UnitedHealthcare Connected™ (Medicare-Medicaid Plan) Quick Reference Guide

The service delivery area covered under this plan is: Harris County region. UnitedHealthcare Connected™ (Medicare-Medicaid Plan) has two dental benefit levels: the Standard dental benefit, and the Waiver dental benefit. Both plans are for eligible **ADULTS ONLY.**

UHCdental.com/medicaid

The Dental Hub may be used to check eligibility, submit claims, and access useful information regarding plan coverage.

To register for the Dental Hub, you will need a W-9 and a recently paid claim, or the verification code from your Welcome Letter. For additional assistance with the Dental Hub, call Provider Services.

Provider services

Phone: **1-877-378-5301**
8 a.m.–5 p.m. CST Monday–Friday (IVR: 24/7)

Member eligibility, benefits, claims, authorizations, network participation and contract questions

Prior authorization

UHC Texas MMP
Attn: Dental Prior Authorizations
P.O. Box 1511
Milwaukee, WI 53201

Appeals for service denials

UHC Texas MMP
Attn: Dental Provider Appeals
P.O. Box 1427
Milwaukee, WI 53201

Claims

UHC Texas MMP
Attn: Dental Claims
P.O. Box 1471
Milwaukee, WI 53201

Claim disputes or adjustments

UHC Texas MMP
Attn: Dental Claim Disputes
P.O. Box 1427
Milwaukee, WI 53201

Corrected claims

UHC Texas MMP
Attn: Dental Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

EDI Payer ID

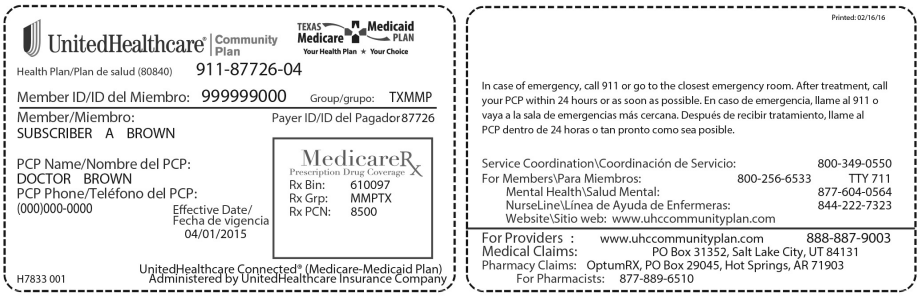
GP133 (Enter MC in the Claim Filing Indicator Field. Failure to enter “MC” in the Claim Filing Indicator field may result in delays in claim payment.)

Prior authorizations and claims may be submitted electronically via your clearinghouse, online via the provider portal or via the mailing addresses here.

Important notes

This guide is intended to be used for quick reference and may not contain all of the necessary information. It is subject to change without notice. For current detailed benefit information, please visit the Dental Hub or call our Provider Services toll free number.

Sample member ID card *



*Please note that the medical ID card is Universal and includes all lines of coverage. The actual member ID card may differ from the sample ID card shown above. Please DO NOT use the Medical claims and appeal addresses listed on the Medical ID card for dental services. Use the addresses on the first page of this document for all Dental Claims, Prior Authorizations and Appeals.

Benefit coverage, limitations, and requirements

UnitedHealthcare Connected™ standard dental plan covers Diagnostic, Preventive, Minor Restorative, and Oral Surgery dental services for eligible **ADULTS** covered under the plan. **This plan has a $1000 annual maximum benefit per year.** The following Benefit Grid contains all covered dental procedures.

All procedures not listed as covered services are available to the member at 75% of the provider's normal billed charges. For those services, no claims or pre-authorization requests need be to submitted. All payments would be provided by the member at the time of service.

UnitedHealthcare Connected™ members who qualify for the Waiver services program are eligible for **additional** dental benefits that are not covered under the standard. To confirm member eligibility, please call our Provider Service Center at 1-877-378-5301. **There is a $5000.00 Annual Maximum benefit under the Waiver services program. The $5000.00 annual maximum expires one year after the member's effective date under the Waiver program. Example: If a member is effective under the waiver program on November 1, 2024, then the $5000.00 annual maximum is good through October 31, 2025.**

UnitedHealthcare Connected™ (Medicare-Medicaid Plan)

Code	Description	Limitations	Prior auth required	Clinical documentation
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	1 per 12 month period	NO	N/A
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	2 per 12 month period	NO	N/A
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	1 per 12 month period	NO	N/A
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D0210	INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES	1 per 3 years	NO	N/A
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	1 per 12 month period	NO	N/A
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	1 per 12 month period	NO	N/A
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274	NO	N/A
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274	NO	N/A

Code	Description	Limitations	Prior auth required	Clinical documentation
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	1 PER 1 PLAN YEAR (CODESET: D0270, D0272, D0273, D0274, D0277)	NO	N/A
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	1 per 12 month period for any combination of D0270, D0272, D0273, or D0274	NO	N/A
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	1 PER 1 PLAN YEAR (CODESET: D0270, D0272, D0273, D0274, D0277)	NO	N/A
D0330	PANORAMIC RADIOGRAPHIC IMAGE	1 per 3 years	NO	N/A
D1110	PROPHYLAXIS ADULT	1 per 12 month period	NO	N/A
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	1 per 12 month period	NO	N/A
D1208	TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH	1 per 12 month period	NO	N/A
D1310	NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION - PER TOOTH	UNLIMITED	NO	N/A
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	UNLIMITED	NO	N/A
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	UNLIMITED	NO	N/A
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	UNLIMITED	NO	N/A
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	UNLIMITED	NO	N/A
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	UNLIMITED	NO	N/A
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	UNLIMITED	NO	N/A
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	UNLIMITED	NO	N/A
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES INVOLVING INCISAL ANGLE (ANTERIOR)	UNLIMITED	NO	N/A
D2391	RESIN-BSED COMPOSITE - ONE SURFACE POSTERIOR	UNLIMITED	NO	N/A
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	UNLIMITED	NO	N/A
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	UNLIMITED	NO	N/A
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	UNLIMITED	NO	N/A
D2510	INLAY - METALLIC - ONE SURFACE	1 PER 5 FLOATING YEAR PER TOOTH	NO	N/A
D2520	INLAY - METALLIC - TWO SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	NO	N/A
D2530	INLAY - METALLIC - THREE OR MORE SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	NO	N/A
D2542	ONLAY - METALLIC - TWO SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	YES	CURRENT X-RAYS, NARRATIVE OF MED. NECESSITY AND/OR TREATMENT PLAN

Code	Description	Limitations	Prior auth required	Clinical documentation
D2543	ONLAY - METALLIC - THREE SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	YES	CURRENT X-RAYS, NARRATIVE OF MED. NECESSITY AND/OR TREATMENT PLAN
D2544	ONLAY - METALLIC - FOUR OR MORE SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	YES	CURRENT X-RAYS, NARRATIVE OF MED. NECESSITY AND/OR TREATMENT PLAN
D2610	INLAY - PORCELAIN/CERAMIC - ONE SURFACE	1 PER 5 FLOATING YEAR PER TOOTH	NO	N/A
D2620	INLAY - PORCELAIN/CERAMIC - TWO SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	NO	N/A
D2630	INLAY - PORCELAIN/CERAMIC - THREE OR MORE SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	NO	N/A
D2642	ONLAY - PORCELAIN/CERAMIC - TWO SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	YES	CURRENT X-RAYS, NARRATIVE OF MED. NECESSITY AND/OR TREATMENT PLAN
D2643	ONLAY - PORCELAIN/CERAMIC - THREE SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	YES	CURRENT X-RAYS, NARRATIVE OF MED. NECESSITY AND/OR TREATMENT PLAN
D2644	ONLAY - PORCELAIN/CERAMIC - FOUR OR MORE SURFACES	1 PER 5 FLOATING YEAR PER TOOTH	YES	CURRENT X-RAYS, NARRATIVE OF MED. NECESSITY AND/OR TREATMENT PLAN
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	4 quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit	YES	PERIODONTAL CHARTING AND PRE-OP X-RAYS
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	4 quadrant per year, any combination of D4341 or D4342, no more than 2 quadrants payable per visit	YES	PERIODONTAL CHARTING AND PRE-OP X-RAYS
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	1 PER 3 FLOATING YEAR PER PATIENT	NO	N/A
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	UNLIMITED	YES	PERIODONTAL CHARTING AND PRE-OP X-RAYS
D4910	PERIODONTAL MAINTENANCE	3 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5110	COMPLETE DENTURE - MAXILLARY	1 PER 5 FLOATING YEAR PER PATIENT	YES	FMX OR PANOREX X- RAYS
D5120	COMPLETE DENTURE - MANDIBULAR	1 PER 5 FLOATING YEAR PER PATIENT	YES	FMX OR PANOREX X- RAYS
D5130	IMMEDIATE DENTURE - MAXILLARY	1 PER 1 LIFETIME PER PATIENT	YES	FMX OR PANOREX X- RAYS
D5140	IMMEDIATE DENTURE - MANDIBULAR	1 PER 1 LIFETIME PER PATIENT	YES	FMX OR PANOREX X- RAYS
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR (CODESET: D5211, D5213, D5225)	YES	FMX OR PANOREX X- RAYS
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR (CODESET: D5212, D5214, D5226)	YES	FMX OR PANOREX X- RAYS
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR (CODESET: D5211, D5213, D5225)	YES	FMX OR PANOREX X- RAYS

Code	Description	Limitations	Prior auth required	Clinical documentation
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR (CODESET: D5212, D5214, D5226)	YES	FMX OR PANOREX X- RAYS
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR PER PATIENT	NO	N/A
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR PER PATIENT	NO	N/A
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR (CODESET: D5211, D5213, D5225)	NO	N/A
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)	1 PER 5 FLOATING YEAR (CODESET: D5212, D5214, D5226)	NO	N/A
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	2 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	2 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	2 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	2 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5630	REPAIR OR REPLACE BROKEN RETENTIVE/CLASPING MATERIAL - PER TOOTH	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5640	REPLACE BROKEN TEETH - PER TOOTH	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5740	RELINE MAXILLARLY PARTIAL DENTURE (CHAIRSIDE)	1 PER 1 PLAN YEAR (CODESET: D5740, D5760)	NO	N/A
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	1 PER 1 PLAN YEAR (CODESET: D5741, D5761)	NO	N/A
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	1 PER 1 PLAN YEAR PER PATIENT	NO	N/A

Code	Description	Limitations	Prior auth required	Clinical documentation
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	1 PER 1 PLAN YEAR (CODESET: D5740, D5760)	NO	N/A
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	1 PER 1 PLAN YEAR (CODESET: D5741, D5761)	NO	N/A
D5850	TISSUE CONDITIONING, MAXILLARY	2 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D5851	TISSUE CONDIDITONING, MANDIBULAR	2 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D6210	PONTIC - CAST HIGH NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	YES	PRE-OP X-RAYS
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	YES	PRE-OP X-RAYS
D6212	PONTIC - CAST NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	YES	PRE-OP X-RAYS
D6214	PONTIC - TITANIUM	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	NO	N/A
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	YES	PRE-OP X-RAYS
D6241	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	YES	PRE-OP X-RAYS
D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	YES	PRE-OP X-RAYS
D6245	PONTIC - PORCELAIN/CERAMIC	1 PER 5 PLAN YEAR (CODESET: D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245)	YES	FMX & CHARTING
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	FMX & CHARTING
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	PRE-OP X-RAYS
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	PRE-OP X-RAYS
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	PRE-OP X-RAYS
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	PRE-OP X-RAYS
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	PRE-OP X-RAYS
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	PRE-OP X-RAYS

Code	Description	Limitations	Prior auth required	Clinical documentation
D6794	RETAINER CROWN - TITANIUM	1 PER 5 PLAN YEAR (CODESET: D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794,)	YES	FMX OR PAN W/ PERIO CHART
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	UNLIMITED	NO	N/A
D7111	EXTRACTION, CORONAL REMNANTS - PRIMARY TOOTH	1 PER 1 LIFETIME PER TOOTH	NO	N/A
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	1 PER 1 LIFETIME (CODESET: D7140, D7210, D7250)	NO	N/A
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	1 PER 1 LIFETIME (CODESET: D7140, D7210, D7250)	NO	N/A
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	1 PER 1 LIFETIME (CODESET: D7140, D7210, D7250)	NO	N/A
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	1 PER 1 PLAN YEAR PER QUADRANT	NO	N/A
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES PER QUADRANT	1 PER 1 PLAN YEAR PER QUADRANT	NO	N/A
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	1 PER 1 PLAN YEAR PER QUADRANT	NO	N/A
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	1 PER 1 PLAN YEAR PER QUADRANT	NO	N/A
D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	UNLIMITED	NO	N/A
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)	UNLIMITED	NO	N/A
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	1 PER 3 FLOATING YEAR PER PATIENT	NO	N/A
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN - MINOR PROCEDURE	UNLIMITED	NO	N/A
D9219	EVALUATION FOR MODERATE SEDATION, DEEP SEDATION, OR GENERAL ANESTHESIA	UNLIMITED	NO	N/A
D9230	INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS	UNLIMITED	NO	N/A
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	1 PER 1 DAY PER PATIENT	NO	N/A
D9943	OCCLUSAL GUARD ADJUSTMENT	2 PER 1 PLAN YEAR PER PATIENT	NO	N/A
D9944	OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH	1 PER 3 FLOATING YEAR PER PATIENT	NO	N/A

Prior authorization

"Prior Authorization required" means, prior to providing services, the practitioner must submit the procedures for approval, with clinical documentation supporting the necessity of the services. To do this complete a standard ADA claim form and check the box marked "Pre-Treatment ESTIMATE." Prior authorization requests can be submitted via the Dental Hub at **UHCdental.com/medicaid**, submitted electronically via your clearinghouse, or by mailing in a 2019 or later ADA form, to the above address, along

with any required supplemental information (films, narrative, perio-charting, etc.). Your office will then receive a determination notice outlining the denial or approval of requested treatment and plan payment amounts when applicable.

Prior approval is required for all treatment plans for Waiver members. A complete treatment plan must be submitted for all dental procedures with the exception of the procedures listed in the standard benefit. If a procedure is covered, and does not require prior authorization under the standard benefit, then it does not require prior authorization under the Waiver plan. Emergency dental services can be approved on a retrospective basis. Proposed Treatment for all other services should be submitted for review and approval prior to initiating treatment. UnitedHealthcare will then review the request and issue a prior authorization approval or denial. The dentist may not bill the UnitedHealthcare Connected™ Waiver member for the remainder of the cost over the approved amount. See above for Prior Authorization submission methods.

Provider appeals and grievances

Providers can appeal prior authorization denials on behalf of their patients. All appeal requests must be made within sixty (60) calendar days of the date on the adverse determination letter. All claims adjustments or requests for reprocessing must be made within sixty (60) calendar days from receipt of payment. An adjustment can be requested in writing or telephonically. To proceed with an appeal please include a copy of the adverse determination notice, a copy of medical records, and any additional information/documentation, which supports the need for this service, and forward to:

UnitedHealthcare Texas
UnitedHealthcare Connected™
Attn: Provider Appeals
PO Box 1427
Milwaukee, WI 53201