FLORIDA Staywell MMA MEDICAID PROGRAM

What is Transition of Care?

Transition of Care is the process whereby Medicaid beneficiaries (Member) who are under a dental provider's care through a previous Medicaid plan may continue seeing the same dental provider prior to becoming a Member of LIBERTY Dental Plan. LIBERTY Dental Plan administers Staywell's Medicaid MMA dental benefits program for Medicaid Members.

Transition of Care Policy

During the first 90 days of enrollment, a new authorization is **not** required for certain Members with dental services previously approved by the State or another Medicaid managed care dental plan.

During the first 90 days of enrollment, LIBERTY will be responsible for the costs of continuation of dentally necessary covered services:

- Without requiring any form of prior approval, and
- Without regard to whether such services are or were being provided within or outside the Staywell/LIBERTY dental provider network.

Any treatment previously approved at a non-standard Medicaid fee will be honored only for the first 30 days of Member eligibility under the Staywell Medicaid Plan, after such time reimbursement will be at Medicaid fees.

After 90 days, Dental Providers must be contracted with LIBERTY Dental Plan in order be reimbursed for any treatment of Staywell members.

NOTE: See separate section below "*Orthodontic Transition of Care*" concerning how this policy pertains to orthodontic treatment in progress.

Completed claim forms for Transition of Care should be sent by mail or fax to:

LIBERTY Dental Plan
Attn: Transition of Care Claims
PO Box 15149, Tampa, FL 33684-5149

Fax: (888) 401-1129
Attn: Transition of Care Claims

Orthodontic Transition of Care

LIBERTY provides Transition of Care for pre-authorized orthodontic treatment. However, in order to calculate any amount owed, the treating orthodontist must send -*---the following additional information:

- Claim form for completed orthodontic services
- An Orthodontic Transition of Care Summary form
- A copy of the claim/authorization (TAR) for treatment and/or a previous Evidence of Payment (EOP) or Evidence of Benefits (EOB) statement from the previous carrier.

Members or providers may download the Orthodontic Transition of Care Form at www.libertydentalplan.com.

Completed forms should be sent via mail or fax to:

LIBERTY Dental Plan
Attn: Claims – Ortho TOC
PO Box 15149, Tampa, FL 33684-5149

Fax: (888) 401-1129
Attn: Claims – Ortho TOC

LIBERTY Dental Plan staff will verify patient eligibility and review the Orthodontic Transition of Care Form for completeness as well as the EOP or EOB (or previously approved TAR) from the previous plan to confirm that the treatment had been authorized by the previous plan. LIBERTY will then determine the remaining fee owed to the orthodontic provider. LIBERTY will work directly with the treating orthodontist to obtain any further necessary supporting documentation.

LIBERTY will process the Orthodontic Transition of Care claim based on the information provided. The treating orthodontist will be notified and the remaining terms of case payment will be noted in LIBERTY's data system for future processing . Submitted claims will be paid according to the residual net amount owing on the previous plan's agreement for treatment in progress.

Florida Medicaid MMA

Orthodontic Transition of Care Summary

Patient Name:

Subscriber/Insured's Name:

Subscriber/Insured's SSN/ID#

Treating Orthodontist:

Orthodontist's LIBERTY Provider Number

Address:

City: State: Zip:

Phone: ( ) - Fax: ( ) -

Please provide the following information for the above named patient:

Original diagnosis/treatment plan (including # of months or # of treatment visits): _____

_____

Date treatment initiated (banding/bonding) *(mm/dd/yyyy)*: _____

Summary of treatment remaining for completion (including estimated number of months/treatment visits: _____

Estimated completion date *(mm/dd/yyyy)*: _____

Original Contract Amount approved by Previous Carrier: **$** _____

Amount Paid by Previous Carrier: **$** _____

Remaining Balance financial obligation: **$** _____

Is there another insurance payment anticipated prior to LIBERTY Dental Plan's coverage effective date (circle one) **YES NO**

If so, amount expected: **$** _____

Please fax or mail this form along with a copy of the previous insurance Evidence of Payment (EOP) to:

LIBERTY Dental Plan
Attn: Claims – Ortho TOC
PO Box 15149, Tampa, FL 33684-5149

Fax: (888) 401-1129
Attn: Claims – Ortho TOC