

VIRGINIA NETWORK MEDICARE

Provider Education Training Q2 2026
Virginia



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ABOUT DENTAQUEST

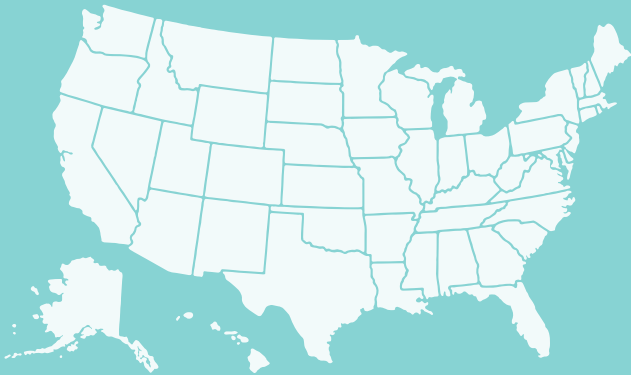


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ABOUT DENTAQUEST



We manage dental and vision benefits for over 35 million Americans and lead the nation as the largest Medicaid dental benefits administrator.



Our dental network spans all 50 states, and our clients include health plans, managed care organizations (MCOs) and state agencies.

Provider Partner Contact Information



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Name: Amber Hudson

Territory: Northern and Northwest VA

Email: amber.hudson@greatdentalplans.com



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Territory: Southwest VA, NC, TN, KY, WVA

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MEDICARE 101

Traditional Medicare

- Only covers Part A & B
 - Part A = Hospital Coverage
 - Part B = Medical Coverage



Medicare DSNP/Advantage Plans

- Covers all services required under Part A and Part B except Hospice
- Offered by private insurance companies (MCO's); DentaQuest contracts with these plans to administer the dental benefits
- Individual selects coverage through a private insurance company and pays monthly premiums to insurance company
- SNP* = Special Needs Plan
 - Members qualify for both Medicare & Medicaid benefits
 - Also referred to as “Dual Eligible” or DSNP

Despite these plans having “HMO” in the plan names, which is for the medical portion of the programs, the dental portion is administered with DentaQuest which utilizes the Medicare PPO network for these members’ dental network needs.

USE MEDICARE ADVANTAGE TO YOUR ADVANTAGE!

- Over 35 million people are enrolled in Medicare Advantage²
- Expand Your Opportunity
 - People age 65 and over who enrolled in a Medicare Advantage plan created for eligible members, many of whom are coming from a traditional employer plan
 - Committed to their oral health, these patients typically show up for appointments on time – and are willing to invest in expanded dental services
- By participating in Medicare Advantage plans, you have more opportunities to expand your patient base and grow your dental practice

Due to the growth of Medicare Advantage in recent years, more seniors have dental coverage today than ever before¹. Dental is more likely than any other supplemental benefit to influence a beneficiary's decision to switch to or stay with a particular plan, which means that oral health is a priority for these patients.

¹ [Dental Benefits in Medicare Advantage: Making a Good Story Great - National Association of Dental Plans](#)

² [Medicare Advantage Enrollment Grew by About 1 Million People, Mainly Due to Special Needs Plans | KFF](#)

IMPORTANT MEDICARE MEMBER DATES

- Annual Election Period (AEP)
 - October 15 – December 7
 - During this time Medicare beneficiaries can make changes to their Medicare Advantage plans, including switching plans or joining a new Medicare Advantage plan
 - Members may call provider offices to see if their dentist is in-network with the plan they are considering
- Medicare Advantage Open Enrollment Period
 - January 1 – March 31
 - Time when patients who are already in a Medicare Advantage plan can make a one-time switch and change to another Medicare Advantage plan
- **Please ensure whomever in your office receives calls from patients understands that you are in-network and contracted to see members under your current provider agreement**

VA MEDICARE SAMPLE CARDS

Member cards



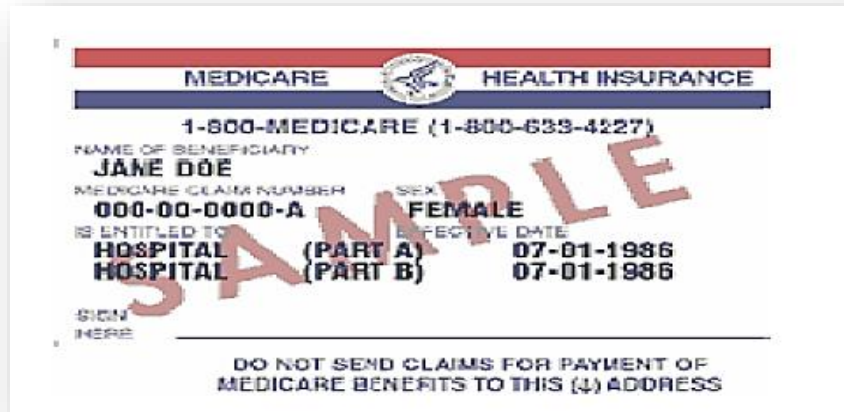
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SAMPLE ID CARDS

Members receive identification cards from their Plan. Participating providers are responsible for verifying that the members are eligible at the time services are rendered and to determine if recipients have other health insurance

Medicare Traditional and Medicare DSNP and Advantage -Sample Cards



Traditional Card



DSNP and Advantage Card



VA AETNA MEDICARE FIDE (HMO DSNP) SAMPLE MEMBER ID CARD

<p>AETNA BETTER HEALTH® OF VIRGINIA (HMO SNP)</p> <p>Member Name Last Name, First Name Member ID # 000000000</p> <p>Health Plan # 80840 RxBIN: 610591 RxPCN: MEDDADV RxGRP: RX8800</p> <p>PCP Last Name, First Name PCP Phone 0-000-000-0000</p> <p>Issue Date: XX/XX/XXXX</p>	  H1610-001	<p>Important information</p> <p>Member Services: 1-855-463-0933 (TTY 711) 24-Hour Nurse Line: 1-855-463-0933 (TTY 711) Behavioral Health: 1-855-463-0933 (TTY 711) Pharmacy Help Desk: 1-866-328-7517 (TTY 711) Website: www.aetnabetterhealth.com/virginia</p> <p>Submit claims to: Aetna Better Health of Virginia P.O. Box 63518 Phoenix, AZ 85082-3518 Claim Inquiry: 1-855-463-0933 (TTY 711)</p> <p>This card does not guarantee coverage.</p>
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DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the health plan identification card is not dated and it does not need to be returned to the health plan should a Member lose eligibility. Therefore, an identification card in itself does not guarantee that a person is currently enrolled in the health plan.

SENTARA COMMUNITY COMPLETE SELECT AND SENTARA COMMUNITY COMPLETE HMO DSNP

Sample Member Card



Sentara Community Complete (HMO D-SNP)

Member Name: <Member Name>
 Member Number: <XXXXXXXXXXXX>
 Effective Date: <MM/DD/YYYY>
 Issuer: 80840
 RxBIN: 610014
 RxPCN: MEDDPRIME
 RxGRP: SHPMEDD
 sentarahealthplans.com

PCP Copay: <\$X>
 SOV Copay: <\$X>

MedicareRx
 Prescription Drug Coverage
H2563-004

Member Services: 1-800-927-6048 (TTY: 711)
 Provider Services: 1-888-946-1167
 24/7 Nurse Advice Line: 1-800-394-2237
 Pharmacist Help Desk: 1-800-922-1557
 DentaQuest: 1-888-696-9549

Submit claims to:	Medical Claims PO Box 8203 Kingston, NY 12402	Behavioral Health Claims PO Box 8204 Kingston, NY 12402
	DentaQuest Claims Providers: 1-844-822-8109	Express Scripts ATTN: Medicare Part D PO Box 14718 Lexington, KY 40512

DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the health plan identification card is not dated and it does not need to be returned to the health plan should a Member lose eligibility. Therefore, an identification card in itself does not guarantee that a person is currently enrolled in the health plan.

JOHN HOPKINS HEALTH PLANS MEDICARE MD

Sample Member Card



Johns Hopkins Advantage MD Select (HMO)

Member Name
NEW ID CA JHH VA 001 PLAN

Effective Date: **January 01, 2024**

Member ID: 100500579
 Health Plan: H1339 001
 PCP: NO PCP SELECTED
 Phone#:

In-Network
 Office Visit Copay: \$0.00
 Specialist Copay: \$40.00
 Urgent Care Copay: \$55.00
 ER Copay: \$100.00

RxBIN: 004336
 RxPCN: MEDDADV
 RxGRP: RX23DU

There are no out-of-network benefits. Members are fully liable for the cost of out-of-network services.



For benefit information call Customer Service (Members and Providers):
 1-877-293-4998
 TTY: 711 or visit
www.hopkinsmedicare.com

DO NOT BILL MEDICARE
 Medicare limiting charges apply.

Submit medical claims to:
 Johns Hopkins Advantage MD
 PO Box 3537
 Scranton, PA 18505

24-hour Nurse Chat Line:
 1-888-202-8828

Over-the-Counter Health Solutions
 1-888-628-2770

For non-Medicare covered dental related inquiries, please contact
 DentaQuest: 1-844-231-8318

Present this card at the time of service and with every prescription.

Prior Authorization: 1-877-293-4998
 Pharmacist Use Only: 1-866-693-4620

DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the health plan identification card is not dated and it does not need to be returned to the health plan should a Member lose eligibility. Therefore, an identification card in itself does not guarantee that a person is currently enrolled in the health plan.

VIRGINIA MEDICARE 2026 BENEFIT OVERVIEW

VIRGINIA



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COVERAGE SUMMARY 2026

<u>PLAN NAME</u>	<u>CALENDAR YEAR</u>	<u>PLAN BENEFITS</u>	<u>CO-PAY</u>	<u>PLAN MAX</u>
Aetna Medicare FIDE (HMO DSNP)	✓	Wrap around		\$3000
Sentara Community Complete HMO (DSNP)	✓	Comprehensive		\$4000
Sentara Community Complete Select HMO (DSNP)-	✓	Comprehensive		\$4000
John Hopkins Health Plans Medicare Advantage MD PPO and PPO Plus	✓	Cleanings, X-rays, and Perio		\$1000
John Hopkins Health Plans Medicare Advantage MD PPO Plus Optional Supplemental	✓	Comprehensive	✓	\$1000
Johns Hopkins Health Plans Advantage MD Group (Employer Group Waiver Program)	✓	Comprehensive	✓	\$1200
Johns Hopkins Health Plans Advantage MD - HMO	✓	Comprehensive	✓	\$1000
Johns Hopkins Health Plans Advantage MD - HMO Optional Supplemental	✓	Comprehensive	✓	\$1000
Johns Hopkins Advantage MD DSNP HMO	✓	Comprehensive		\$2500
Johns Hopkins Advantage MD Select HMO	✓	Comprehensive		\$2400

AETNA MEDICARE FIDE (HMO DSNP)-DENTAL BENEFITS OVERVIEW

- Annual max \$3000 - Calendar year
- Wrap benefits-"mix of codes" that are not covered by the Medicaid plan.
- Refer to the Office Reference Manual (ORM) for details
- **There are no cleanings, exam, or routine x-rays covered, no extractions or dentures.**

SENTARA COMMUNITY COMPLETE HMO DSNP-DENTAL BENEFITS OVERVIEW

- Annual Max \$4000 Calendar year-Sentara Community Complete HMO-(DSNP)
- Refer to the Office Reference Manual (ORM) for details
- Covered services include:
 - Cleanings (2 x 12-month period)
 - Exam (2 x 12-month period)
 - Routine X-rays (one set per 12-month period)
 - Fluoride (2 x 12-month period)
 - Fillings, Dentures
 - Extractions (other Oral Surgery procedures)

*Annual maximum applies to all services except preventive

SENTARA COMMUNITY COMPLETE SELECT HMO DSNP-DENTAL BENEFITS OVERVIEW

- Annual Max \$4000 Calendar year-Sentara Community Complete Select HMO-(DSNP)
- Refer to the Office Reference Manual (ORM) for details
- Covered services include:
 - Cleanings (2 x 12-month period)
 - Exam (2 x 12-month period)
 - Routine X-rays (one set per 12-month period)
 - Fluoride (2 x 12-month period)
 - Fillings, Dentures
 - Extractions (other Oral Surgery procedures)

*Annual maximum applies to all services except preventive

JOHN HOPKINS HEALTH PLANS MEDICARE ADVANTAGE MD PPO AND PPO PLUS-DENTAL BENEFITS OVERVIEW

- Annual Max \$1,000
- Refer to the Office Reference Manual (ORM) for details-Exhibit A (PPO) Exhibit B (PPO Plus)
 - No co-pay
 - Exams and Cleanings
 - Periodontics
 - Limited Adjunctive Service

Annual max applies to Comprehensive services

JOHN HOPKINS HEALTH PLANS MEDICARE ADVANTAGE MD PPO PLUS OPTIONAL SUPPLEMENTAL-DENTAL BENEFITS OVERVIEW

- Annual Max \$1000
- Refer to the Office Reference Manual (ORM) for details-Exhibit C
 - Co-pay on selective codes
 - Exams and Cleanings Restorative/crown/bridges
 - Periodontics
 - Extractions/Oral Surgery services
 - Dentures
 - Limited Adjunctive Service

Annual max applies to Comprehensive services

JOHN HOPKINS HEALTH PLANS ADVANTAGE MD GROUP (EMPLOYER GROUP WAIVER PROGRAM)- DENTAL BENEFITS OVERVIEW

- Annual Max \$1200
- Refer to the Office Reference Manual (ORM) for details-Exhibit D
 - Co-pay on Selective codes
 - Exams and Cleanings Restorative/crown/bridges
 - Periodontics
 - Extractions/Oral Surgery services
 - Dentures

Annual max applies to Comprehensive services

JOHN HOPKINS HEALTH PLANS ADVANTAGE MD HMO-DENTAL BENEFITS OVERVIEW

- Annual Max \$1000
- Refer to the Office Reference Manual (ORM) for details-Exhibit E
 - Co-pay on selective codes
 - Exams and Cleanings Restorative/crown/bridges
 - Periodontics
 - Extractions/Oral Surgery services
 - Dentures

Annual max applies to Comprehensive services

JOHN HOPKINS HEALTH PLANS ADVANTAGE MD HMO OPTIONAL SUPPLEMENTAL- DENTAL BENEFITS OVERVIEW

- Annual Max \$1000
- Refer to the Office Reference Manual (ORM) for details-Exhibit F
 - Co-pay on Selective Code
 - Exams and Cleanings Restorative/crown/bridges
 - Periodontics
 - Extractions/Oral Surgery services
 - Dentures

Annual max applies to Comprehensive services

JOHN HOPKINS ADVANTAGE MD DSNP HMO- DENTAL BENEFITS OVERVIEW

- Annual Max \$2400
- Refer to the Office Reference Manual (ORM) for details-Exhibit G
 - No co-pay
 - Exams and Cleanings Restorative/crown/bridges
 - Periodontics
 - Extractions/Oral Surgery services
 - Dentures

Annual max applies to Comprehensive services

JOHN HOPKINS ADVANTAGE MD SELECT HMO- DENTAL BENEFITS OVERVIEW

- Annual Max \$2500
- Refer to the Office Reference Manual (ORM) for details-Exhibit H
 - No co-pay
 - Exams and Cleanings Restorative/crown/bridges
 - Periodontics
 - Extractions/Oral Surgery services
 - Dentures

Annual max applies to Comprehensive services

OFFICE REFERENCE MANUAL- ORM

DentaQuest Medicare Advantage dental plan Office Reference Manuals (ORM), which provides information on the plans, covered benefits, criteria and limitations, etc., can be found

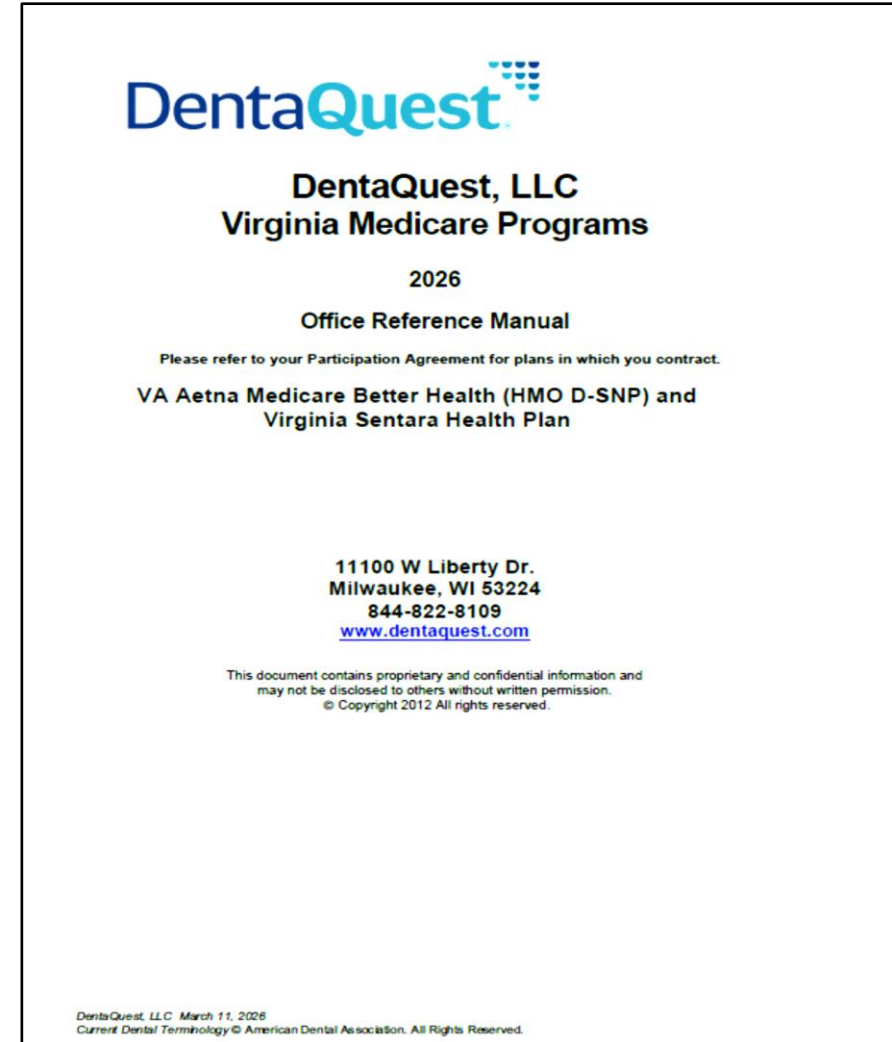
DentaQuest Website
[Sun Life DentaQuest provider portal](#)

The ORM should be reviewed to determine if planned service code is covered and/or requires pre-authorization prior to treatment

The Medicare related ORMs are:

VA Medicare ORM

MD Medicare ORM



OFFICE REFERENCE MANUAL- ORM (CONTINUED)



**DentaQuest, LLC
Maryland Medicare Programs
Office Reference Manual**

Please refer to your Participation Agreement for plans in which you contract.

**Johns Hopkins Health Plans Advantage MD
CareFirst BlueCross BlueShield Advantage**

11100 W. Liberty Drive
Milwaukee, WI 53224
(800) 508-6757

www.dentaquestgov.com

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DentaQuest, LLC, April 27, 2020
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***Disregard CareFirst BlueCross BlueShield
Advantage in the MD Medicare ORM**

This plan doesn't pertain to VA providers

DUAL ELIGIBLE MEMBERS



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WHAT ARE DUAL ELIGIBLE MEMBERS?

- Some members may be eligible for both Medicare and Medicaid. These individuals are called “dual eligibles”
- Some members receive the full range of Medicaid benefits while others only receive assistance with Medicare premiums or cost sharing
- Individuals that qualify for both Medicare and Medicaid benefits will receive Medicaid covered services even if Medicare doesn’t cover the service. There is a Coordination of Benefit requirement between Medicare and Medicaid benefits.
- Plans are expected to coordinate benefits and payment for services between Medicare and Medicaid, based on member’s eligibility and if provider is participating/contracted with Medicaid
- Medicaid is “always” the payer of last resort
- The member’s benefit would be reviewed under Medicare first and then coordinated with Medicaid

APPOINTMENT AVAILABILITY



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APPOINTMENT AVAILABILITY PER CONTRACT AND ORM

Appointment Availability requirements are as follows per the provider contract and Office Reference Manual (ORM) that under reasonable, routine circumstances, appointment times shall be the usual and customary and not to exceed:

- 24 hours for Emergency Appointments
- 48 hours for Urgent Appointments (includes but not limited to chipped tooth, sensitivity and mild pain)
- Follow up Appointments made within 30 days of treatment plan, as appropriate

MEDICARE NON COVERED SERVICES MEMBER WAIVER AND REQUIREMENTS



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Non-Covered Services



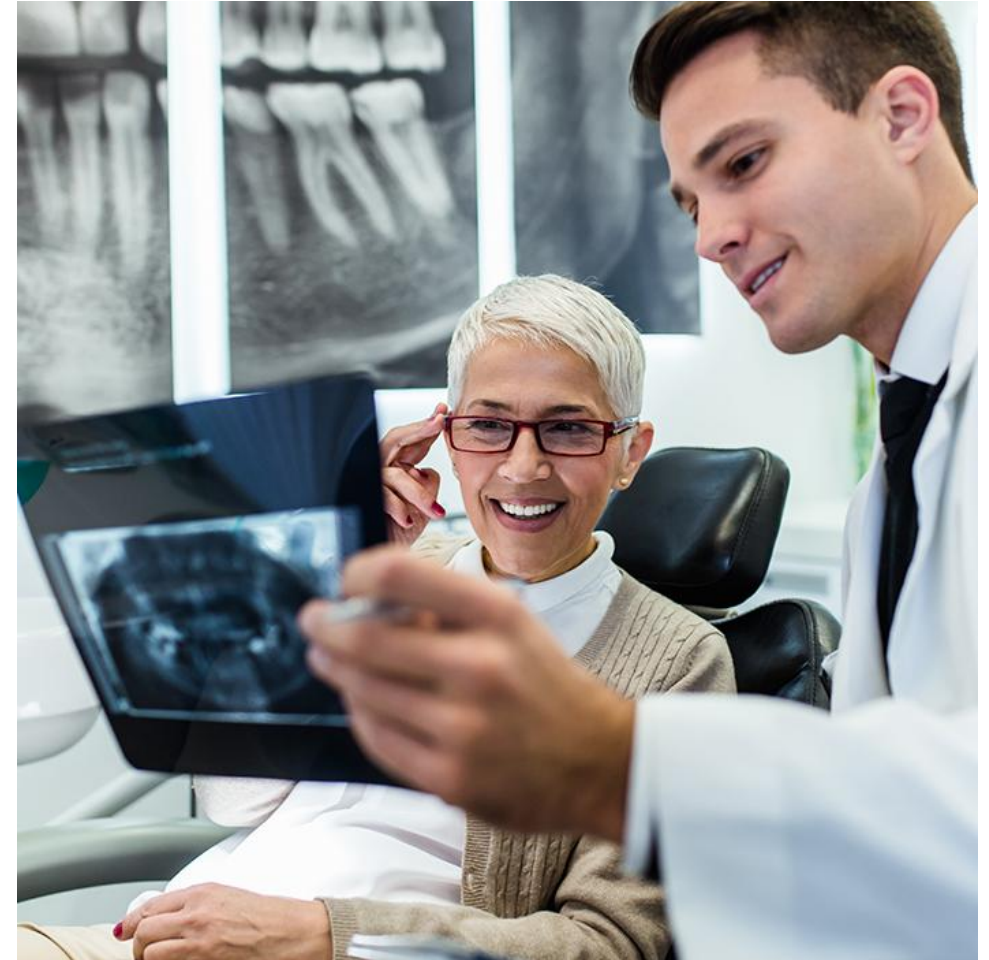
Non-covered services include services not covered by the plan and those that exceed a member's benefit limitation and/or annual maximum.



For non-emergent treatment, it is recommended to submit a prior-authorization to DentaQuest—even if known to be not covered—to ensure written documentation of the denial.




Have members sign and date a code specific treatment plan (or organization determination) clearly outlining their out-of-pocket responsibility prior to rendering services.



MEMBER CONSENT FORM/NON-COVERED WAIVER

Members can be billed for any covered services that exceed the member’s benefit limitation or annual max. Additionally, members can be billed for non-covered or denied services if they are notified by the provider ahead of time and agree to pay for such services in writing. It is highly encouraged to submit such services for prior-authorization when treatment is non-emergent.



MEDICARE MEMBER DISCLOSURE OF ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR NON-COVERED SERVICES

Medicare Member Name (“Member”)	
Treating Provider (“Provider”)	
Office/Location Name	
Office/Location Address	

The Medicare Member, or the Member’s legal representative, hereby acknowledges that he or she has been informed that the following health care services to be provided to the Member have not been approved for payment under the CMS Medicare guidelines and health benefit program.

Accordingly, the undersigned agrees that the Member or the Member’s legal representative, not the applicable health benefit program, will bear full financial responsibility for payment of all charges for these services and attests to receiving a copy of the Provider’s denial letter from DentaQuest.

Code	Description	Date of Service month/day/year	Tooth	Surface	Arch	Cost
						\$
						\$
						\$

WAIVER CONTENTS

Waivers should include the following:

- Member full name
- Member ID number
- Treating provider name
- Treating service office location/address
- Each ADA code listed
- Fee for each code
- Description of each code
- The reason the code is not covered (i.e. over the annual max)
- Member/guardian signed document prior to services being preformed
- Signed document dated
- Office staff signature (as a witness the waiver was read and understood fully)

*Prior authorize non-covered service or any service that they suspect will not be covered for system review

MEMBER ELIGIBILITY



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HOW TO CHECK MEMBER BENEFITS

Via the Provider Web Portal at [Sun Life DentaQuest provider portal](#)

Via Home Screen or Members
tab

Enter Location and Provider

Enter DOS, DOB, and
member id or name



Via the IVR Line

Call 888-307-6547 and enter
your NPI/TIN

Press 1 for eligibility

Enter member's subscriber ID



Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment

CLAIMS AND AUTHORIZATIONS



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AUTHORIZATION REQUIRED?

Prior authorization is NOT required prior to rendering services. However, some services will be reviewed by DentaQuest under Pre-Payment Review. Check the Office Reference Manual (ORM) to see if documentation is required to be submitted with a claim and for a list of covered benefits.

Oral and Maxillofacial Surgery						
Code	Brief Description	Age Limitation	Teeth Covered	Prepayment Review Required	Benefit Limitations	Documentation Required
D7240	removal of impacted tooth-completely bony	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251) per 1 Lifetime Per patient per tooth. D7250 requires evidence of previous failed extraction with retained root and not by the same provider or group.	
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251) per 1 Lifetime Per patient per tooth. D7250 requires evidence of previous failed extraction with retained root and not by the same provider or group.	
D7250	surgical removal of residual tooth roots (cutting procedure)	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251) per 1 Lifetime Per patient per tooth. D7250 requires evidence of previous failed extraction with retained root and not by the same provider or group.	pre-operative radiographs
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251) per 1 Lifetime Per patient per tooth. D7250 requires evidence of previous failed extraction with retained root and not by the same provider or group.	
D7260	oroantral fistula closure	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7260, D7261) per 1 Day(s) Per patient per quadrant.	
D7261	primary closure of a sinus perforation	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7260, D7261) per 1 Day(s) Per patient per quadrant.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	All Ages	Teeth 1 - 32	No	One of (D7270, D7272, D7280, D7282) per 1 Lifetime Per patient per tooth.	
D7272	tooth transplantation (includes reimplantation from one site to another)	All Ages	Teeth 1 - 32	No	One of (D7270, D7272, D7280, D7282) per 1 Lifetime Per patient per tooth.	

CLAIMS & AUTHORIZATIONS

Claims/Auths should be sent:

Direct entry on the provider web portal – [Sun Life DentaQuest provider portal](#)

Via Clearinghouse – **Payer ID CX014**

Include address on electronic claims

DentaQuest, LLC

PO Box 2906

Milwaukee, WI 53201-2906

Paper Claims/Auths should be sent:

DentaQuest-Claims/Auths

PO Box 2906

Milwaukee, WI 53201-2906

Fax: (262) 834-3589

DUPLICATE SUBMISSIONS OF PRIOR AUTHORIZATIONS



A duplicate submission of a prior authorization occurs when a treating provider submits a previously denied request to review the same services for the same member within 60 days of the original decision.



Per CMS guidelines, the resubmission of a denied prior authorization within 60 days of the initial adverse determination constitutes an appeal and will be denied.



To avoid delays and ensure that members get access to necessary services, providers are expected to submit complete and accurate information with each initial request.



If the submissions are inaccurate or incomplete, providers are expected to promptly respond to requests for missing documentation.

IMPORTANT THINGS TO REMEMBER



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WHAT IS AN APPEAL?

Appeal: The formal mechanism which allows the provider the right to have actions taken by DentaQuest or the health plan reviewed when the provider:

- has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness.
- is aggrieved by any rule or policy or procedure or decision by DentaQuest or the health plan.
- ❖ appeals must be filed within 65 days of the action taken by DentaQuest or the health plan that gave rise to the appeal. Appeals must be filed in writing.

PROVIDER COMPLAINTS AND GRIEVANCES

A provider may choose to file an Appeal without first filing a Complaint. In addition, a provider may file a Complaint and if the provider is unhappy with the outcome, the provider can then request an Appeal of the matter.

Provider grievances and post-service (claims) appeals should be submitted directly to DentaQuest. Appeals are required to be submitted in writing either via portal or mail to:

DentaQuest, LLC
Attention: Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906

APPEALS TIPS

Providers have the right to submit documentation with their Complaint or Appeal. It is advantageous for the provider to clearly outline his/her Complaint or Appeal and to provide supporting information. The provider should indicate why a decision should be made in the provider's favor. Complaints and Appeals will be responded to in writing within thirty (30) calendar days of receipt.

When submitting an appeal for a denied prior authorization, it's essential to include all documentation originally submitted with the prior authorization (PA) request.

This includes, but is not limited to:

- X-rays
- Medical records
- Previously submitted supporting documents/new supporting documentation related to the service/treatment

ELETRONIC FUNDS TRANFER (EFT)

Change or adding EFT follow the instructions:

- Complete EFT form (direct deposit)
- Complete appropriate sections on the standard update form
- Include voided check and/or bank letter
- Submit to standardupdates@greatdentalplans.com
- DentaQuest staff will reach out via phone for verification and confirmation that the EFT request is valid for your business **(until verification is completed the changes or add will not occur)*ensure contact for business is up to date**

REQUEST FOR MEMBER RECORDS

For all procedures, every Provider in the DentaQuest program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

Requests are made for:

- Quality Assessments
- Service Utilization
- Quality Improvement
- Investigation of Member Complaints or Grievances
- Random Chart Audits

PROVIDER WEB PORTAL



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PROVIDER WEB PORTAL REGISTRATION

Sun Life DentaQuest provider portal

The screenshot shows the Sun Life DentaQuest provider portal registration page. At the top left, the Sun Life and DentaQuest logos are displayed. The main heading is "Practice administrator registration" in a teal banner. Below this, the text asks "Ready to register for the new provider portal?" and provides instructions: "Even if you have an existing account with Sun Life or DentaQuest, you'll have to reregister, but don't worry— it's easy! Follow the on-screen prompts or follow the instructions below!". A large number "1" in a blue circle is positioned on the left side of the registration options. There are two main options: "Welcome" with a "Sign in" button and "Ready to register?" with a "Get started" button. The "Get started" button is highlighted with a red border.

Sun Life | DentaQuest

Practice administrator registration

Ready to register for the new provider portal?

Even if you have an existing account with Sun Life or DentaQuest, you'll have to reregister, but don't worry— it's easy!
Follow the on-screen prompts or follow the instructions below!

1

Welcome
Sign in to the provider portal to access member and benefits information.
[Sign in](#)

Ready to register?
Create an account on the provider portal where you can access information about plans, claims and more.
[Get started](#)

Your practice administrator will need to register your office's TIN and can later create accounts for other practice employees.

Practice administrators and 3rd party administrators can have multiple TINs linked to one portal login.

PROVIDER WEB PORTAL RESOURCE HUB

Sun Life DentaQuest provider portal

PRO TIPS

Get the most out of the Provider Portal through these tips.

INDIVIDUAL USER ACCOUNTS
Set up users →

STREAMLINED PORTAL LOGIN
Remember me →

SINGLE LOGIN ACCESS
Login access →

PRO TIP MATERIALS

How-to documents ^

RESOURCES AND TRAINING MATERIALS

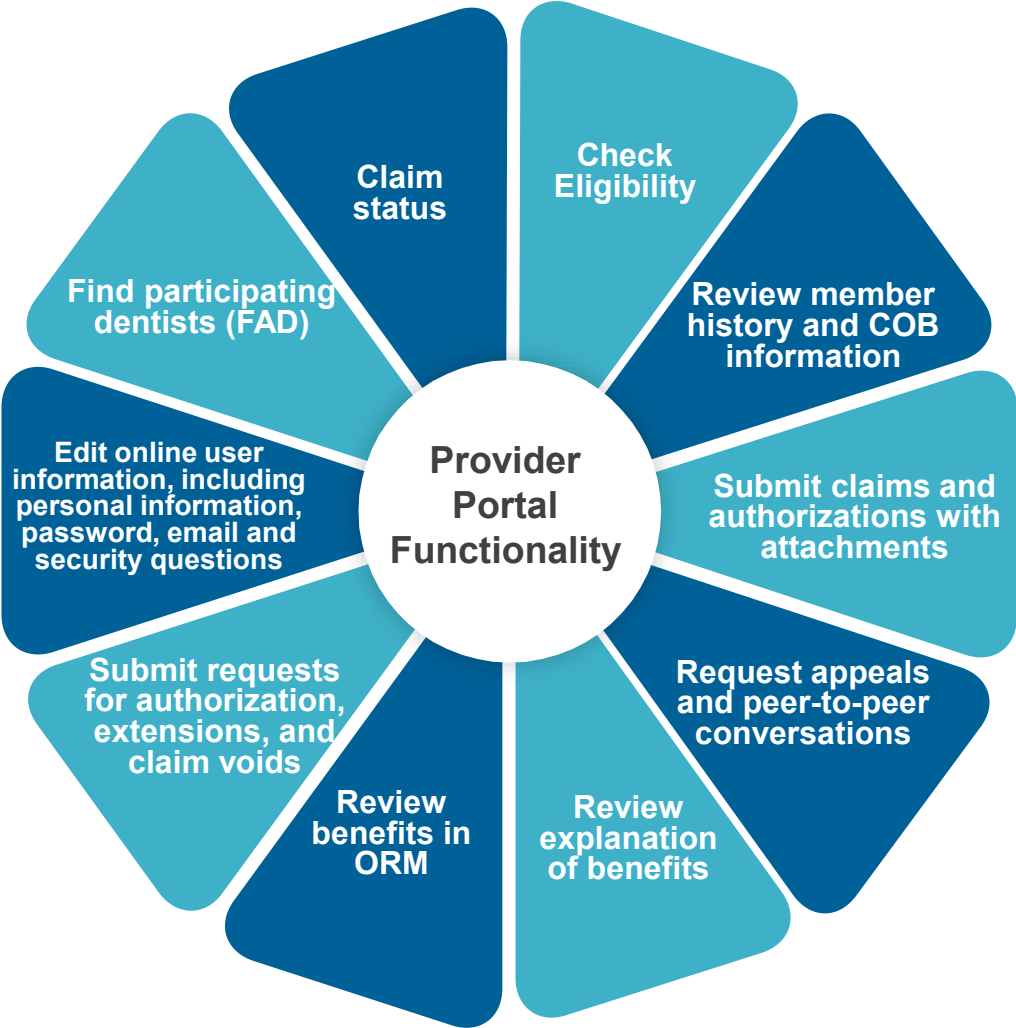
Take a peek at the resources and training materials below to help you get going.

Resources ▾

Training Videos ▾

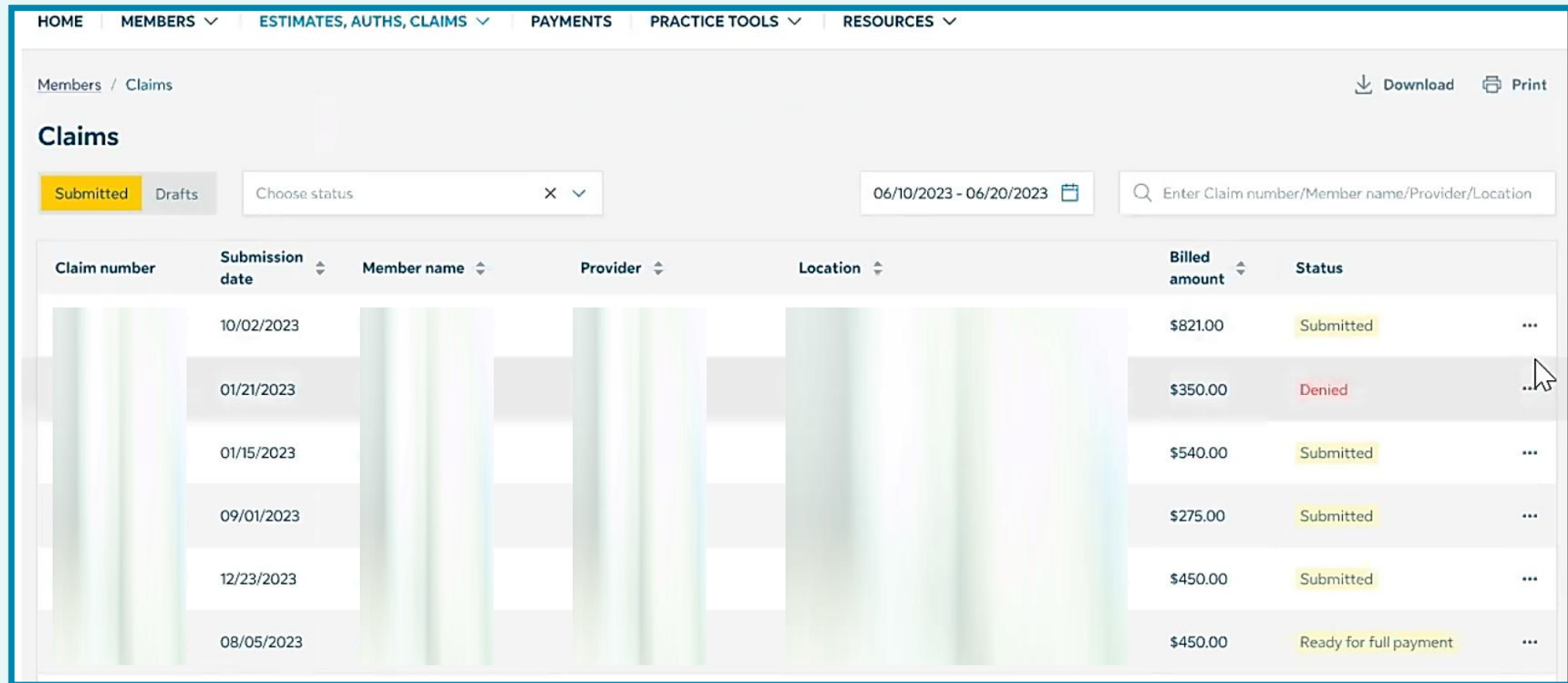
Our Resource Hub, **Resource and Training Materials**, features step-by-step training videos and other helpful documents

PROVIDER WEB PORTAL OVERVIEW & KEY FEATURES



PROVIDER WEB PORTAL – CLAIM AND PRIOR AUTH STATUSES

Claim, prior-authorization, and real-time coverage estimate history can be viewed within member details or within Estimates/Auths/Claims navigation tab.



The screenshot displays the 'Claims' section of a web portal. At the top, there is a navigation bar with tabs: HOME, MEMBERS, ESTIMATES, AUTHS, CLAIMS (selected), PAYMENTS, PRACTICE TOOLS, and RESOURCES. Below the navigation, the breadcrumb 'Members / Claims' is visible, along with 'Download' and 'Print' icons. The main heading is 'Claims'. There are filters for 'Submitted' (selected) and 'Drafts', a 'Choose status' dropdown, a date range filter '06/10/2023 - 06/20/2023', and a search bar 'Enter Claim number/Member name/Provider/Location'. The table below lists claims with columns for Claim number, Submission date, Member name, Provider, Location, Billed amount, and Status. The status column shows 'Submitted' (yellow), 'Denied' (red), and 'Ready for full payment' (yellow). Each row has a three-dot menu icon on the right.

Claim number	Submission date	Member name	Provider	Location	Billed amount	Status	
	10/02/2023				\$821.00	Submitted	...
	01/21/2023				\$350.00	Denied	...
	01/15/2023				\$540.00	Submitted	...
	09/01/2023				\$275.00	Submitted	...
	12/23/2023				\$450.00	Submitted	...
	08/05/2023				\$450.00	Ready for full payment	...

UPDATING AND CONFIRMING YOUR INFORMATION

Accurate practice information helps ensure members can easily connect with your office, as well as supporting compliance with directory standards.

The following methods can be used to update office information for DentaQuest and DHA credentialed providers:

- Provider Portal (Real-Time Updates)
 - Located under Practice Tools
 - Demographic Info
 - Sign Up for Electronic Funds Transfer (EFT)
- Provider Update Form
 - Adding new location or TIN
 - EFT or payment method updates
 - Electronic Funds Transfer Form

Provider Update Form - Provider Operations
You may send this form by e-mail to Sunlife.Provider.Updates@greatdentalplans.com
or StandardUpdates@greatdentalplans.com

Section 1: Current Information (Complete for ALL Requests - Asterisk denotes required fields)

*Effective Date (if different than current date): _____

*Provider Last Name: _____ *Provider First Name: _____

*Individual National Provider Identifier (NP) #: _____

Date of Birth: _____ Social Security #: _____ Gender: _____

*Specialty: _____ *Personal Email: _____

Requestor Information

*Requestor Name: _____ *Title: _____

*Requestor Contact Information (Phone or Email): _____

Section 2: Type of Update - Check all that Apply (Complete for ALL Requests - For Questions contact your Dental Network Managers or Customer Service)

Business (Tax ID) - Add/Term/Update - Complete Sections 1, 6, 7 and 8

Credentialing Correspondence Change/Update - Complete Sections 1 and 5

EFT/Payment - Complete Sections 1 and 8

License Change - Complete Sections 1 and 4

Name Change - Complete Sections 1 and 3

Location - Add/Term/Update - Complete Sections 1 and 6

Termination Request - Complete Sections 1 and 9

Section 3: Name Change (Attach supporting legal documentation)

New Last Name: _____ New First Name: _____

New Middle Name: _____ New Suffix: _____

Please Note: Before your name can be changed in our system, your license must reflect the change.

Section 4: License Change

New Dental License Number: _____ State: _____

New DEA License Number: _____ State: _____

New State Drug License Number: _____ State: _____

New Medicaid License Number: _____ State: _____

Other License Name: _____

Other License Number: _____ State: _____

PROVIDER UPDATES

Demographic Updates

- Office phone, fax, or email changes
- Physical address or office hours updates

Provider Updates

- Add or remove a provider
- Change in credentials or specialties

Location Updates

- Open, close, or relocate an office

Ownership Updates

- Change in ownership or legal name
- Mergers or acquisitions

Financial Updates

- EFT or payment method updates
 - Electronic Funds Transfer Form
- Tax ID (TIN) changes

Provider Update Form - Provider Operations

You may send this form by e-mail to Sunlife.Provider.Updates@greatdentalplans.com
or StandardUpdates@greatdentalplans.com

Section 1: Current Information (Complete for ALL Requests - Asterisk denotes required fields)

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New Medicaid License Number: _____ State: _____

Other License Name: _____

Other License Number: _____ State: _____

ADDITIONAL NETWORK CONTACT INFORMATION

VA Medicare Provider Services

Medicare Provider Services:
844.822.8109

John Hopkins Provider Services:
800.580.6757

Virginia Team: 866-853-0657

Provider Portal Support: 866-556-2388

DentaQuest Provider Portal and Website

Provider Web Portal:
[Sun Life DentaQuest provider portal](#)

*Page 2 of each ORM includes many other contacts/addresses

QUESTIONS?

“There is no such thing as a dumb question”

“A prudent question is one-half of wisdom.”



We wish to express our gratitude for your time and for your continued support in working with us to provide quality dental care and improve the oral health of patients in your community.

Thank you for all you do!

