

SECTION B – 16A – PREVENTIVE DENTAL – BASE 1 SCREEN

PBP 2008 Data Entry System - #16a Preventive Dental - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Select type of benefit for Oral Exams:

Mandatory
 Optional

Is this benefit unlimited for Oral Exams?

Yes
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Prophylaxis (Cleaning):

Mandatory
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?

Yes
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Fluoride Treatment:

Mandatory
 Optional

Is this benefit unlimited for Fluoride Treatment?

Yes
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION B – 16A – PREVENTIVE DENTAL – BASE 2 SCREEN

PBP 2008 Data Entry System - #16a Preventive Dental - Base 2

File

Select type of benefit for Dental X-Rays:

Mandatory

Optional

Is this benefit unlimited for Dental X-Rays?

Yes

No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

Select the Coverage Basis for Maximum Plan Benefit Coverage:

Published Fee Schedule

MA Organization Developed Fee Schedule

MA Organization Developed Cost Structure

Medicare Fee-for-Service Charge Structure

Medicare Fee-for-Service Prospective Payment System

Other, describe

SECTION B – 16A – PREVENTIVE DENTAL – BASE 3 SCREEN

PBP 2008 Data Entry System - #16a Preventive Dental - Base 3

File

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Is there an enrollee Coinsurance?
 Yes
 No

Is there a combination of services included in a single cost per Office Visit?
 Yes
 No

Select which combination of services are included in a single cost per Office Visit:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Indicate Coinsurance percentage for Office Visit:

Select the Coinsurance Coverage Basis for combination of services included in a single cost per Office Visit:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

SECTION B – 16A – PREVENTIVE DENTAL – BASE 4 SCREEN

PBP 2008 Data Entry System - #16a Preventive Dental - Base 4

File

Indicate Minimum Coinsurance percentage for Oral Exams:

Indicate Maximum Coinsurance percentage for Oral Exams:

Select the Coinsurance Coverage Basis for Oral Exams:

- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):

Select the Coinsurance Coverage Basis for Prophylaxis (Cleaning):

- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

Indicate Minimum Coinsurance percentage for Fluoride Treatment:

Indicate Maximum Coinsurance percentage for Fluoride Treatment:

Select the Coinsurance Coverage Basis for Fluoride Treatment:

- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

SECTION B – 16A – PREVENTIVE DENTAL – BASE 5 SCREEN

File

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

Select the Coinsurance Coverage Basis for Dental X-Rays:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

SECTION B – 16A – PREVENTIVE DENTAL – BASE 6 SCREEN

PBP 2008 Data Entry System - #16a Preventive Dental - Base 6

File

Is there an enrollee Copayment?
 Yes
 No

Is there a combination of services included in a single cost per Office Visit?
 Yes
 No

Select which combination of services are included in a single cost per Office Visit:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Indicate Copayment amount for Office Visit:

Indicate Minimum Copayment amount for Oral Exams:

Indicate Maximum Copayment amount for Oral Exams:

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):

Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

SECTION B – 16A – PREVENTIVE DENTAL – BASE 7 SCREEN

File

Enrollee must receive Authorization from one or more of the following:

- None
- Primary Care Physician (Internist/Family Practice, General Practice)
- Physician Specialist
- Organization Medical Director/Utilization Management/Utilization Review
- Other, describe

Is a referral required for Preventive Dental Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 1 SCREEN

PBP 2008 Data Entry System - #16b Comp Dental - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Emergency Services
 Diagnostic Services
 Restorative Services
 Endodontics/Periodontics/Extractions
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Emergency Services:

Mandatory
 Optional

Select type of benefit for Diagnostic Services:

Mandatory
 Optional

Is this benefit unlimited for Emergency Services?

Yes
 No, indicate number

Is this benefit unlimited for Diagnostic Services?

Yes
 No, indicate number

Indicate number of visits for Emergency Services:

Indicate number of visits for Diagnostic Services:

Select the Emergency Services periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select the Diagnostic Services periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 2 SCREEN

PBP 2008 Data Entry System - #16b Comp Dental - Base 2

File

<p>Select type of benefit for Restorative Services:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p>	<p>Select type of benefit for Endodontics/Periodontics/Extractions:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p>	<p>Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p>
<p>Is this benefit unlimited for Restorative Services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Endodontics/Periodontics/Extractions?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p>
<p>Indicate number of visits for Restorative Services:</p> <p><input type="text"/></p>	<p>Indicate number of visits for Endodontics/Periodontics/Extractions:</p> <p><input type="text"/></p>	<p>Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <p><input type="text"/></p>
<p>Select the Restorative Services periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Select the Endodontics/Periodontics/Extractions periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 3 SCREEN

PBP 2008 Data Entry System - #16b Comp Dental - Base 3

File

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
<p>Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Preventive Dental Category 16a</p> <p><input type="radio"/> Plan-specified amount per period</p>	<p>Select the Maximum Enrollee Out-of-Pocket Cost type:</p> <p><input type="radio"/> Covered under Preventive Dental Category 16a</p> <p><input type="radio"/> Plan-specified amount per period</p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <input type="text"/>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>
<p>Select the Coverage Basis for Maximum Plan Benefit Coverage:</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Medicare Fee-for-Service Charge Structure</p> <p><input type="radio"/> Other, describe</p>	

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 4 SCREEN

PBP 2008 Data Entry System - #16b Comp Dental - Base 4

File

Is there an enrollee Coinsurance?
 Yes
 No

Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits:

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Other, describe

Indicate Minimum Coinsurance percentage for Emergency Services:

Indicate Maximum Coinsurance percentage for Emergency Services:

Select the Coinsurance Coverage Basis for Emergency Services:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 5 SCREEN

File

Indicate Minimum Coinsurance percentage for Diagnostic Services: <input type="text"/>	Indicate Minimum Coinsurance percentage for Restorative Services: <input type="text"/>
Indicate Maximum Coinsurance percentage for Diagnostic Services: <input type="text"/>	Indicate Maximum Coinsurance percentage for Restorative Services: <input type="text"/>
Select the Coinsurance Coverage Basis for Diagnostic Services: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Medicare Fee-for-Service Prospective Payment System <input type="radio"/> Other, describe	Select the Coinsurance Coverage Basis for Restorative Services: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Medicare Fee-for-Service Prospective Payment System <input type="radio"/> Other, describe

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 6 SCREEN

PBP 2008 Data Entry System - #16b Comp Dental - Base 6

File

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions: <input type="text"/>	Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions: <input type="text"/>	Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Select the Coinsurance Coverage Basis for Endodontics/Periodontics/Extractions: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Medicare Fee-for-Service Prospective Payment System <input type="radio"/> Other, describe	Select the Coinsurance Coverage Basis for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Medicare Fee-for-Service Prospective Payment System <input type="radio"/> Other, describe
Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No	
Indicate Deductible Amount: <input type="text"/>	

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 7 SCREEN

PBP 2008 Data Entry System - #16b Comp Dental - Base 7

File

Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Copayment amount for Diagnostic Services: <input type="text"/>	Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Indicate Minimum Copayment amount for Medicare Covered Benefits: <input type="text"/>	Indicate Maximum Copayment amount for Diagnostic Services: <input type="text"/>	Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Indicate Maximum Copayment amount for Medicare Covered Benefits: <input type="text"/>	Indicate Minimum Copayment amount for Restorative Services: <input type="text"/>	
Indicate Minimum Copayment amount for Emergency Services: <input type="text"/>	Indicate Maximum Copayment amount for Restorative Services: <input type="text"/>	
Indicate Maximum Copayment amount for Emergency Services: <input type="text"/>	Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions: <input type="text"/>	
	Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions: <input type="text"/>	

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 8

PBP 2008 Data Entry System - #16b Comp Dental - Base 8

File

Indicate whether a separate office visit cost share applies for services:

- Yes
- No
- Sometimes, describe

Enrollee must receive Authorization from one or more of the following:

- None
- Primary Care Physician (Internist/Family Practice, General Practice)
- Physician Specialist
- Organization Medical Director/Utilization Management/Utilization Review
- Other, describe

Is a referral required for Comprehensive Dental Services?

- Yes
- No

Notes (Optional):

Import Text