Benefit Options

Envolve Dental Utilization Management Process

Envolve Dental's Code Search tool is an electronic benefit grid that clearly indicates whether providers need any prior authorization or prepayment review. Documents required for these two processes are outlined on the Dental Code Search tool along with the corresponding clinical policy, which can also be found on the Provider Web Portal (PWP).

Note: Envolve Dental Commercial and Medicare plans do NOT require or process prior authorization. Please see provider documentation for these products before rendering services in line with Envolve Dental Clinical Policy, which is available on the PWP.

Submitting a Prior Authorization to Envolve Dental

The best way to submit a prior authorization to Envolve is through our free online PWP. However, Envolve offers multiple methods for participating providers to submit an authorization request:

- Provider Web Portal: envolvedental.com/logon
- Electronic Clearing House (Change Healthcare, NEA, etc.): Payor ID 46278
- Paper Authorization submission
- Alternative, pre-arranged, HIPAA-compliant electronic files
- For emergency requests, call Customer Service or mark authorizations "Expedited"
  - Envolve Dental may downgrade expedited requests to standard if services do not meet emergency criteria
  - When submitting emergency request, supporting documentation submitted should support the member's medical emergency.

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

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

Prepayment Review

If our online Dental Code Search tool indicates that pre-payment review is required, claims are reviewed with supporting documentation submitted by you to assure services met necessity and clinical criteria. The tool will indicate what supporting documentation

needs to be submitted with your claim for review. If your service is denied by this process, a paper corrected claim will be necessary with correct documentation in order to receive payment.

When Your Authorization Keeps Getting Denied

If your prior authorization is denied more than once and you believe all relevant information was submitted, **DO NOT KEEP RESUBMITTING**. Please email our Provider Relations team at ProviderRelations@EnvolveHealth.com.

When to Peer to Peer

If your prior authorization is denied and you disagree with the decision, you have the right to request a Peer to Peer within 30 days of the initial denial. A Peer to Peer will allow the rendering dental provider to discuss the authorization denial with the Dental Consultant that reviewed the prior authorization request. Providers can present additional information at this time as well for reconsideration.

When to Appeal

If your prior authorization is denied and you disagree with the decision, you have the right to appeal your authorization. See chart below for appeal timelines as they can differ per state. An appeal will allow the rendering dental provider to submit additional supporting documentation to be reviewed by a dental consultant who is not the original determining provider.

Please see following page for Utilization Management time frames.

Envolve Dental Time Frames for Utilization Management

State/Plan	Authorization Appeal Timely Filing
Ambetter	N/A
Ascension	N/A
Allwell	N/A
AZ	365 calendar days of receiving the authorization denial notice
GA	30 days of receiving authorization denial notice
IL	90 calendar days
IN	67 days after the denial determination
KS	63 calendar days
LA	N/A
MI	N/A
MS	30 calendar days
MO	30 calendar days
NM	30 calendar days
OH	180 days following the date the denial letter was mailed
PA	60 calendar days of the NOA
WI	90 calendar days after the date of the authorization denial notice