The Provider Portal Guide for Dentists

univera HEALTHCARE

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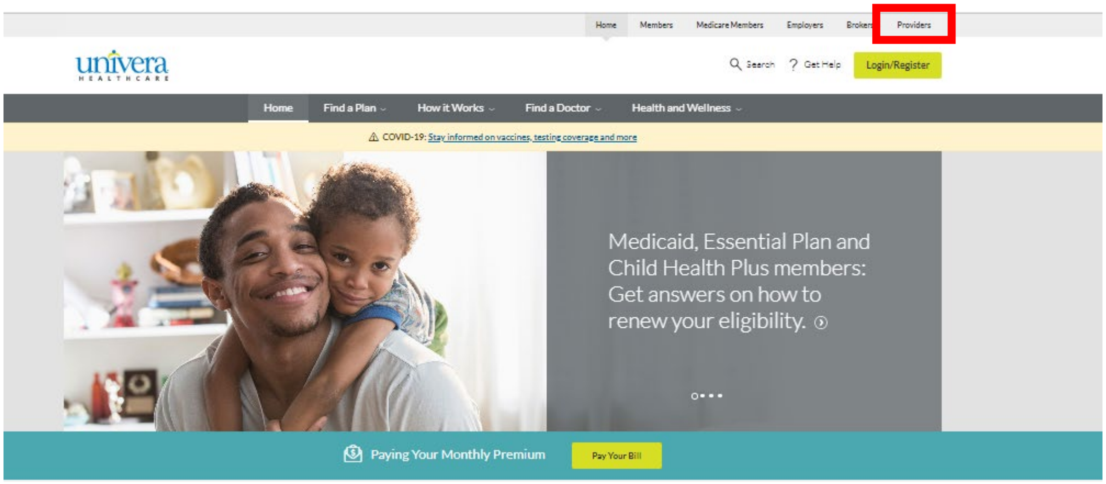
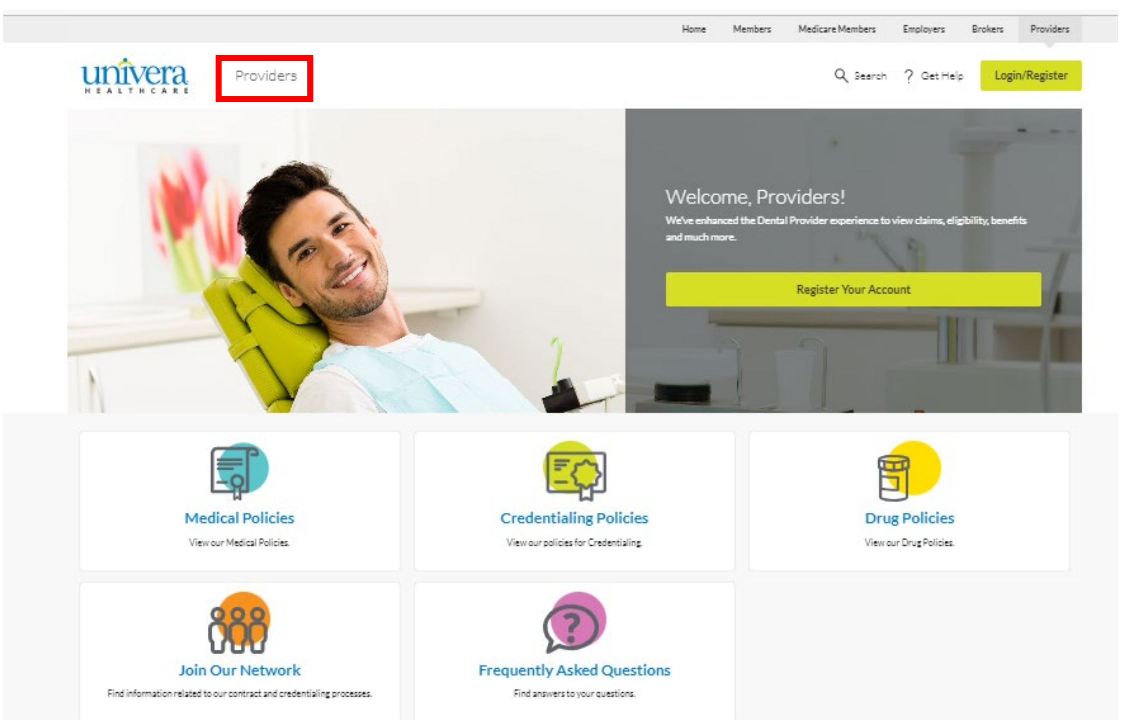
Univera Healthcare Provider Portal

The Univera Healthcare website (www.UniveraHealthcare.com) contains an area that is dedicated to the various types of provider we partner with. This area, called the Provider portal, can be located by selecting Providers at the top of our Home page.



The Provider public home page includes information such as how to join our network and links to our Corporate Medical, Credentialing, and Drug Policies.

The Frequently Asked Questions tile provides answers to common questions such as how to register, log in, and manage staff access to the secure portion of the Provider portal.



Secured Portion of the Provider Portal

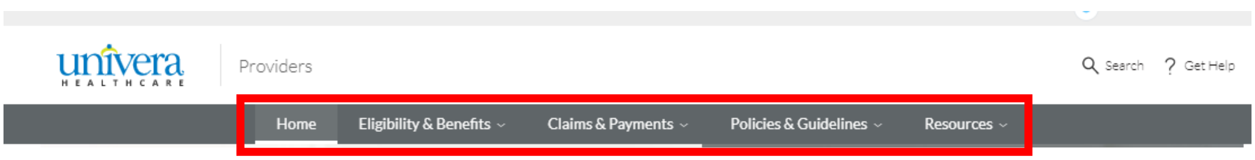
The secured portion of the Provider portal includes proprietary information that can only be viewed by provider and their staff who are registered with Univera Healthcare. Dentists will receive a letter from Univera Healthcare listing the dentist's Unique Provider ID and the last four digits of the corresponding tax ID. This information is required to register and log in to the Provider secure portal.

Logging in to the Provider Portal

To login into the secure portion of the Provider portal:

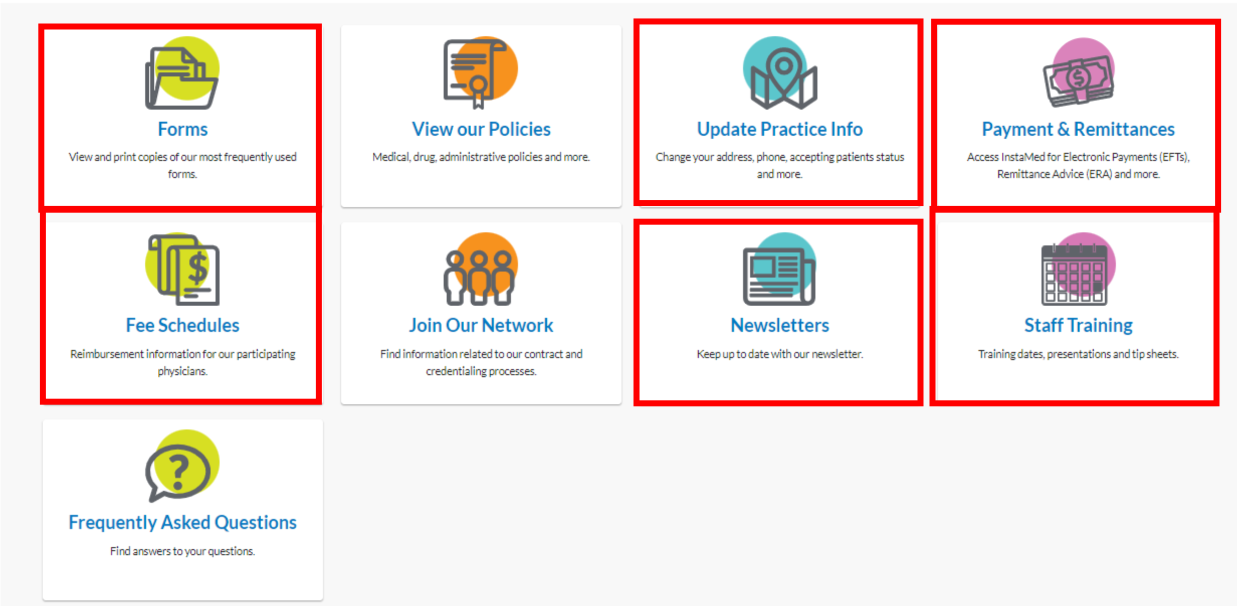
1. Go to Provider.UniveraHealthcare.com/login.
2. Enter your Username and Password
3. Click Log In

The screen will then reflect the user's name and option to Log Out at the top and various options for the user to select from: Home (default page), Eligibility & Benefits, Claims & Payments, Policies & Guidelines, and Resources.



Home Page

The Home page will include the tiles available to everyone (View Our Policies, Update Practice Info, Join Our Network, and Frequently Asked Questions, and includes the secure tiles (Forms, Update Practice Info, Payments & Remittances, Fee Schedules, Newsletters, and Staff Training).



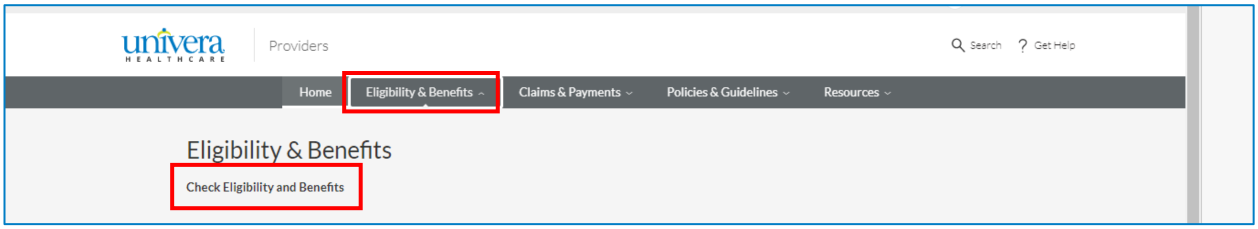
- Forms – includes frequently use items such as claim forms that can be viewed or printed
- Update Practice Info – participating dentists can use this link to obtain access to the instructions and online form or PDF to update demographic changes to a practice
- Payments & Remittances – includes information and a link to sign up for electronic payment through InstaMed®
- Fee Schedules – a listing of custom fee schedules for the employer groups
- Newsletters – a link to news and updates including The Floss Dental Newsletter
- Staff Training – a link to all training topics, dates, and times, as well as presentations, guides, and tip

Eligibility and Benefits

To check a patient's eligibility and benefits:

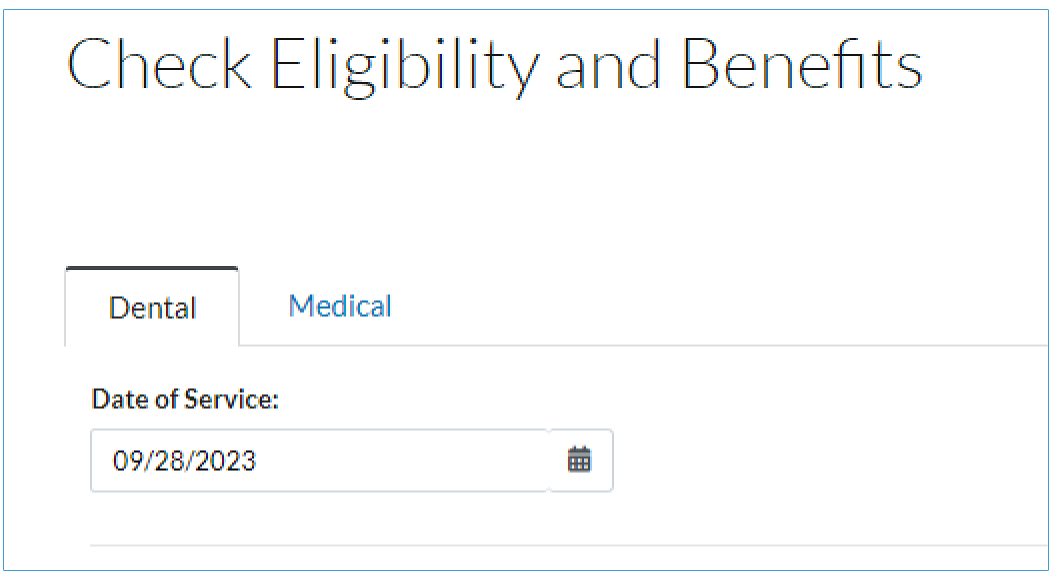
1. Click on the Eligibility & Benefits at the top of the Provider Home page

2. Select Check Eligibility and Benefits.



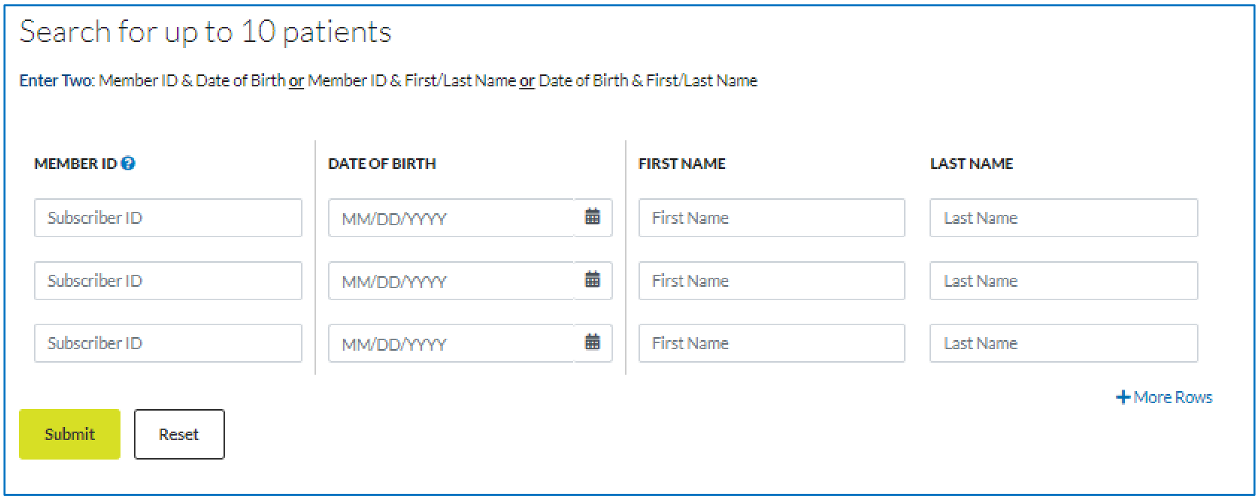
3. There are two tabs at the top giving the user the option of selecting Dental or Medical eligibility and benefits; however, the screen defaults to dental.

4. Select the Date of Service by clicking on the calendar icon and selecting the applicable date. Note: Only one date of service can be selected regardless of the number of members being searched. Selecting the correct date of service will ensure that the eligibility and benefits such as deductible and amount met, or benefit limitations are reflected accurately for the time period specified.

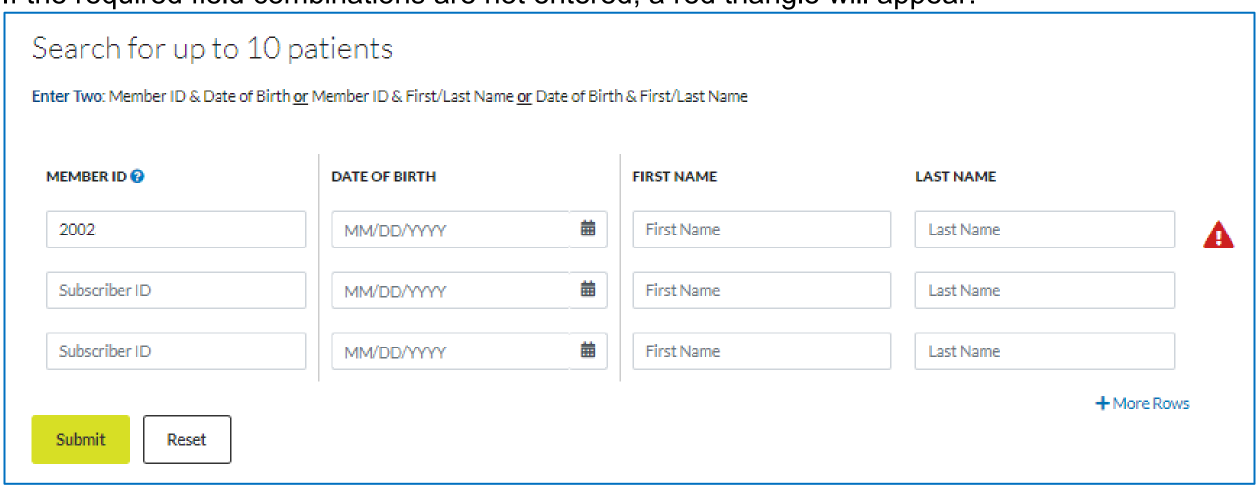


5. The portal allows up to ten members to be searched using one of the following combinations:
    - Member ID & Date of Birth **or**
    - Member ID & First/Last Name **or**
    - Date of Birth & First/Last Name

    Once the selected information is entered, click Submit.

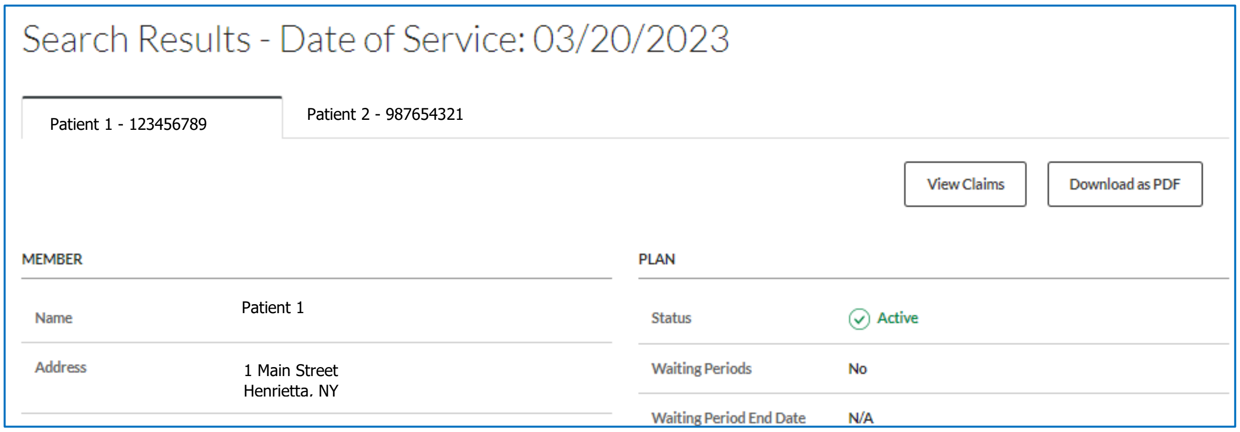


If the required field combinations are not entered, a red triangle will appear.

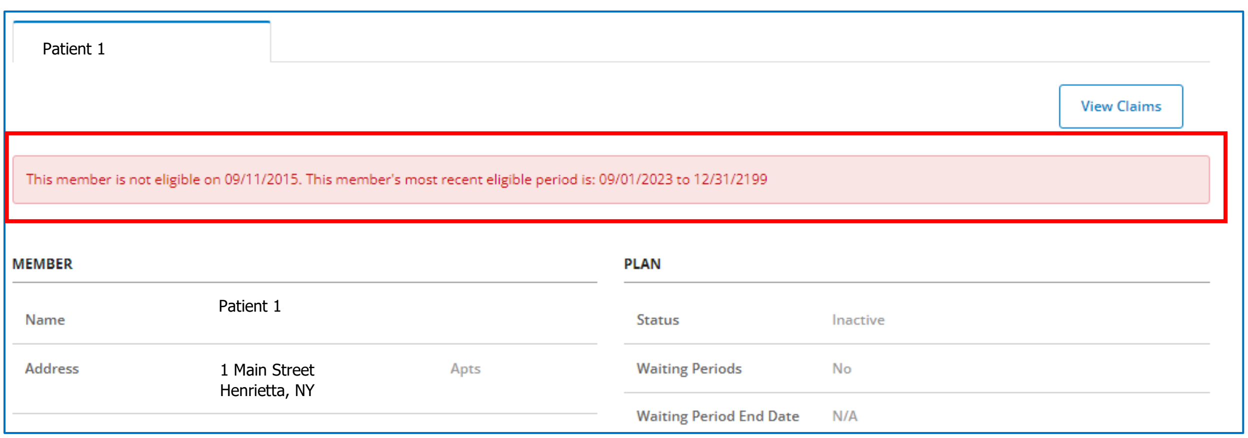


6. When the search produces a match, each patient entered will have his/her own separate tab and will default to the first patient entered in the search. To select another patient, click on the applicable tab.

   Eligible members will also reflect the options to View Claims and to Download the eligibility and benefits as a PDF.



   Ineligible members for the date of service entered, will reflect eligibility details when applicable.



Eligibility and Benefits Search Results

The search results are broken into the following categories and fields:

Member	
Name	The name of the patient entered
Address	The address of the member
Phone	The phone number for the member
Date of Birth	The patient's date of birth
Gender	The patient's gender
ID Card	If the identification card for the member is available, a link to the card will be listed.
Subscriber	
Name	The name of the person holding the policy
Address	The policy holder's address
Phone	The phone number for the member
Active Plan Members	The names of all active members under the same plan

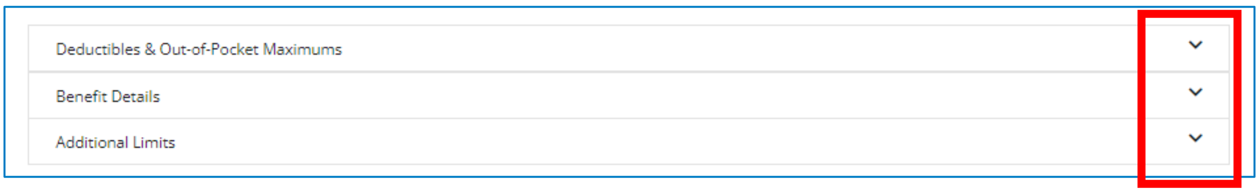
Plan	
Status	Eligible members will reflect Active as the status
Waiting Periods	This field indicates if waiting periods apply to the specific member
Waiting Period End Date	If waiting periods apply, the date reflected in this field indicates when the waiting period will end.
Effective	The effective dates of coverage. Please note active coverage will indicate a 12/31/2199 end date.
Plan Year Effective Date	The date that this plans 12-month period of benefit coverage begins. For example, a 01/01 plan year will run from 01/01 to 12/31.
Member ID	Displays the member's identification number and suffix
Plan Name Product Type	Displays the name of the insurance plan, product, and policy.

Policy	Note: a custom group displays a “C” in the fourth charter of the product type. (e.g. DSSC0001 – Custom Dental Product)
Group Name Group #	Displays the employer group name and number
Out of Area Provider Network	This field indicates if there is out of area provider network available. • N/A: the member’s plan does not offer the DenteMax pricing benefit • DenteMax: a pricing agreement is available to provider who participate with this network
Relationship	Displays the patient relationship to the subscriber or policy holder
Dependents	Displays the dependent age limit
Other Coverage	When applicable, this section will display the primary insurance carrier, status, effective date, and member ID, for any primary insurance coverage the Health Plan has on file
Medicare	Displays Medicare information that the Health Plan has on file

To view Benefits, click on the drop-down arrows to the right of the following options:

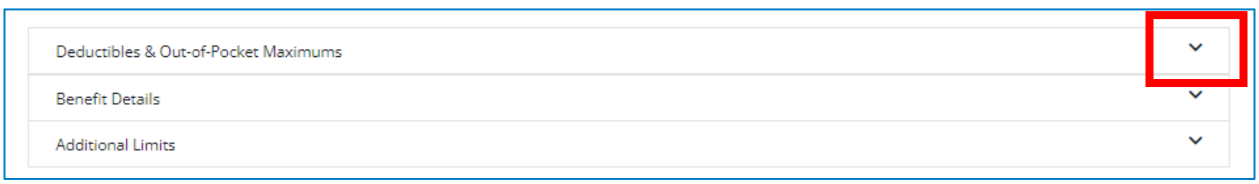
- Deductibles & Out of Pocket Maximums
- Benefit Details
- Additional Limits

Note: When the member is enrolled in Child Health Plus (CHP), Medicaid Managed Care (MMC), or Essential Plans, the information in these sections will be blank as dental services are provided by Healthplex.

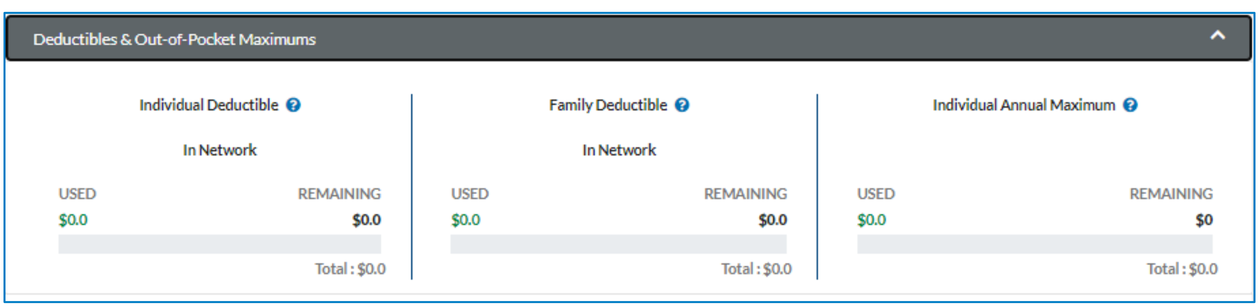


Deductibles and Out of Pocket Maximums

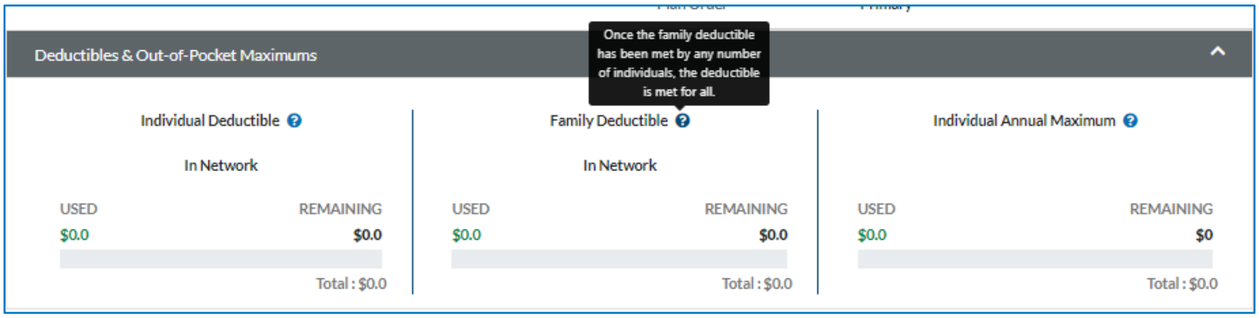
To review the policy in network family or individual deductible and individual annual maximums, click on the drop-down arrow to the right of Deductibles & Out of Pocket Maximums.



The individual deductible, family deductible, and individual maximum will be listed along with the amount currently used, and the amount remaining for the date of service entered.

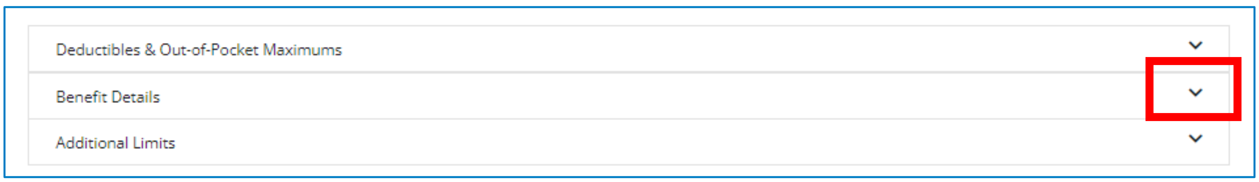


The question mark to the right of each category provides additional information related to the category. In the example below, the question mark provides additional information on how the family deductible applies to individuals and the family.

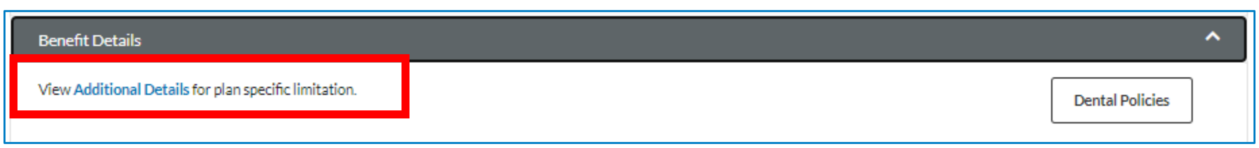


Benefit Details

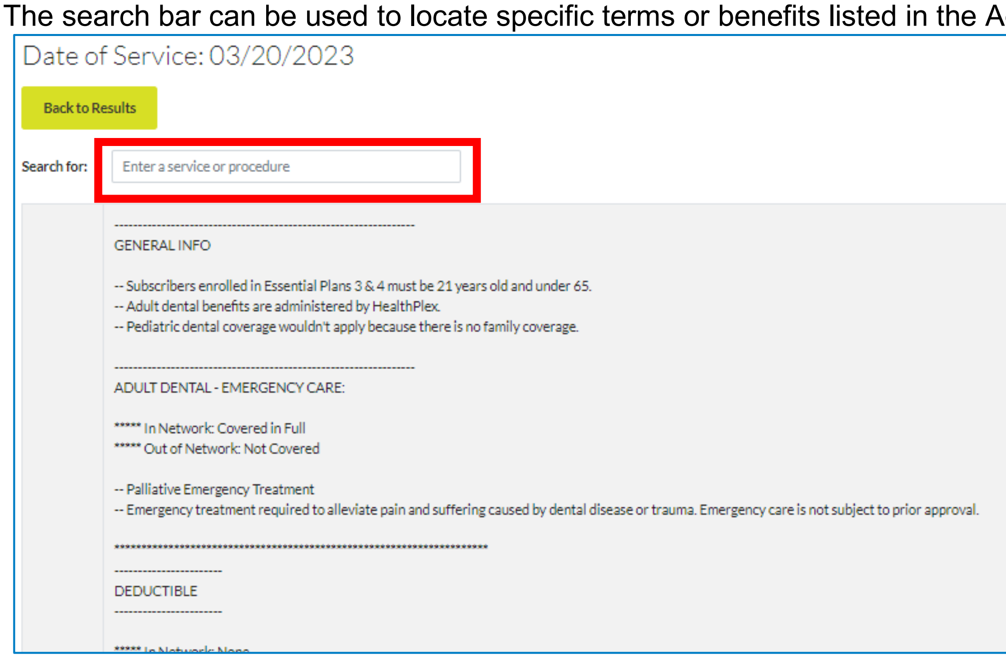
For additional details on corporate dental policies and patient costs for in and out of network services, click on the drop-down arrow to the right of Benefit Details.



For a detailed list of plan specific benefits and limitations, click on Additional Details.



The search bar can be used to locate specific terms or benefits listed in the Additional Details.



The top right-hand side provides a link to the Dental Policies

Benefit Details

View **Additional Details** for plan specific limitation.

Dental Policies

After clicking on the box, the list of dental related Medical Policies will be listed.

Medical Policies

In accessing our medical policies you signify your agreement to our Terms of Use. Learn more about how medical policies are developed and about experimental & investigational procedures.

For certain member contracts, the Health Plan has delegated utilization management of the following services to eviCore Healthcare MSI, LLC d/b/a eviCore Healthcare: **implantable cardiac devices, radiology/imaging, radiation therapy, and musculoskeletal services (large joint replacement, pain management, and spine services)**. The Health Plan has adopted eviCore's medical policies and guidelines as a basis for the determination of medical necessity and appropriateness of care.

Please refer member-specific questions to the Customer Care number on the back of the member ID card. Final determination of coverage is subject to the member's benefits and eligibility on the date of service.

Make a Comment

We invite practitioners to review & comment on our policies

Search by Name, Code or Category... or Dental Reset

Showing 1 - 6 of 6 Results

TITLE	LAST UPDATED	CATEGORY
Dental and Oral Care under Medical Plans 7.01.21	2022-07-15	Dental
Dental Crowns and Veneers 13.01.02	2022-07-15	Dental

The Benefit Details then lists the different categories of services, and patient costs for both in and out of network provider.

Benefit Details

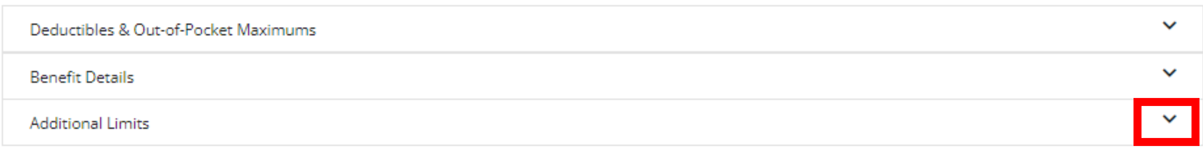
View **Additional Details** for plan specific limitation.

Dental Corporate Policies

SERVICE	PATIENT COST IN NETWORK	PATIENT COST OUT OF NETWORK
Class I - Preventive/Diagnostic Services	\$0.00 Deductible 0% Coinsurance \$0.00 Annual Limit	\$0.00 Deductible 0% Coinsurance \$0.00 Annual Limit
Class II - Basic Restorative Services	\$50.00 Deductible 20% Coinsurance \$1,000.00 Annual Limit	\$50.00 Deductible 20% Coinsurance \$1,000.00 Annual Limit
Class IIA - Periodontic Services	\$50.00 Deductible 20% Coinsurance \$1,000.00 Annual Limit	\$50.00 Deductible 20% Coinsurance \$1,000.00 Annual Limit
Class III - Major Restorative Services	\$50.00 Deductible 50% Coinsurance \$1,000.00 Annual Limit	\$50.00 Deductible 50% Coinsurance \$1,000.00 Annual Limit
Class IV - Orthodontia Services	\$0.00 Deductible 50% Coinsurance \$500.00 Annual Limit	\$0.00 Deductible 50% Coinsurance \$500.00 Annual Limit

Additional Limits

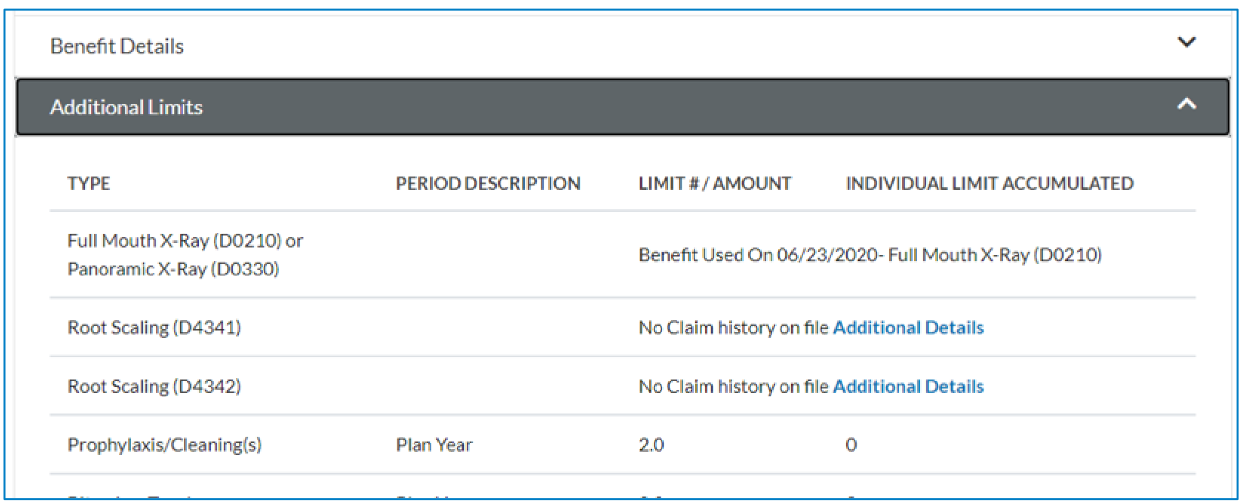
To determine the number of times a type of service can be performed within a given timeframe, or if there is a dollar limitation to a service, click on the drop-down arrow to the right of Additional Limits.



The Additional Limits will provide a listing of the type of service, period, limit, and the individual limit accumulated.

For full mouth X-rays, panoramic X-rays, and root scaling, when used, the Limit # / Amount field will reflect when the benefit was used and will list the service, code, tooth, or quadrant.

If the full mouth X-rays, panoramic X-rays, and root scaling benefits are not used, the Limit # / Amount field will reflect No Claim history on file and will have a link to the Additional Details section where the benefit and limits can be found.

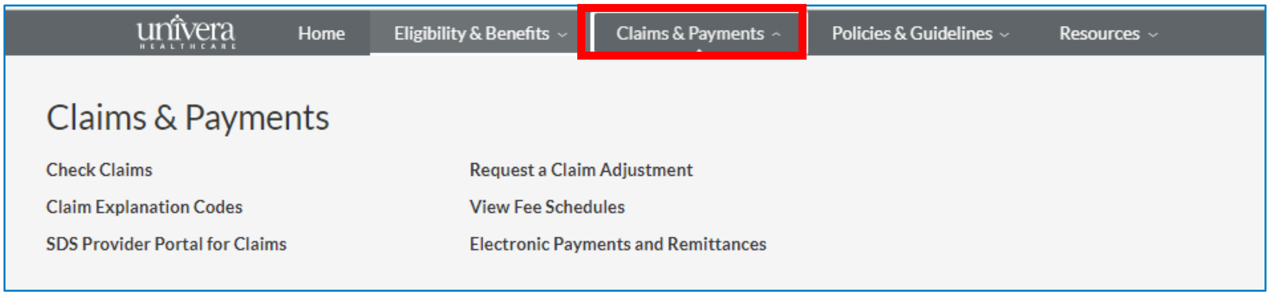


TYPE	PERIOD DESCRIPTION	LIMIT # / AMOUNT	INDIVIDUAL LIMIT ACCUMULATED
Full Mouth X-Ray (D0210) or Panoramic X-Ray (D0330)		Benefit Used On 06/23/2020- Full Mouth X-Ray (D0210)	
Root Scaling (D4341)		No Claim history on file Additional Details	
Root Scaling (D4342)		No Claim history on file Additional Details	
Prophylaxis/Cleaning(s)	Plan Year	2.0	0

Note: Bitewings are limited to any combination of 4 films per plan year for most standard Dental Plans. Always review the additional benefits tab for specific plan limitations.

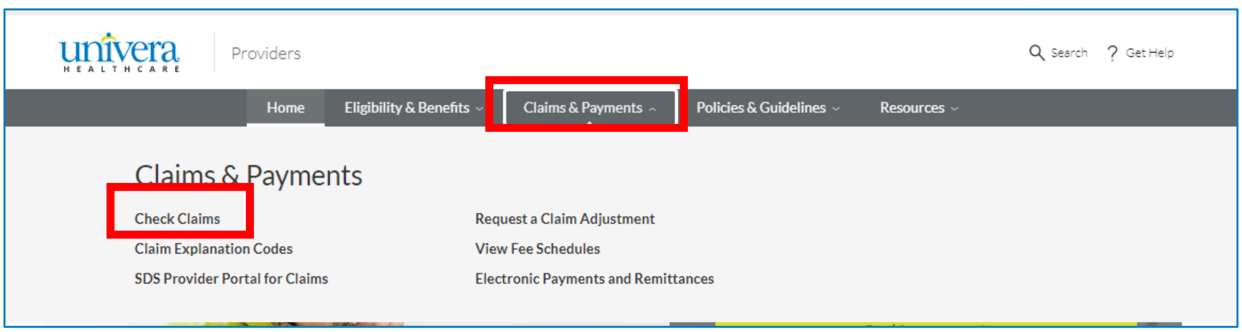
Claims & Payments

Under the Claims and Payments area, the user can check claims, review claim explanation codes, review the information and links to the Smart Data Solutions, Inc. (SDS) portal, request a claim adjustment, view fee schedules, review the information and links for electronic payments and remittances.



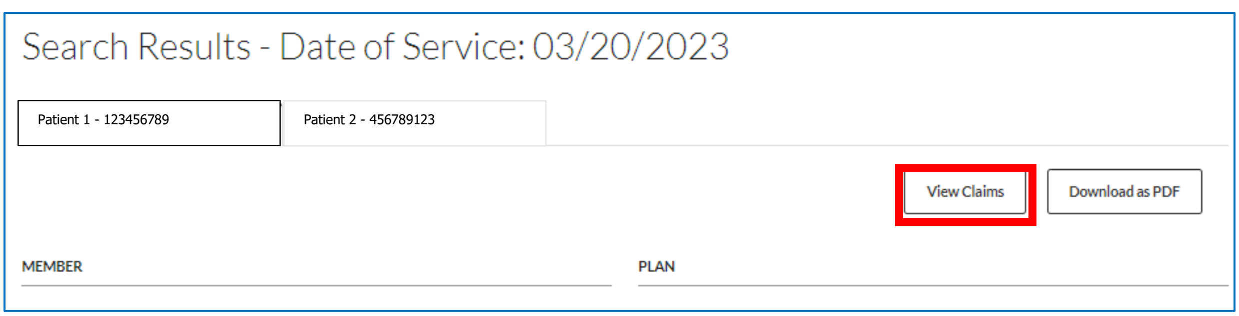
Dental Claims

To review claims or pre-estimate treatments, the user can click on Claims & Payment and Check Claims:



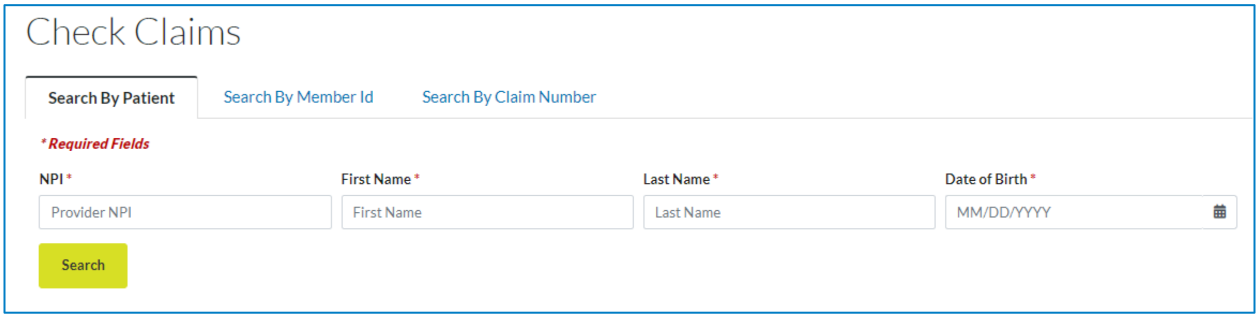
OR

Click on Check Claims from the Eligibility and Benefits screen:

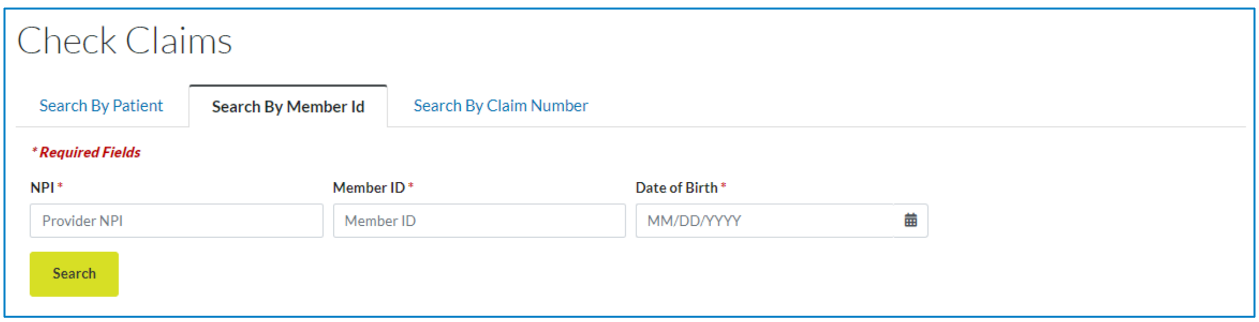


When the dental claim search page appears, there are three tabs with different options on how to search for a claim:

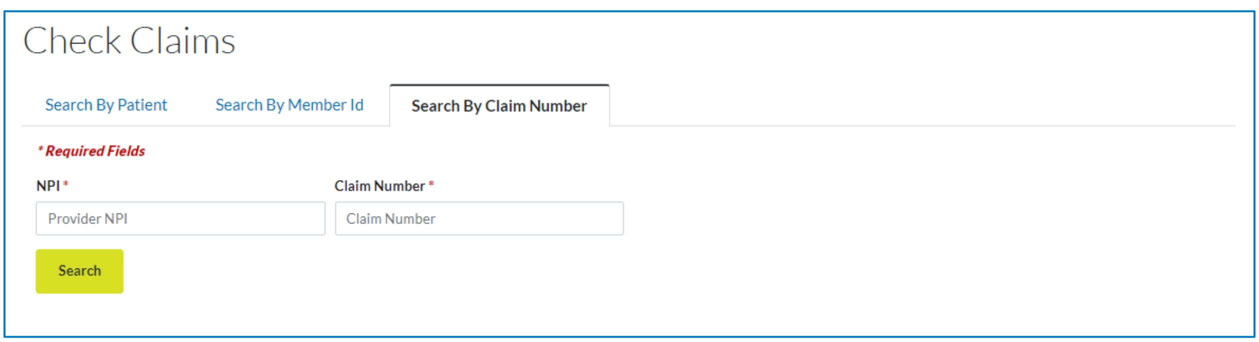
1 - Search By Patient = NPI, First Name, Last Name, and Date of Birth are required



2 - Search By Member ID = NPI, Member ID, and Date of Birth are required

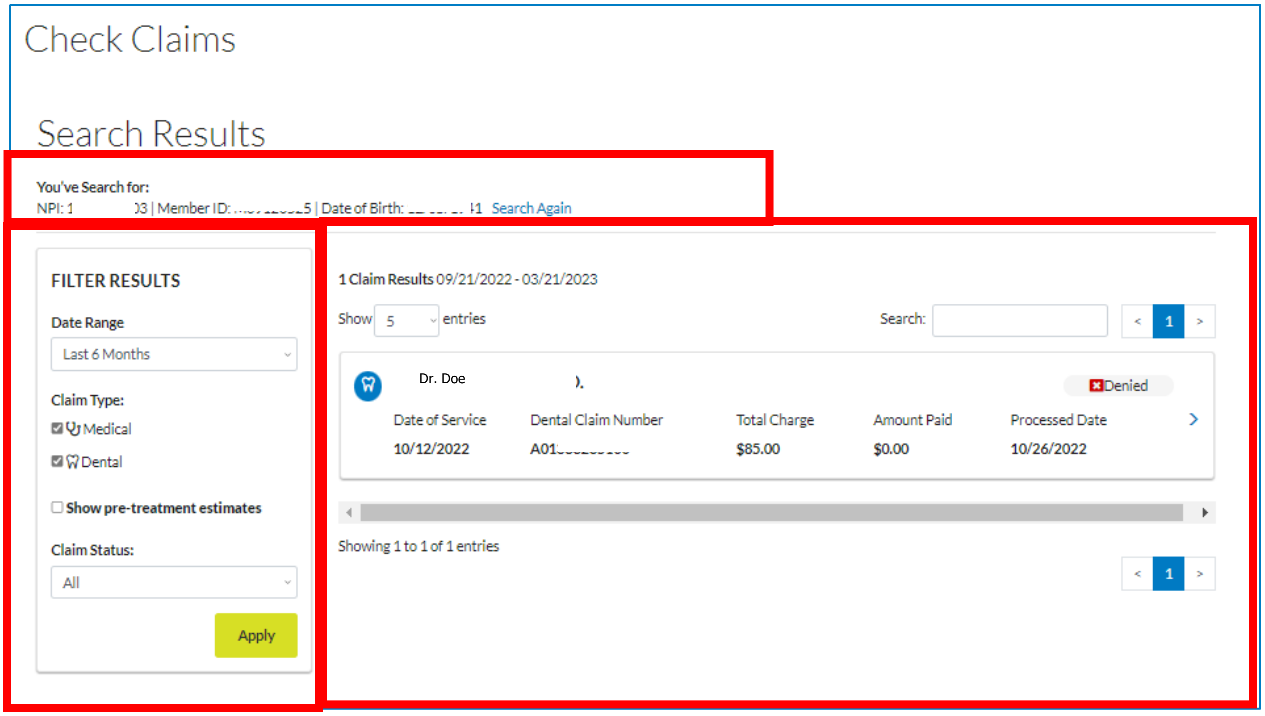


3 - Search by Claim Number = NPI and Claim Number are required



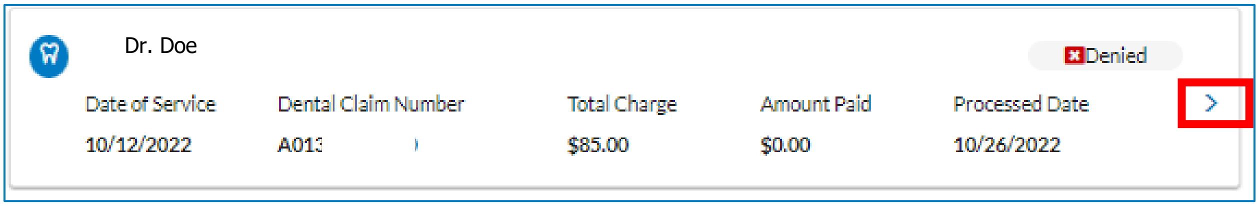
Search Results Page

The search results page is broken out in to three areas:

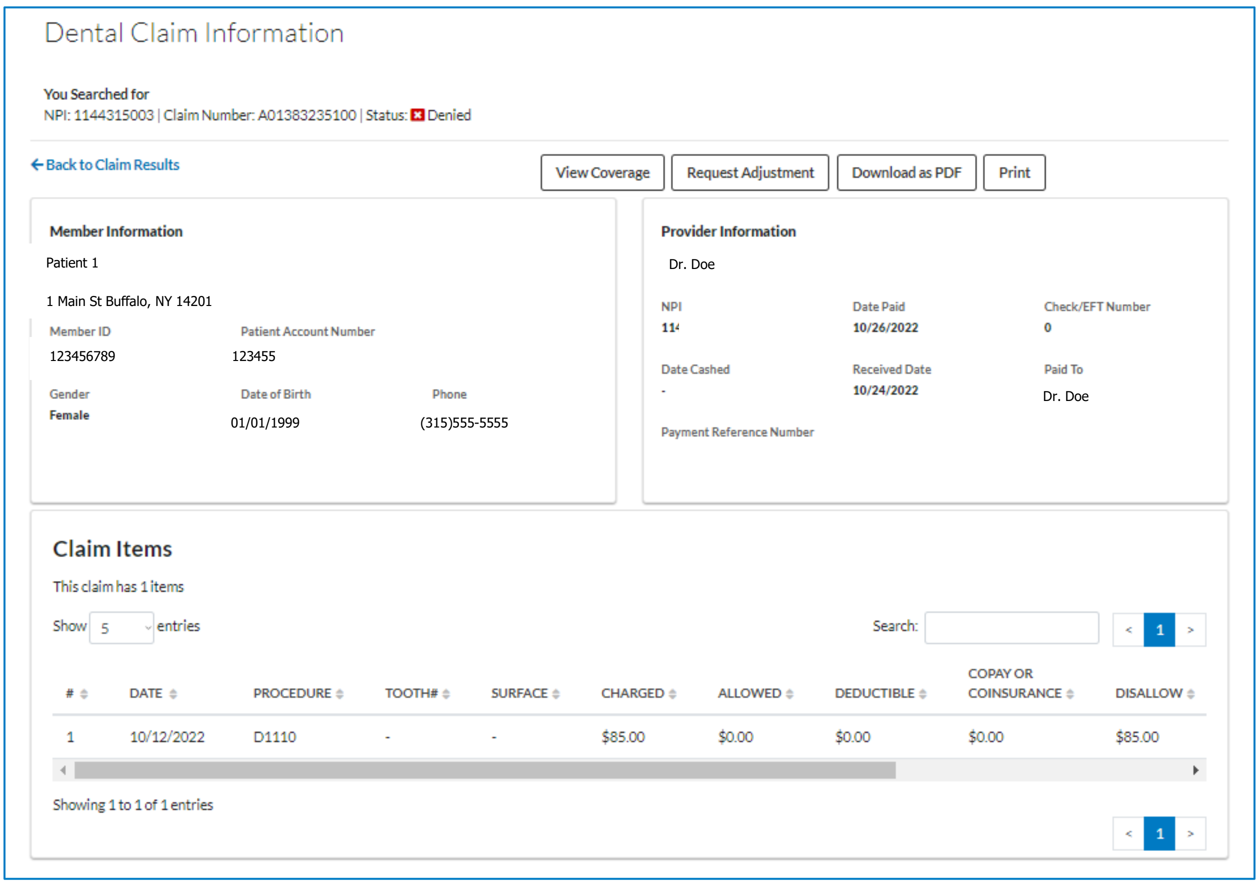


Search Criteria	Reflects the information entered in the search and the link to Search Again.
Filter Results	This area allows you to filter by: • Date range (last 6 months, year to date, last 12 months, last 24 months, or select a date range) • Medical or dental claim types • To show or not show pre-estimates • Claim status (All, in process, processed, denied, pre-determination in process, and pre-determined).
Claim Results	This area reflects: • The date range used for the search, the maximum number of entries that will listed, and a search box for additional filtering • A list of claims with the medical or dental icon, provider's name, claim status, date of service, dental claim number, total charges, amount paid, and date paid

To open a claim, click on the arrow to the right of the applicable claim to review the details:



The Dental Claim Information screen will appear.



At the top is the search criteria, the option to go Back to Claims Results, A box to View Coverage, Request Adjustment, Download as a PDF, or Print.

Check Claims

Dental Claim Information

You Searched for
NPI: 161 | Claim Number: R001 | Status: Denied

← Back to Claim Results

View Coverage | Request Adjustment | Download as PDF | Print

Below that is the Member and Provider Information:

Member – Name, Address, ID, Patient Account Number, Gender, Date of Birth and Phone

Member Information

Patient 1

1 Main St Buffalo, NY 14201

Member ID	Patient Account Number	
123456789	123455	
Gender	**Date of Birth**	**Phone**
Female	01/01/1999	(315)555-5555

Provider – Name, NPI, Date Paid, Check or EFT Number, Date the check was cashed, Received Date, Paid To name, Payment Reference Number.

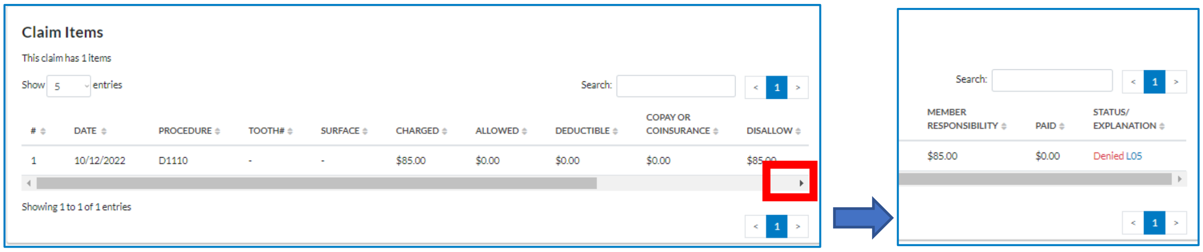
Provider Information

Dr. Doe

NPI	Date Paid	Check/EFT Number
114	10/26/2022	0
Date Cashed	**Received Date**	**Paid To**
-	10/24/2022	Dr. Doe

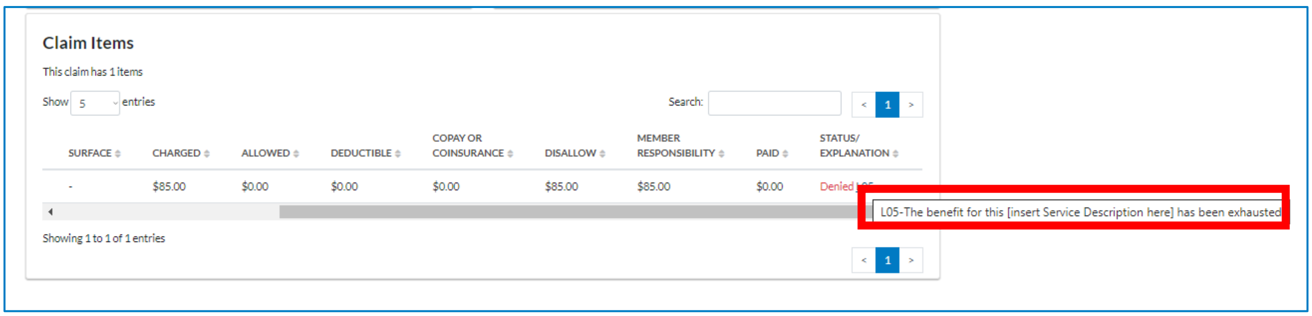
Payment Reference Number

Claim Items are listed under the Member and Provider sections.



The scroll bar can be used to view all details on the claim – line number, date of service, procedure code, tooth number, surface, charged amount, allowed amount, deductible applied, copay or coinsurance applied, disallow amount, member responsibility, other insurance amount, paid amount, and status/explanation code.

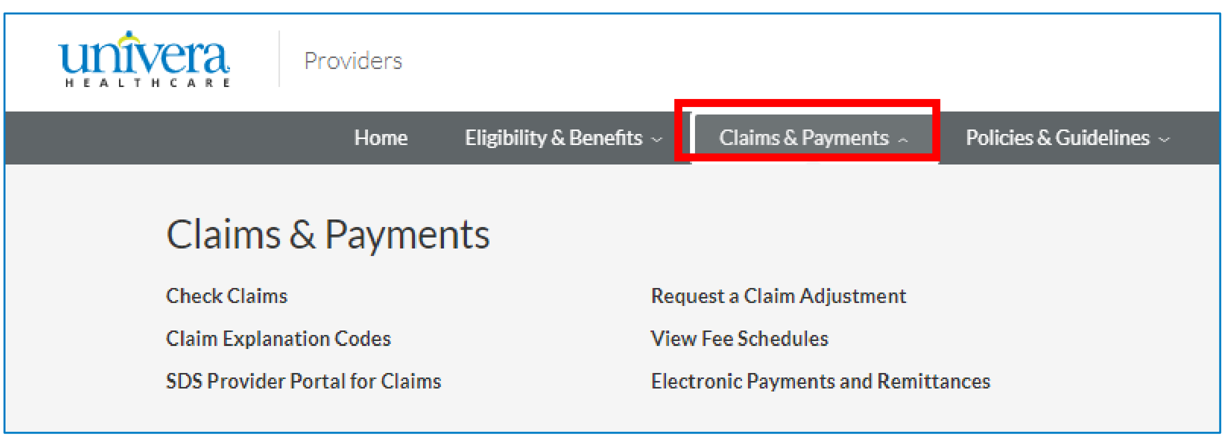
When the status of a claim is Denied, hover over the explanation code to see the denial verbiage.



Please note - when submitting a secondary claim, printouts of the dental portal cannot be used in place of an explanation of benefit or provider remittance statement, as the portal does not contain the detail needed to process the secondary claim.

Claims & Payments

Under the Claims & Payments area, additional items and resources are available to the user.



Claim Explanation Codes

The claim explanation codes is a listing of denial codes and their descriptions. To view the full list, click on the link to download, and open the file.

Claim Explanation Codes

Claim Explanation Codes

The file will open to an excel spreadsheet.

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Claim Denial Codes

Explanation Code	Description
001	Postpone payment of claim > 2 weeks
002	Increased allowable
003	Reduced allowable
009	Administrative Approval
016	Reduced allowable amount per unit
018	Reduced allowable units
019	Disallowed amount

SDS Portal for Claims

The SDS portal for Claims provides information on how to register, sign in, and submit claims to our partner SDS through a web-based platform.

Request a Claim Adjustment

If a claim adjustment is needed, this area of the portal provides the form needed for the adjustment as well as the information on how to address overpayments.

View Fee Schedules

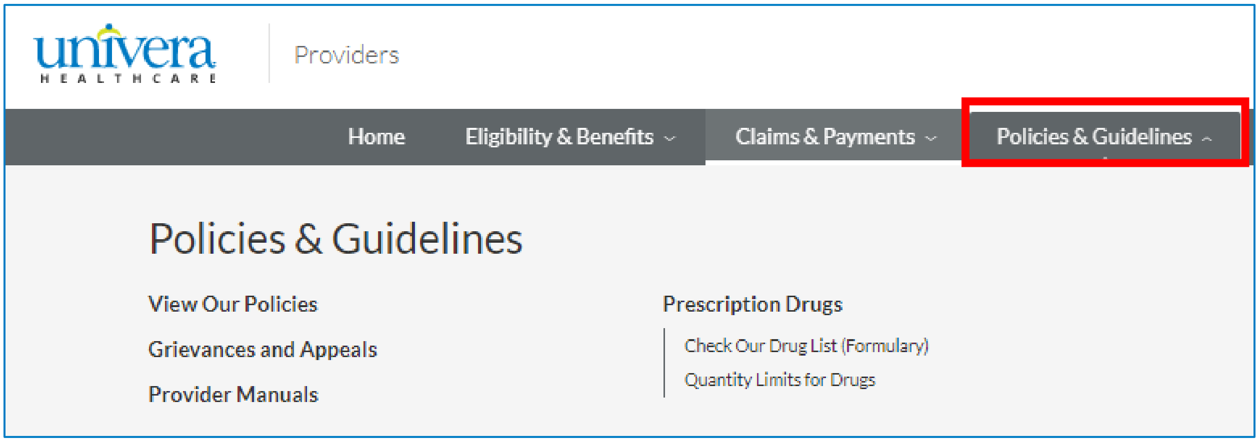
Custom employer or group specific fee schedules are listed in this area and provide a current and previous year listing of codes, descriptions, in and out of network allowances, and what area the benefit falls within if covered. The search box can be used to search by a Group Name or Product ID that can be found in the eligibility and benefits section under Group Name or Product Type. To open the fee schedule, click on the link to download, and open the file.

Electronic Payments and Remittances

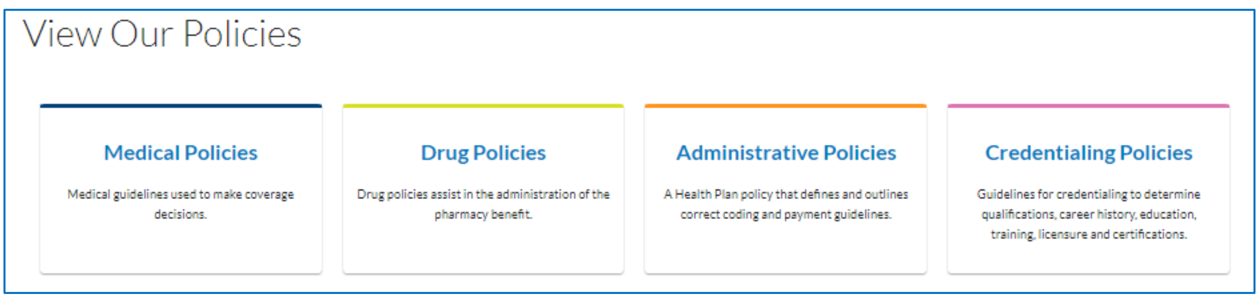
This area provides details regarding our partner for electronic payments and remittance advice - InstaMed, including a link to their online registration, benefits of InstaMed and details on who to call for different types of questions.

Policies & Guidelines

The Policies & Guidelines area of the portal includes reference material and prescription drug formularies.



View our Policies



The View Our Policies section, provides tiles that link to the following:

Medical Policies – includes all medical and dental corporate policies that are used in making coverage decisions.

Drug Policies – includes all drug related policies that assist in the administration of pharmacy benefits.

Administrative Policies – a policy that defines and outlines correct coding and payment guidelines. After clicking on this link, the user must agree to the terms prior to viewing the list. The search bar at the top allows the user to search for a specific topic.

Credentialing Policies – includes information on the different types of medical and dental providers, and their policies on credentialing.

Grievances and Appeals

The Grievances and Appeals area includes our policies related to adverse determinations.

Grievances and Appeals

The grievance and appeal process is intended to provide a reasonable opportunity for a full and fair review of an adverse determination. The process varies slightly based on federal and state regulations.

For additional information, please refer to our Participating Provider Manual

- **For Commercial Members** - Section 4.12 Utilization Review Appeals and Grievances
- **For Medicare Members** - Section 9.5 Member Grievances, Organization Determinations and Appeals
- **For Medicaid Members** - Section 10.11 Member Grievance and Utilization Review Appeal Policy and Procedure

Provider Manuals

The Provider Manual is a reference and source document for physicians and other providers who participate with Univera Healthcare.

Provider Manuals

Univera Healthcare Provider Manual

ENTIRE MANUAL

Section 1	Introduction
Section 2	Administrative Information
Section 3	General Provider Information
Section 4	Benefits Management
Section 5	Pharmacy Management
Section 6	Behavioral Health
Section 7	Billing and Remittance
Section 8	Quality Improvement
Section 9	Medicare Advantage Programs
Section 10	Government Programs

Univera Healthcare Health and Recovery Plan Manual

Univera Healthcare Health and Recovery Plan (HARP) Manual

Prescription Drugs

The Prescription Drugs area includes links to the Drug Formularies and quantity limits for drugs.

Prescription Drugs

Choices in this section include:

Check Our Drug List (Formulary)

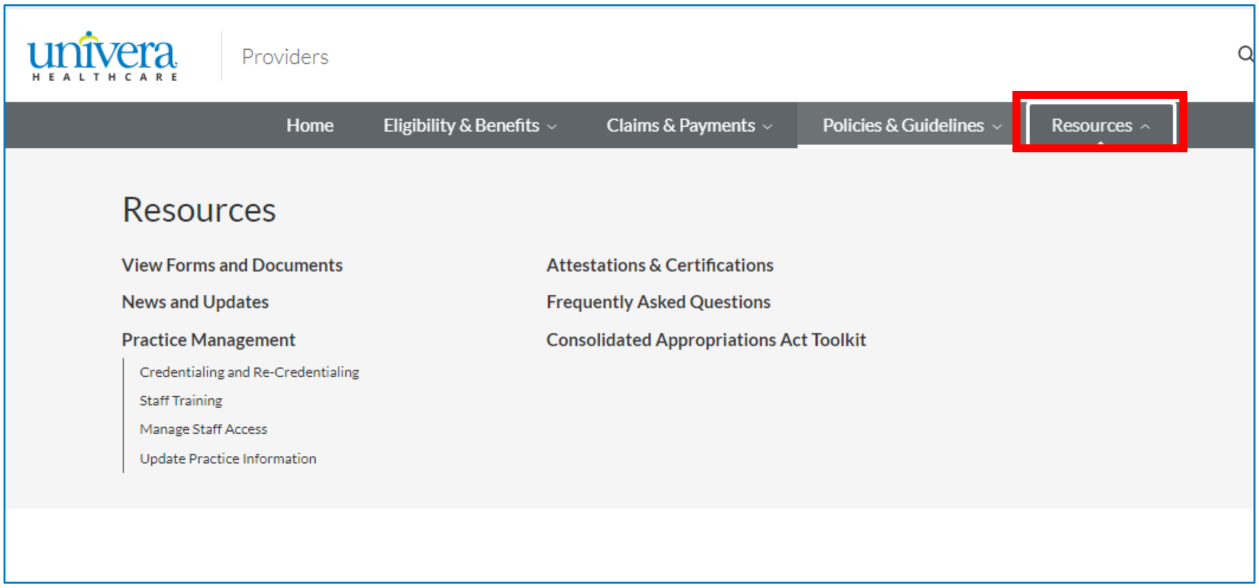
View or print our formularies. Preview upcoming changes to formularies.

Quantity Limits for Drugs

To help assure access to safe, effective drug therapy and to protect against misuse and waste, we require quantity limits on selected prescription medications.

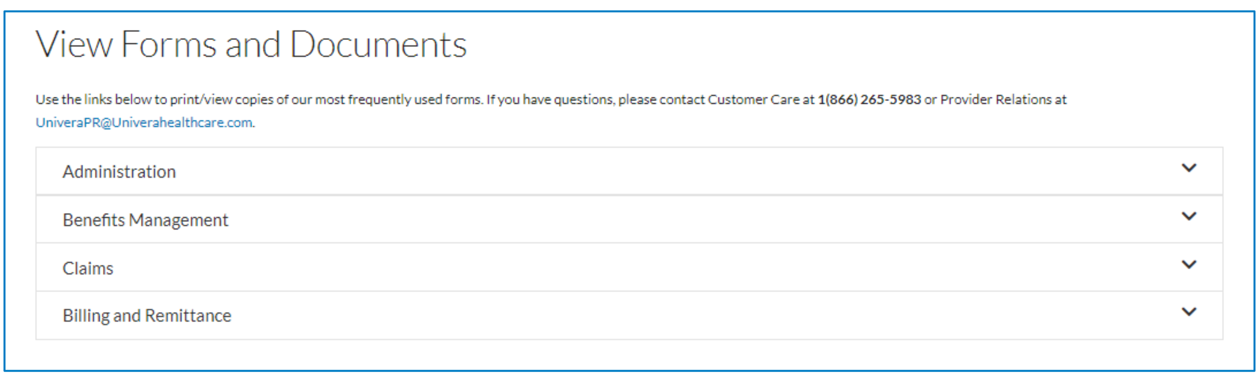
Resources

The Resources area also includes a variety of reference and training materials, videos, includes links to current and past provider communications, and practice related information and links to assist provider in running their day-to-day business, and maintaining their records with the Health Plan.



View Forms and Documents

Under the view forms and documents section, there are links to a variety of forms and documents that can be downloaded, viewed, and printed.



The forms are broken out in to four categories – Administration, Benefits Management, Claims, and Billing and Remittance related forms. Click on the arrow to the right of the topic and the sub list of topics will appear:

Administration

- Application for Dental Enrollment
- Practitioner Demographic Changes
- Review Dental Enrollment Checklist

Benefits Management

- Medicare Advantage Dental Benefit Plan Year 2023
- Request for Grievance or Appeal Form

Claims

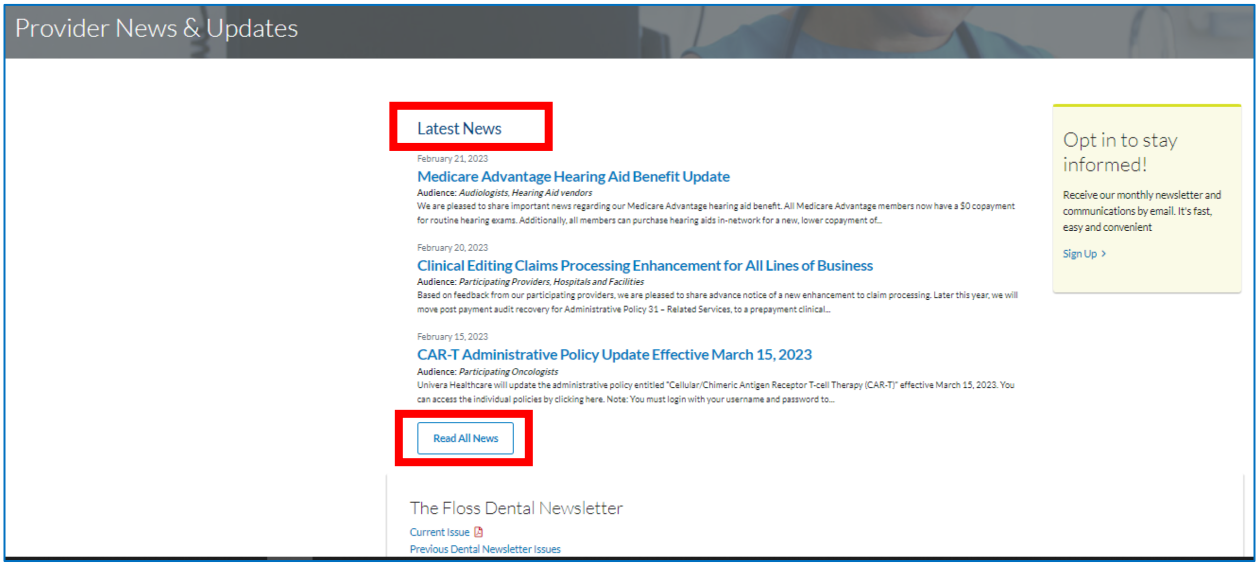
- Dental Claim Adjustment Form
- ADA Dental Claim Form
- Procedure Codes that Require Dental Record Submission

Billing and Remittance

- Request for Timely Filing Review
- Tooth Billing Requirement Guide

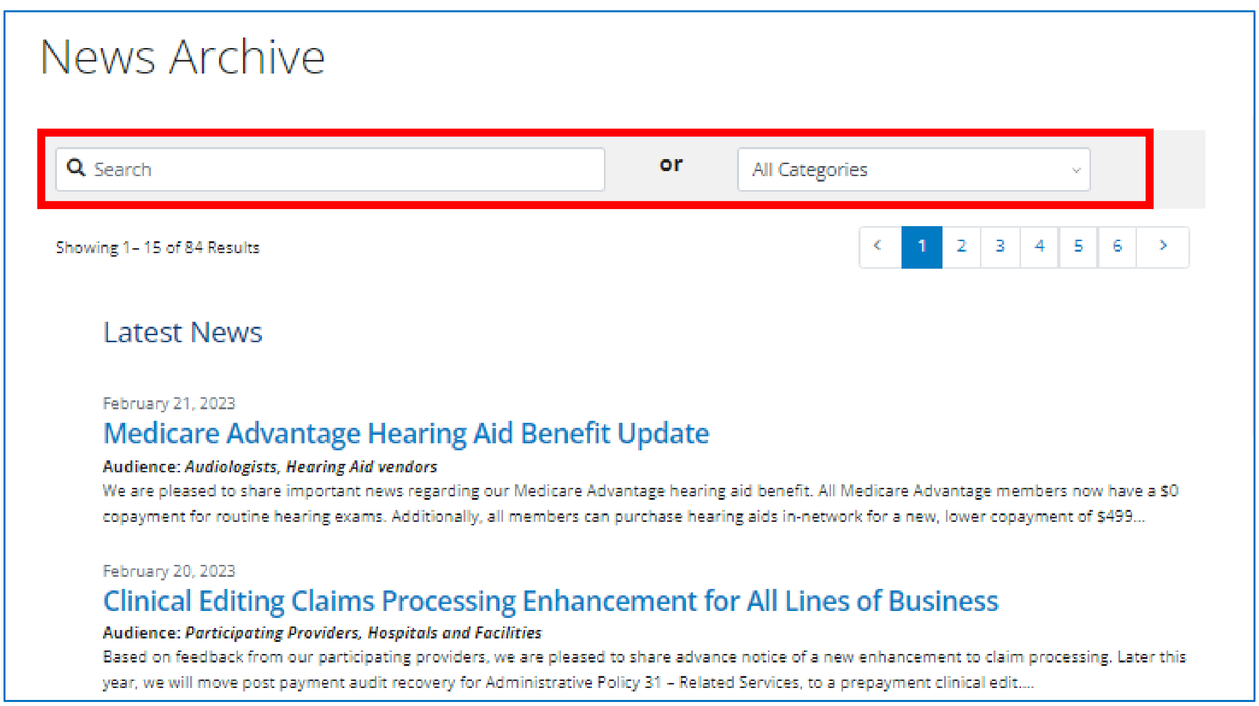
News and Updates

The News and Updates section includes communication that we mail or email to our provider.



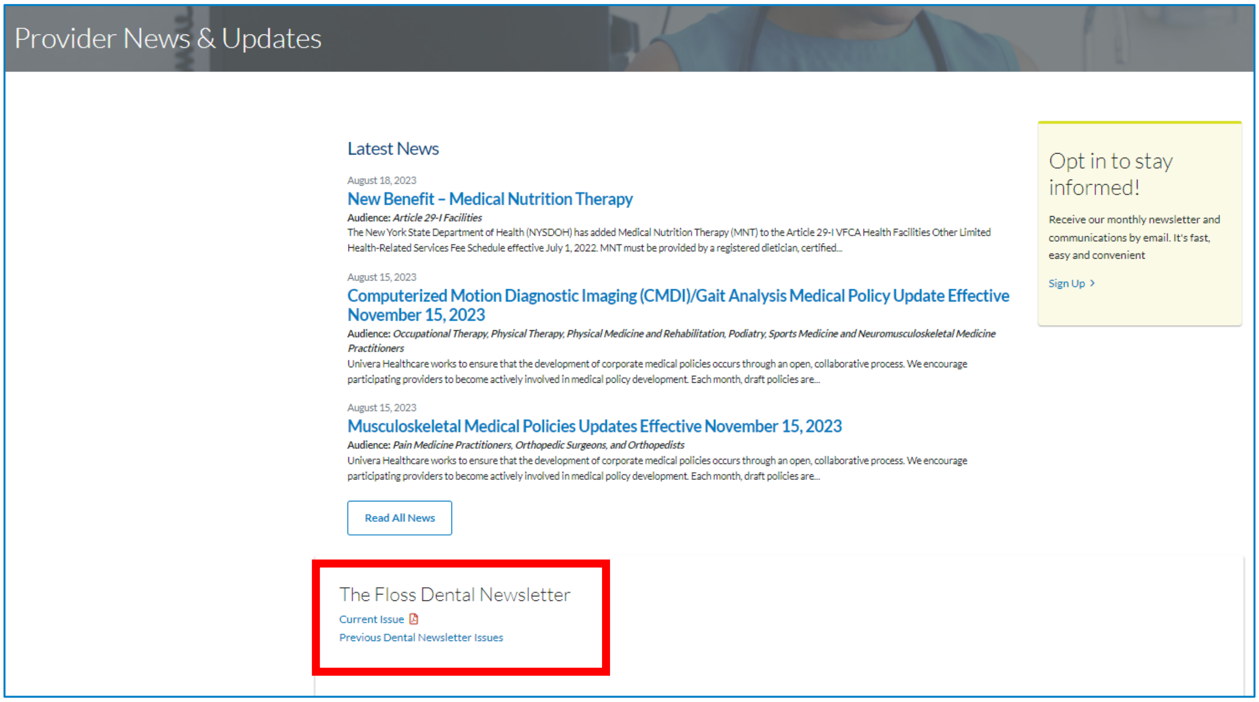
The **Latest News** includes links to recent communication mailed or emailed to medical and dental provider when applicable.

To read all communication, click on the button for Read All News and the **News Archive** page will appear. This view also allows the user to search by a specific topic or filter by a specific topic within the communication area.



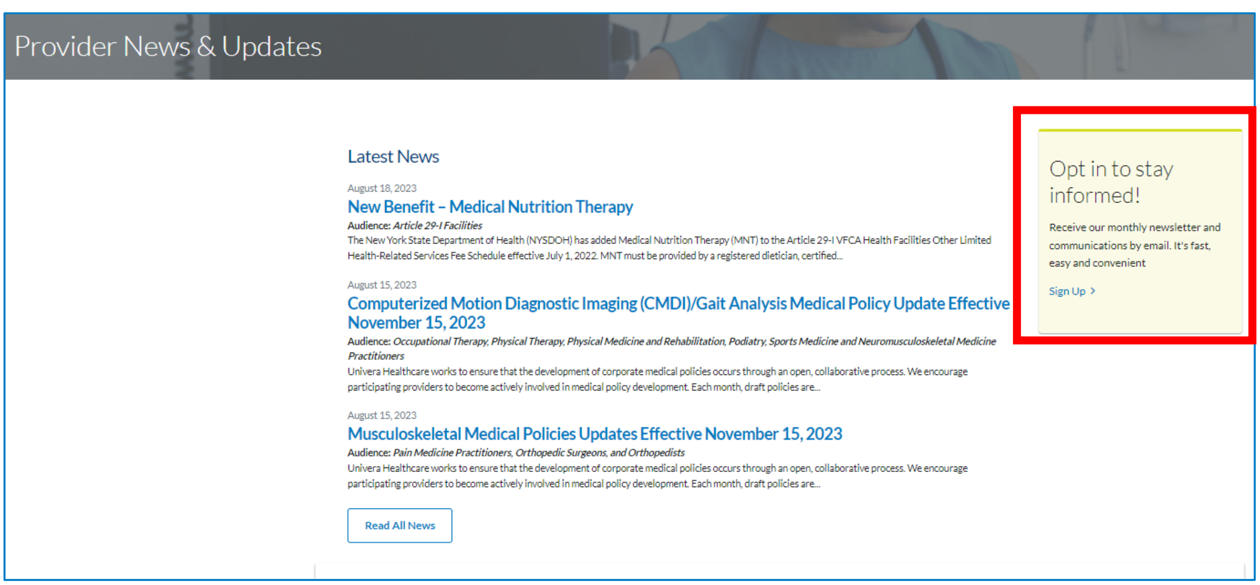
The Floss Dental Newsletter

Communication related to system changes, updates, trends, and tips, are communicated through our dental newsletter “The Floss”. To view the issues, click on either the current or previous issue link found on the bottom of the Provider News and Updates page.



Opting In

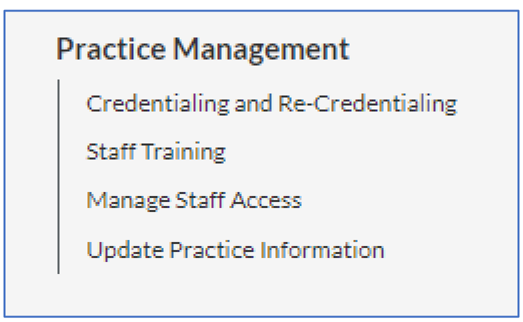
To receive the newsletter and communications via email, dentists can click on the Sign Up link found on the right hand side of the Provider News & Updates page.



The Sign-Up page will appear requesting additional information. To ensure that you are receiving dental communication, please select “General Dentistry” in the Practice Specialty field.

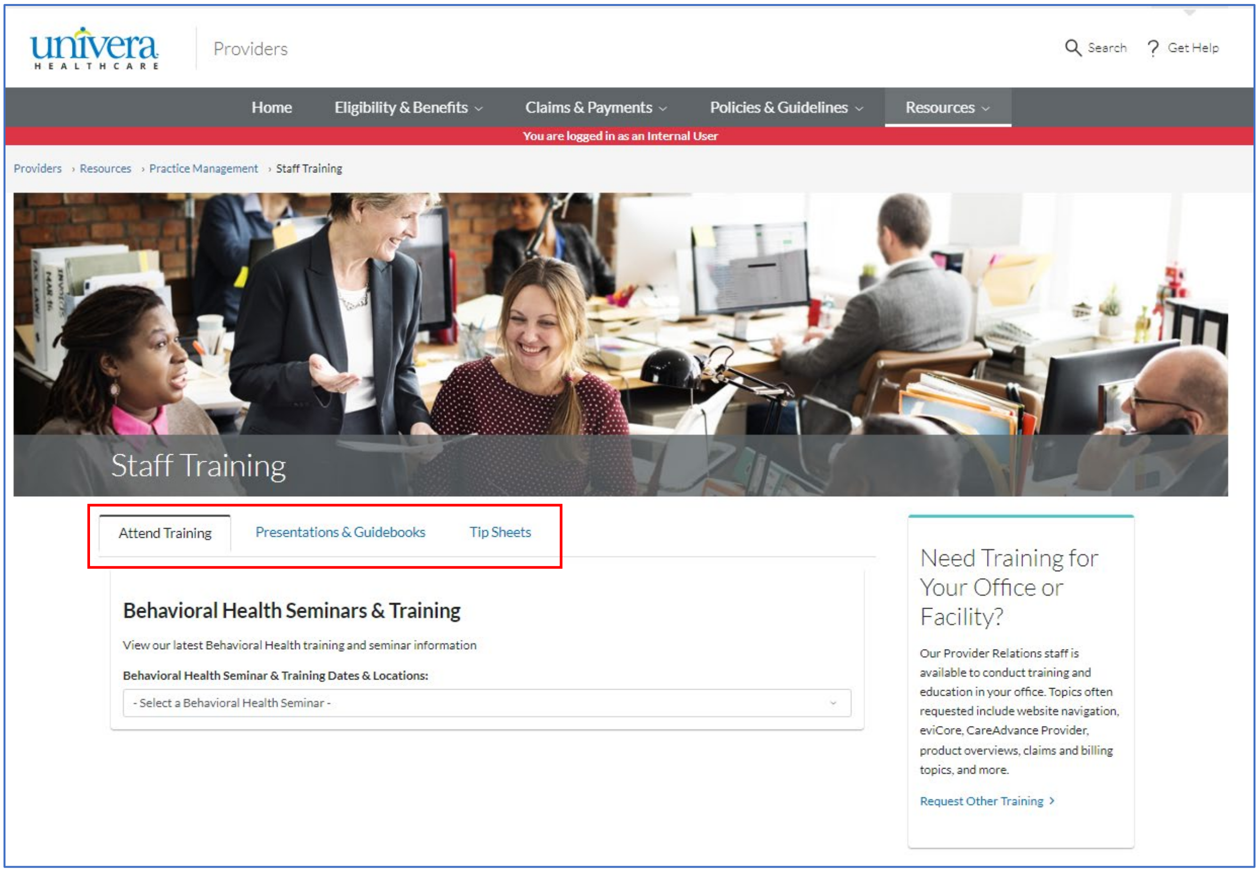
Practice Management

Practice Management includes links to items that a provider or practice would utilize for new or required periodic trainings, updating practice information, and managing their staffs access to the secure portion of the portal.

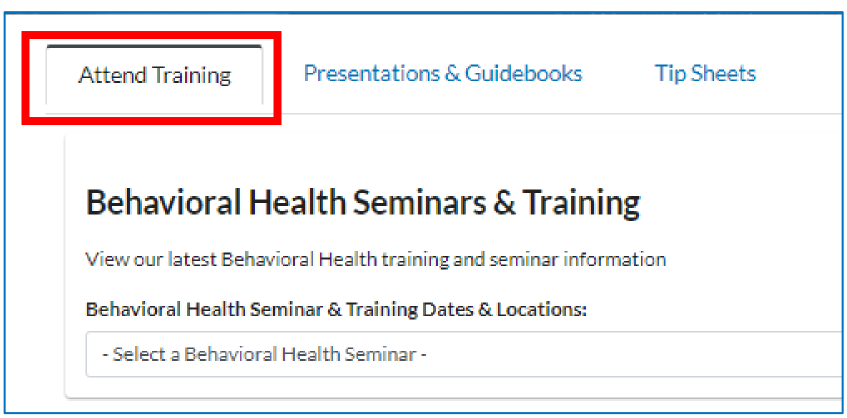


Staff Training

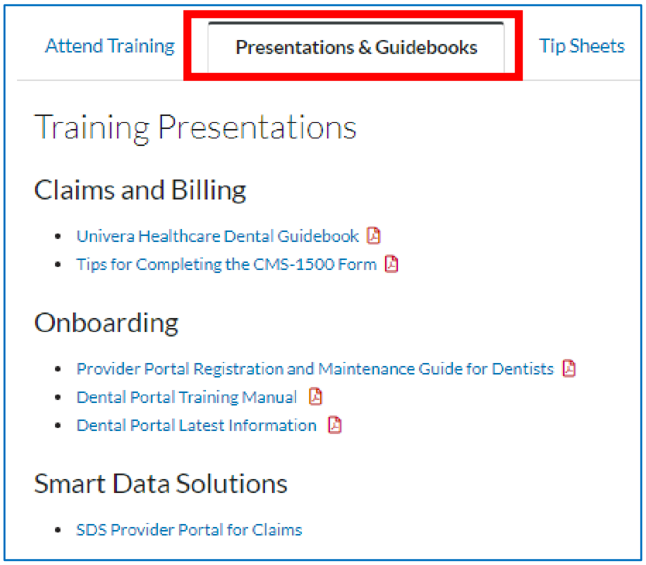
The Staff Training section is broken down in to three tabs.



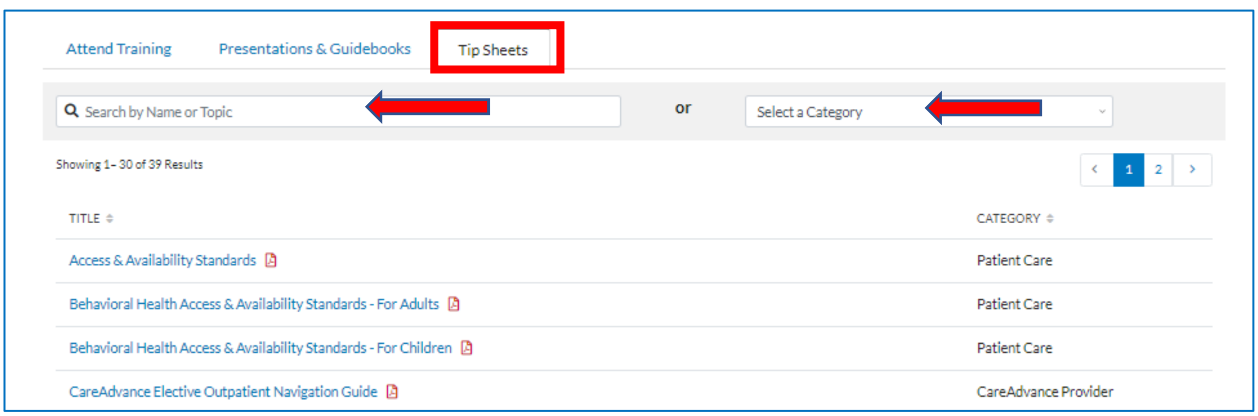
The Attend Training tab provides a listing of available trainings.



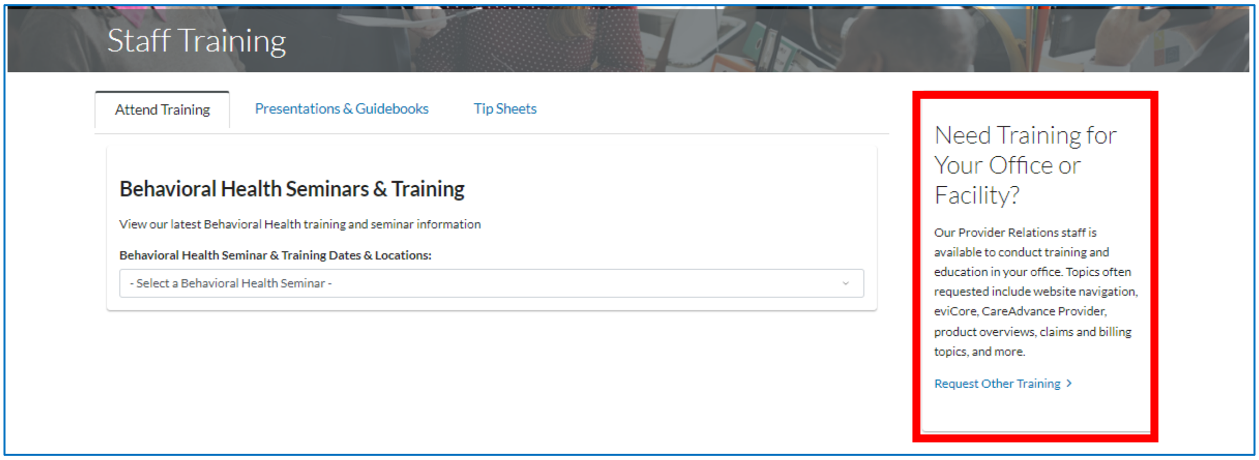
The Presentations & Guidebooks tab provides links to reference material and videos for training purposes.



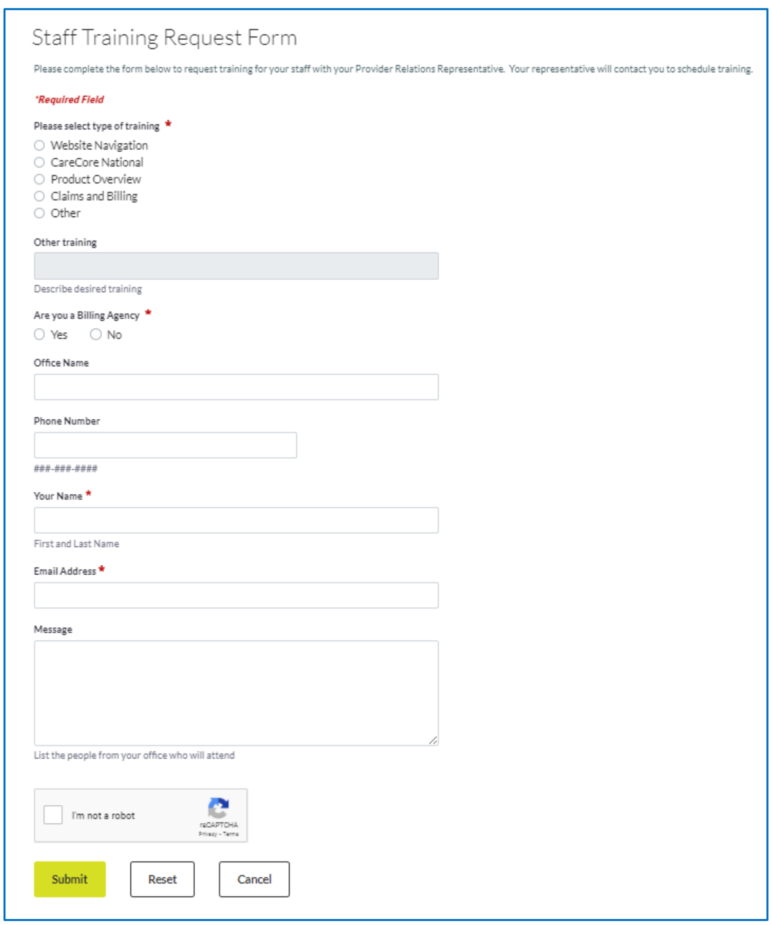
The Tip Sheets tab includes links to tip sheets and guides that will assist users with specific topics or systems. The search bar at the top can be used to search for a topic or category.



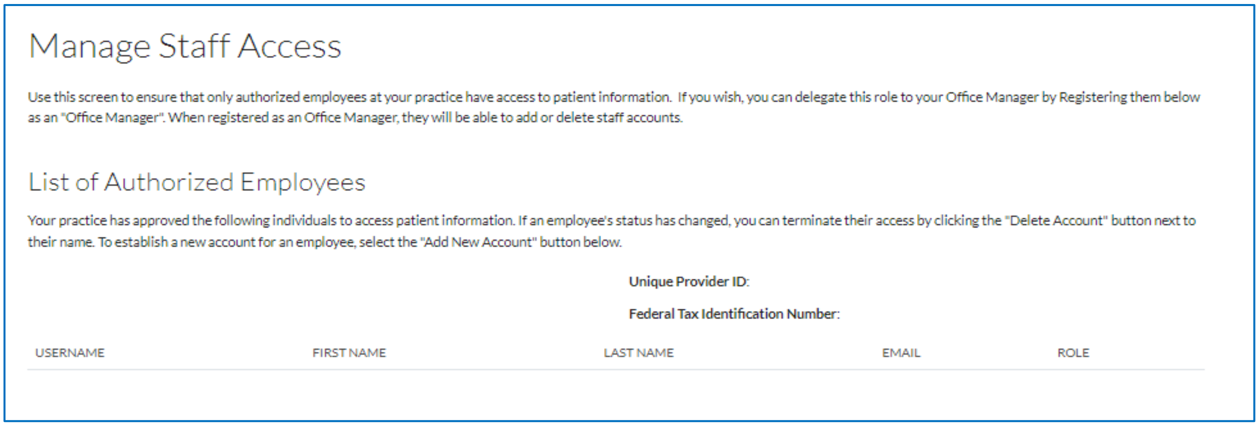
To the right of the tabs is an area where training can be requested by clicking on the arrow to the right of Request Other Training.



The Staff Training Request Form will appear. Users can fill out all required fields and click submit to request the training.



Manage Staff Access



Manage Staff Access is used to view, add, modify, or delete authorized employees of the practice. Please refer to The Provider Portal Registration & Maintenance Guide for further details.

Update Practice Information

Update Practice Information provides details on what information can be updated, how to submit the changes, and links to the forms.

Attestations & Certifications

This area is a centralized location for the annual Cultural Competency, Model of Care, Provider Directory Data, and OMIG training, attestation, or certifications.

Frequently Asked Questions

The Frequently Asked Questions section includes questions that we commonly receive and the answers to those questions.

Consolidated Appropriations Act Toolkit

This area provides information related to the Consolidated Appropriations Act and the Transparency in Coverage regulation including a number of provisions relating to health insurance and group health plan coverage.