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Benefit Options

Envolve Dental Claim Submission Process

How to Submit a Claim to Envolve Dental

Envolve offers **3 ways** for participating providers to submit claims for processing:

- Provider Web Portal (PWP): envolvedental.com/logon
- Electronic Clearing House: Payor ID **46278**
- Paper Claim submission

Please see your provider manual, as each state has a different mailing address for paper claim submission.

The PWP is updated in real time, letting all providers monitor claim status and submit electronic claims at no additional cost. This is one of the many benefits offered to Envolve Dental contracted providers.

Timely Filing Time Frames

Timely filing for Medicaid states is outlined in the chart at the end of this document. Note: Our Medicare Advantage and Commercial plans are identified separately.

How to Submit a Corrected Claim to Envolve Dental

Corrected Claims can be submitted on the Provider Web Portal (PWP). Most corrections can be performed via this method. However, if you are removing an original line of service, this correction must be submitted via Paper Corrected Claim.

Envolve also accepts corrected claims via paper submission. Remember to check your provider manual, as each state has a different mailing address for paper claim submission.

Tips for submitting a corrected claim:

- Write **Corrected Claim** at the top of an original 2012 ADA form (or newer version) with the original claim number written directly below
- In box 35 or in a separate narrative, please advise why you're sending a corrected claim

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Envolve Paper Claim Submission

If you are submitting a paper claim by mail for submission:

- Claims must be submitted on an original 2012 ADA Form or newer version (photocopies will not be accepted)
- Attach any supporting documents
- Handwritten claims are not accepted

Submitting Claims With Envolve as Secondary Payor

Please see the Timely Filing grid below when Envolve is identified as either a primary or secondary payor on member claims. When a member has a primary insurance, we commonly come across the following scenarios:

- **IF** a member has a primary insurance that has paid the max allowable, **THEN** Envolve will not pay additional monies. Providers cannot be reimbursed more than the max allowed by the primary payor for services that are covered under the member's primary benefit.
- **IF** you submit a claim on the PWP where the member has a primary insurer, **THEN** you must fill out the *Other Coverage* section **AND** coordinate primary insurance payment information for each service line. Additionally, you must attach the EOP from the primary payor under *Attached Documents*.

If Your Claim is Denied More Than Once

If your claim is denied more than once, **do not continue to resubmit**. Please email ProviderRelations@EnvolveHealth.com for guidance.

General FQHC Billing

Facilities such as Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs) and Rural Health Clinics (RHCs) are reimbursed through encounter payments. These providers can choose one of the claim submission options to submit encounters. Note the following requirements:

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

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Timely Filing Time Frames for Primary and Secondary Claims

State/Plan	Timely Filing as Primary	Timely Filing as Secondary	Corrected Claims Timely Filing	Claim Appeal Timely Filing
Ambetter	180 calendar days from DOS		180 calendar days from date of notification or denial	180 calendar days from date of notification of payment or denial
Ascension	365 calendar days from DOS	180 days from EOP of primary insurer. 180 calendar days from the date of notification of denial	180 calendar days from date of notification or denial	180 calendar days from date of notification of payment or denial
Allwell	365 calendar days from DOS		365 calendar days from denial date	30 calendar days from denial date
AZ	120 calendar days from date of service	180 calendar days from EOP of primary insurer	365 calendar days from DOS	365 calendar days from DOS; *OR* 12 months after eligibility posting; *OR* 60 calendar days after the payment or the non-payment notification date
GA	180 calendar days from DOS	N/A	6 months from date in which service was rendered or 3 months from date of notification of payment or denial, whichever is later	30 calendar days after denial was issued or non-payment notification was made as indicated on remittance advice
IL	180 calendar days from DOS	180 calendar days from the date the primary insurance pays the claim	180 calendar days from date of notification or denial	180 calendar days
IN	90 calendar days from DOS for in-network provider 365 calendar days from DOS for OON providers	90 calendar days from the date the primary insurance pays claim	60 calendar days from initial denial on EOB	60 calendar days after the denial
KS	180 calendar days from DOS	180 calendar days from the date the primary insurance pays claim	365 calendar days from denial date	63 calendar days
LA	365 calendar days from DOS	180 calendar days from the date the primary insurance pays claim	90 calendar days	90 calendar days
MI	180 calendar days from DOS	180 calendar days from the date the primary insurance pays claim	60 calendar days from initial denial on EOB	60 calendar days after denial
MS	180 calendar days from DOS	180 calendar days from the date the primary insurance pays claim	90 calendar days	CAN: 30 calendar days from notice of action determination CHIP: 90 calendar days from notice of action
MO	180 calendar days from DOS	180 calendar days from the date the primary insurance pays claim	180 calendar days from date of notification or denial	30 calendar days after denial was issued or non-payment notification was made as indicated on remittance advice
NM	90 calendar days from DOS	180 calendar days from the date the primary insurance pays claim	180 calendar days from date of notification or denial	30 calendar days after denial was issued or non-payment notification was made as indicated on remittance advice
OH	365 calendar days from DOS	N/A	180 calendar days from date of notification or denial	180 calendar days from date of notification of denial
PA	180 calendar days from DOS	N/A		60 calendar days after denial or non-payment date
WI	90 calendar days from DOS	90 calendar days from date the primary insurance pays claims	90 calendar days from date of denial	90 calendar days after date of denial