UnitedHealthcare Community Plan of Texas STAR+PLUS Medicaid Dental Quick Reference Guide

The service delivery areas covered under this plan are: Bexar County, Dallas County, Harris County, Hidalgo County, Tarrant County, Travis County, MRSA Northeast and MRSA Central regions. UnitedHealthcare Texas STAR+PLUS 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 STAR+PLUS
Attn: Dental Prior Authorizations
P.O. Box 1511
Milwaukee, WI 53201

Appeals for service denials

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

Claims

UHC Texas STAR+PLUS
Attn: Dental Claims
P.O. Box 1471
Milwaukee, WI 53201

Claim disputes or adjustments

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

Corrected claims

UHC Texas STAR+PLUS
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 Texas STAR+PLUS standard Medicaid dental plan routine exams, cleanings, and x-rays for Medicaid eligible **ADULTS** covered under the plan. **This plan has a $500 annual maximum benefit per year.** The following Benefit Grid contains all covered dental procedures.

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 are required. All payments would be provided by the member at the time of service.

STAR+PLUS members who qualify for the 1915(c) STAR+PLUS Waiver services program are eligible for **additional** dental benefits that are not covered under the standard STAR+PLUS benefit. To confirm member eligibility under STAR+PLUS Waiver plan, please call Provider Services 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, 2025, then the $5000.00 annual maximum is valid through October 31, 2026.**

STAR+PLUS Standard Benefit

Code	Description	Limitations	Prior auth required	Clinical documentation
D0120	Periodic Oral Evaluation - Established Patient	1 per 6 month period		
D0140	Limited Oral Evaluation - Problem Focused	1 per 6 month period		
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per 12 month period		
D0210	Intraoral - Complete Series of Radiographic Images	1 per 3 years		
D1110	Prophylaxis - Adult	1 per 6 month period		
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

Prior authorization

"Prior authorization required" means that, before delivering services, the provider must submit the procedures for review along with clinical documentation demonstrating medical necessity. 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 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.

STAR+PLUS Waiver Authorization

Prior approval is required for all treatment plans for STAR+PLUS Waiver members. A complete treatment plan must be submitted for all dental procedures, with the exception of the procedures listed in the standard STAR+PLUS benefit. If a procedure is covered, and does not require prior authorization under the standard STAR+PLUS benefit, then it does not require prior authorization under the STAR+PLUS 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 review the request and issue a prior authorization approval or denial. The dentist may not bill the STAR+PLUS Waiver member for the remainder of the cost over the approved amount.

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 STAR+PLUS
Attn: Provider Appeals
PO Box 1427
Milwaukee, WI 53201

Dental Benefit Providers®