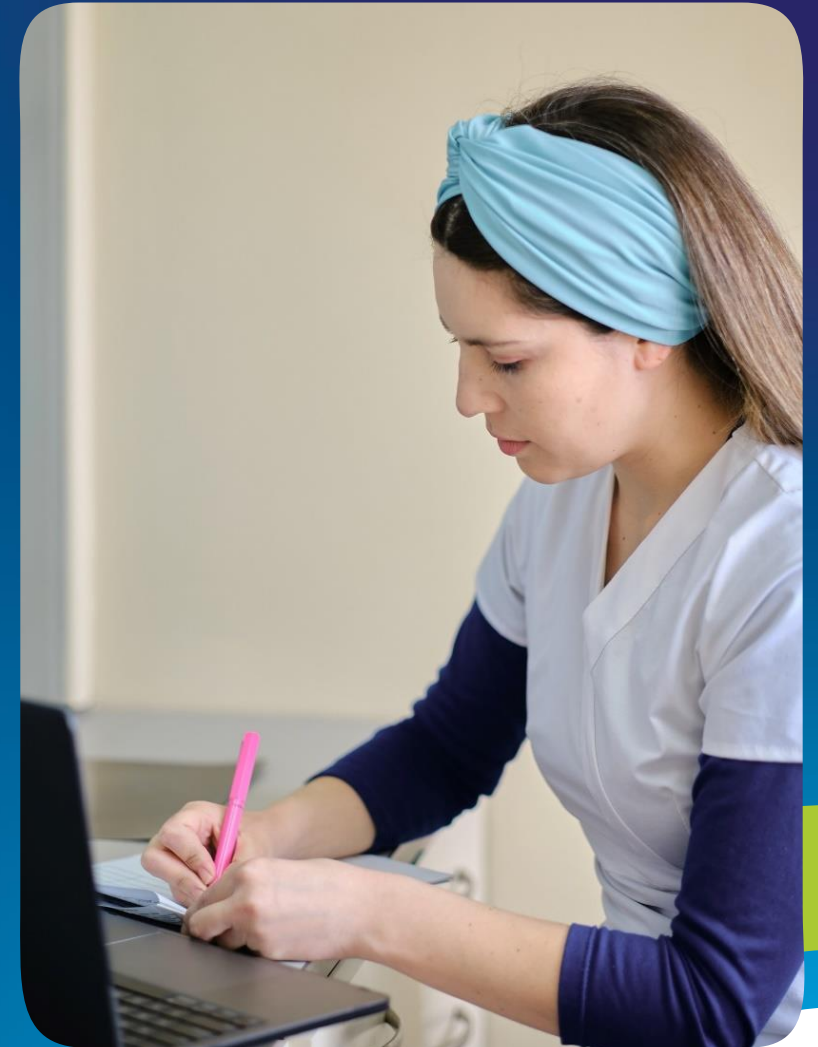
- Active year
- Line of business
- State
- Product or plan name

Review the hyperlinks for more information:

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

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 KS
P.O. Box 25857
Tampa, FL, 33622-5857
- Authorizations will be determined within 7 calendar days.
- Authorizations are good for 180 calendar days from the date of approval.



Claims

Claims Submissions:

- Provider Web Portal
- Paper Claim:
 - Must be submitted on current ADA claim form
 - Cannot be handwritten
 - Mail to:
 - Centene Dental - Claims KS
P.O. Box 25857
Tampa, FL 33622-5857
- Electronically through a Clearinghouse
 - Payor ID is: 46278

Turnaround Times:

- Timely Filing:
 - Medicaid - Claims must be submitted within 180 days from Date of Service.
 - Ambetter - Claims must be submitted within 180 days from Date of Service.
- When filing to Centene Dental Services as secondary payor, timely filing is 180 calendar days from date on primary EOB.

Coordination of Benefits

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

Frequently Asked Claims Questions

Appeals – Grievances (Medicaid)

- Authorization Appeals:
 - Timely Filing: 63 Calendar Days after the notice of action date.
 - Determination: 30 Calendar Days
 - Mail to: Sunflower Health Plan Appeals, P.O. Box 10287, Van Nuys, CA 91410-0287
- Claim Appeals:
 - Timely Filing: 63 Calendar Days after the notice of action date.
 - Determination: 30 Calendar Days
 - Mail to: Centene Dental Appeals and Grievances, P.O. Box 25857, Tampa, FL 33622-5857
 - Secure Email (DentalAppeals@Centene.com)
- Claim Reconsideration (optional at provider's request):
 - Must be requested within 120 calendar days of the Notice of Action date. Three additional
 - calendar days will be allowed for mailing time.

*Reconsiderations and appeals will be resolved within 30 calendar days from the date of receipt.



Contact us:



- Provider Relations: email: DentalProviderRelations@Centene.com
- Provider Customer Service: 855-434-9245
- Credentialing Department: DentalCredentialing@Centene.com
- Network Department: DentalNetwork@Centene.com
- Envolve Dental Fraud Waste and Abuse Hotline: 866-685-8664
 - Email: EBOSIU@Centene.com
- Appeals and Grievances:
- Appeals Email: DentalAppeals@Centene.com
- Grievances Email: DentalGrievances@Centene.com

Questions?





Dental HUB

Dental Hub



The [Dental Hub](#) is the go-to website for your practice's administrative tasks.



Use a single sign-on to see and manage your business — even if you have multiple practices and locations



Submit claims through a streamlined process with instant edits that help you avoid errors



Convert determined prior authorization requests into claims with ease



Process claims in real time and collect out-of-pocket amounts from patients while they're still in the office. Real-time adjudicated claims and patient responsibility reports eliminate having to rely on estimates.



Be informed of important processes and events through automated notifications

Weekly Live Dental Hub Webinar

Join an upcoming live webinar held every Thursday at 12:00 PM Central or watch the video on-demand

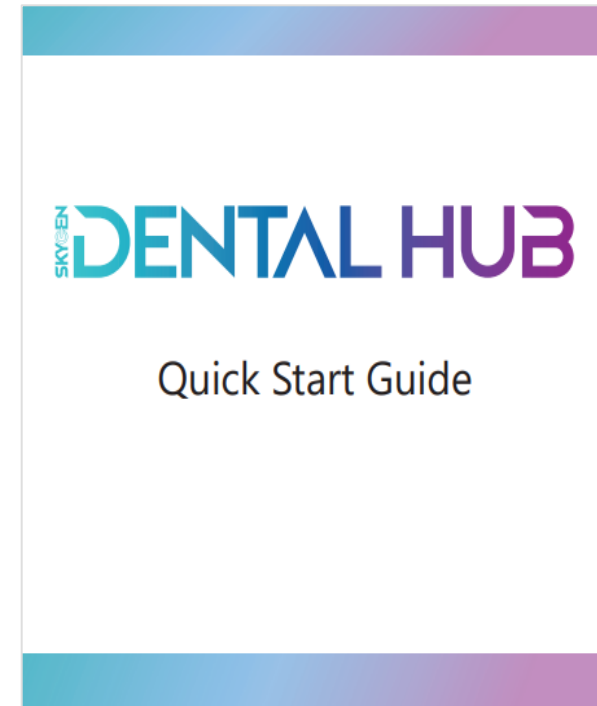
The webinar will cover:

- Intro to the Dental Hub
- Self-registration
- Set-up
- Add a patient
- Check eligibility
- Treatment estimate
- Submit claims
- Reports
- Real-time patient responsibility

dentalhub.com/webinars

Email: dentalhubsupport@skygenusa.com

Dental HUB Support: 855-619-5156





Member information

Sample Member ID Card

Members are issued an identification (ID) card by UnitedHealthcare Community Plan.



There will not be separate dental cards for UnitedHealthcare Community Plan members.

The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the **health plan**.

Please remember:

- A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

To verify a member's dental coverage, go to uhcdental.com/medicaid and sign into the Dental HUB or contact the dental Provider Services line at 855-878-5372, Monday – Friday 7:45 a.m. – 4:30 p.m. CST (IVR: 24/7).

	
Health Plan (80840)	911-96385-07
Member ID: 99999993112	Group Number: KSKCMD
Member: NEW ENGLISH DOB: 02/04/1947 PCP Name: DOUGLAS GETWELL PCP Phone: (620)852-3550	Payer ID: 96385
Effective Date: 06/16/2013	<div>Optum Rx® Rx Bin: 610494 Rx Grp: ACUKS Rx PCN: 9999</div>
Copays: \$0 0501	Administered by UnitedHealthcare of the Midwest, Inc.

In an emergency go to nearest emergency room or call 911.		Printed: 01/30/23
This card does not guarantee coverage. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan or call.		
For Members:	877-542-9238	TTY 711
NurseLine:	855-575-0136	TTY 711
Behavioral/Dental/Vision/Transportation(reservation):	877-542-9238	TTY 711
For Providers:	UHCprovider.com	877-542-9235
Medical Claims:	PO Box 5270, Kingston, NY, 12402-5270	
Transportation (where is my ride?):	877-542-9238	
Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334		
For Pharmacists: 877-305-8952		



Patient eligibility verification

Patient eligibility and dental benefits may be verified online or via phone.

- Once you have registered with the Dental HUB, you can verify your patients' eligibility online with just a few clicks, 24 hours a day, 7 days a week.
- If verifying a patient's dental coverage via phone, contact the dental Provider Services line at 855-878-5372, Monday – Friday 7:45 a.m. – 4:30 p.m. CST.
- We also offer an Interactive Voice Response (IVR) System for eligibility verification 24 hours a day, 7 days a week.

Here are some key points to keep in mind:

- Eligibility should be verified on the **date of service**.
- Verification of eligibility is **not** a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions.



UHCdental.com/medicaid



1-855-878-5372



Authorizations & Claims

Authorization Timelines & Submissions

To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services. Refer to the provider manual and QRG for a complete listing of procedures requiring authorization.



We will make a determination on standard authorizations within 2 days of receipt of the request. Written notification of denied determinations will be sent within 14 calendar days of receipt of the request.



We will make a determination on expedited authorizations within 24 hours of receipt of the request. Written notification denied determinations will be sent within 2 business days of receipt of the request.



Authorization approvals will expire 180 days from the date of determination.



For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **855-878-5372**



The Dental HUB
UHCdental.com/medicaid
Payer ID GP133



Paper
UnitedHealthcare Authorizations
PO Box 2135
Milwaukee, WI 53201



Electronic
Clearinghouse
Payer ID GP133

Claims Submission & Timely filing

Submission



The Dental Hub
UHCdental.com/medicaid
Payer ID GP133



Paper
UnitedHealthcare KS Claims
PO Box 1158
Milwaukee, WI 53201



Electronic
Clearinghouse
Payer ID GP133

Timely submission (Timely filing)

All claims should be submitted within 180 calendar days from the date of service.

Secondary claims must be received within 180 calendar days of the primary payer's determination.

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



Corrected Claim

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information. As part of the process, the original claim will be recouped, and a new claim processed in its place with any necessary changes.

Examples of correction(s) for a prior paid claim are:

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

A corrected claim may be submitted using the methods below:

- Electronically through Clearing House
- Electronically through the Dental Hub.
- Paper to the mailing address below:
UnitedHealthcare Community Plan Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

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

- Must be submitted to the Corrected Claims P.O. Box for proper processing and include the following:
 - The most current version of the ADA claim form and all required information
 - The ADA form must be clearly noted “Corrected Claim”
 - In the remarks field (Box 35) on the ADA claim 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.

If a claim or service originally DENIED due to incorrect or missing information/authorization, 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. Submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

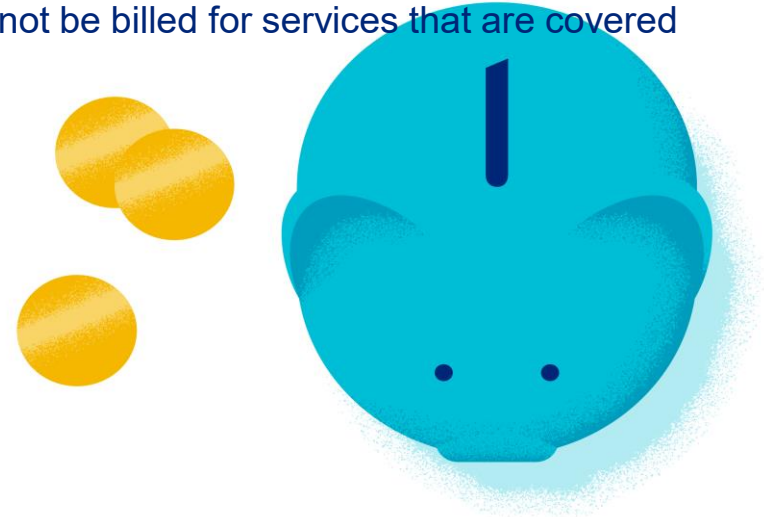
If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to the appeals language on the Provider Remittance Advice for guidance with the appeals process applicable to the state plan.



Payment for non-covered services

When non-covered services are provided for Medicaid members, providers shall hold members and UnitedHealthcare Community Plan harmless, except as outlined below. In instances when Medicaid non-covered services are recommended by the provider or requested by the member, an Informed Consent Form or similar waiver must be signed by the member confirming:

- That the member was informed and given written acknowledgement regarding proposed treatment plan and associated costs of non-covered services in advance of rendering treatment; that those specific services are not covered under the member's plan and that the member is financially liable for such services rendered.
- That the member was advised that they have the right to request a determination from the insurance company prior to services being rendered.
- Please note: It is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered. Members are held harmless and cannot be billed for services that are covered under the plan.



Tips for successful claim experiences

Do not let claim issues grow or go unresolved. Call Provider Services if you can't verify a claim is on file.

Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.

File adjustment requests and claim disputes within contractual time requirements.

If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. This should also include if a service is not identified as covered but is medically necessary for treatment.

UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.

Secondary claims must be received within 365 calendar days from the date of service, even if the primary carrier has not made payment. The timely filing is for all claims.

When submitting appeal or reconsiderations requests, provide the same information required for a clean claim.

Explain the discrepancy, what should have been paid and why.

**If you have questions, call Provider Services.
855-878-5372**





Provider resources

Provider Essentials Cheat Sheet

Need:	Address:	Phone Number:	Payer I.D.	Submission Guidelines:	Form(s) Required
Claim Submission (initial)	Claims: UnitedHealthcare KS Claims P.O. Box 1158 Milwaukee, WI 53201	1-855-878-5372	GP133	Within 180 calendar days from the date of service. For secondary claims, within 180 calendar days from the primary payer determination	ADA* Claim Form, 2024 version
Corrected Claims	Corrected Claims: UnitedHealthcare KS Claims P.O. Box 481 Milwaukee, WI 53201	1-855-878-5372	N/A	Within 365 days plus 3 calendar days of the date the denial letter was mailed or the date of the Provider Remittance.	ADA Claim form Reason for requesting adjustment or resubmission
Claims Appeals (Appeal of a denied or reduced payment)	Claim Appeals: UnitedHealthcare Appeals P.O. Box 1244 Milwaukee, WI 53201	1-855-878-5372	N/A	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Authorization Requests	Pre-authorizations: UnitedHealthcare Authorizations P.O. Box 2135 Milwaukee, WI 53201	1-855-878-5372	GP133	N/A	ADA Claim Form – check the box titled: Request for Predetermination/Preauth orization section of the ADA Dental Claim Form
Member Benefit Appeal for Services Authorization (Appeal of a denied or reduced service)	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	1-866-293-1796	N/A	Within 60 calendar days from the date of adverse benefit determination	N/A



Provider Road Map

We are committed to providing your office accurate and timely information about our programs, products and policies. Our Provider Services Line 855-878-5372 and Provider Services teams are available to assist you with any questions you may have.

Our toll-free provider services number is available during normal business hours and is staffed with knowledgeable specialists. They are trained to handle specific dentist issues such as eligibility, claims, benefits information and contractual questions.

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



Resources

Resources for Dental Providers



Becoming a KanCare Dental Provider—Steps and Benefits

JULY 28, 2025

<https://pathwaystooralhealth.org/blog/>



info@oralhealthkansas.org
PO BOX 4567, Topeka, KS 66604

Filing Medicaid (KanCare) Claims

Your decision to provide dental care for Kansans insured through the Medicaid (KanCare) program will make a real difference to your neighbors. Once you've provided your services, you'll want to file a claim so you can get paid for your work. That process may vary, depending on which of the three MCOs your patient is enrolled with.

Healthy Blue

Dental claims for Healthy Blue members are administered by a subcontractor called SKYGEN. There are three ways to submit a claim:

- Electronically, through their provider web portal called [Dental Hub](#)
- Electronically, via a clearinghouse, using Payer ID: **SCION**
- By mail: SKYGEN Healthy Blue Kansas: Claims PO BOX 359 Milwaukee, WI 53201

Detailed information about the Dental Hub can be found in this [Quick Start Guide](#).

Sunflower

Sunflower Health Plan's dental claims are managed by Envolve Dental, doing business as Centene Dental Services. They offer three ways for participating providers to submit claims:

- Electronically, via the Envolve [Provider Web Portal \(PWP\)](#)
- Electronic Clearing House: Payer ID: **46278**
- Mail to: Centene Dental Services Claims PO Box 25857, Tampa, FL 33622-5857

You can also download the [Centene Dental Services Provider Manual](#) for additional information. Claims information begins on p. 23.

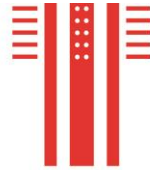
Providers who encounter problems can phone Provider Services: **855-434-9245**

United Health Care

United also uses the Dental Hub to streamline administrative processes, like claims submission. To use the website, go to <https://www.uhcdental.com/dental/portal-medicare.html> and register or login for Dental Hub as a participating user. To register on the site, you will need information on a prior paid claim or a Registration code. To receive your Registration code and for other Dental Hub assistance, call Provider Services at **1-800-822-5353**.

<https://pathwaystooralhealth.org/wp-content/uploads/2025/06/Filing-Claims-v5.pdf>

Resources for Dental Providers



ORAL HEALTH KANSAS

ADVOCACY • PUBLIC AWARENESS • EDUCATION

Medicaid (KanCare) Adult Dental Benefits Frequently Asked Questions for Providers



Who is eligible for the new adult dental benefit?

All people over age 21 who are eligible for Medicaid have access to new dental benefits. Adults who are eligible for Medicaid include people with disabilities, older adults, and pregnant people.

When did the adult dental benefits go into effect?

- Coverage for fillings, crowns, and gum disease care for people over age 21 went into effect on July 1, 2022.
- Coverage for dentures went into effect on July 1, 2023.
- Coverage for dental exams, x-rays, and cleanings for all adults without an annual limit on July 1, 2024.

What services are covered for people 18-20?

The services covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) are in effect for people up to age 21, and then the adult benefits kick in.

Does the new Kansas adult Medicaid dental coverage extend to pregnant persons? Are they able to get the same benefits: dentures, restorative, and cleanings under this new plan? Or are there tiers where some are eligible while others are not?

The new adult dental benefits are available to pregnant people who are over age 21. All of the services are available to all people over age 21 who have Medicaid coverage.



For Providers

- Frequently Asked Questions, including who is eligible and how a practice can understand the needs of Medicaid consumers.
- Enroll to become a Medicaid provider.
- List of codes covered in the new benefit and the rates for each.
- **Dr. Aaron Bumann**, Kansas City, Missouri, pediatric dentist shares myths and facts about being a Medicaid dental provider in this video.

<https://oralhealthkansas.org/MedicaidAdultDentalBenefits.html>

I'm here to help!

Bryan Thompson, Dental Medicaid Facilitator

bthompson@oralhealthkansas.org

785-493-2649



ACCESSIBLE ORAL HEALTH 2025 ECHO:

BUILDING CONFIDENCE IN DENTAL TEAMS TO SERVE PEOPLE WITH DISABILITIES

- This series will include 5 courses on Thursdays, beginning September 4 through October 2, 2025.
- All courses will be held via Zoom Noon – 1:00 PM CST.



Register Here:

bit.ly/AccessibleOralHealth2025ECHO



Dental Provider Advisory Group



DENTAL PROVIDER ADVISORY GROUP

Share your experiences and explore existing barriers and possible strategies as we work to improve the dental landscape for providers and all Kansans.



Who: Dentists & Dental Hygienists

Where: Virtual

When: Quarterly Meetings

Time: Approx. 8 hours/year

A stipend will be provided

Scan the QR code

or [click here](#) to
learn more



For further information please contact
info@oralhealthkansas.org

Scan the QR code



or click here to
sign up for our

Weekly
Wednesday
Update.



**Bringing people together to lead innovation in
overall health for Kansans**

Friday, November 7

**Hybrid: KU Edwards Campus
12600 S Quivira Rd
Overland Park, Kansas**

**Scan to
learn
more
and
register**



New Era, New Opportunities Webinar Series

August 19: Medicaid Dental: New Rates, Better Coverage

August 26: Your Practice, Your Way: Managing Your Patient Mix

September 2: Get to Know Your MCOs

September 9: Enrollment & Credentialing

September 16: Filing Medicaid Claims

September 23: Do Well by Doing Good: Medicaid Opportunities

September 30: My Dental Care Passport

