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1. How do I login to the Provider Portal?

- Go to https://providers.massdhp.com/

PLEASE NOTE THE FOLLOWING:

- If you have registered prior to March 21, 2025, you must register again to set up a **single shared master account** for your entire office. Select "C*lick here to*

register a new account" and follow the instructions.

CLICK HERE TO REGISTER A NEW ACCOUNT

- If you already registered with an email address, login using the registered email address and password.
- If an individual has already registered within your organization with a **tax ID** and **NPI,** a message will appear indicating that you have already been registered

  Our records indicate that you have already registered.

  If you have forgotten your password, please use the Forgot Password link located on the Provider Login page.

  If you believe that you have reached this message in error, please contact us for further assistance.

  If you are unable determine what email was used to register your office, please contact us for assistance.
- In the future, we will introduce the ability to create individual user accounts for enhanced access management.

2. How do I check eligibility and service history?

- Starting on April 1, 2025*, member eligibility can be verified on the provider portal

  **Continue to verify eligibility through the DentaQuest provider portal through Monday March 31st.*
- Starting April 1, a "Member Eligibility & History" button will be available on the left-side menu once logged onto the secure provider portal
- Click on "Member Eligibility & History" to navigate to verify member eligibility

  Member Eligibility & History
- Enter member ID and Date of Birth (DOB) for each member that you need to include in the member eligibility report. Multiple members can be verified in one report.

Add Member to Report:

By entering the Member's information and viewing their dental history report, you confirm that you have proper written authorization from the Member to access their records.

Member ID: [ ]

Date of Birth: [ ] / [ ] / [ ]

[Add Member]

- When you are finished adding members, select “Click here” to run the report

When you are finished adding Members:

Click here to run the report.

- When you run the report, the report will automatically download to your device.
- The report will include both information about the member’s eligibility (whether they are eligible on the date the report was run, their coverage type, and TPL if applicable) and the member’s service history.

<u>Sample eligibility report format:</u>

Date that the eligibility report was run → Printed on 3/31/2025

MassHealth Dental Program

Disclaimer: Eligibility for Medicaid can change daily. Member eligibility should be verified on the date of service. The claim history reflected below is based on the latest claims received, and does not include claims in process, claims incurred but not yet received or any denied services. If you have any questions about the eligibility or claim listing below, please call the MassHealth Dental Program at 844-MH-DENTL (844-643-3685).

TPL: TPL Plan Name will only appear if member has active TPL

Member ID	Name	Date of Birth	Eligibility as of 3/31/2025	Coverage Type	Age Band
123456789123	FIRST LAST	MM/DD/YYYY	Y / N	MH Regular / MH Limited / CMSP / HSN / DDS	Child / Adult

If Member has any dental claim history on file, the recent service history will show below:

Date of Service	Tooth Number	Surface(s)	Procedure Code	Description	Provider
MM-DD-YYYY	#		D####		

- After use, please ensure that you securely store or properly dispose of the eligibility report file to protect any sensitive information.
- This report can be saved as proof that eligibility was verified on the date the report was run (i.e. replacing previously required screenshots). Please remember to continue to verify eligibility on the actual date of service.

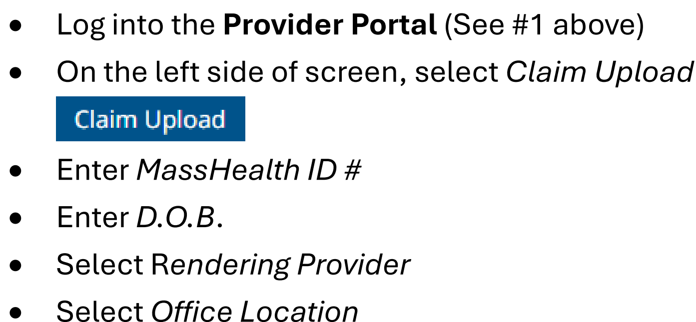
PLEASE NOTE THE FOLLOWING:

- Make sure that pop-ups are enabled
- If you are running multiple members, allow time for the report to run
- Need to have member ID and DOB
    - Eligibility verification by member name and date of birth is not currently enabled. If you need to verify eligibility by member name, please call 844-MH-DENTL (844-643-3685) to verify by phone.
- The eligibility report only shows eligibility on the date that the report was run
    - Eligibility verification for a date other than the current date on which the report is being run is not currently enabled. If you need to verify eligibility for a past or future date, please call 844-MH-DENTL (844-643-3685) to verify by phone
- TPL coverage will only show on the report if there is TPL active
    - If there is no TPL coverage listed on the member eligibility report, then there is no active TPL coverage on the date that the eligibility report was run
- The eligibility report runs with the service history and there is currently not an option to run the report without service history
- The provider portal does not currently include information on the CMSP $750 annual maximum balance. If you need to verify the CMSP $750 annual maximum balance, please call 844-MH-DENTL (844-643-3685) to verify by phone.

3. How do I submit a Claim, Prior Authorization, or Pre-determination Request?

<u>Step 1</u>

- Log into the **Provider Portal** (See #1 above)
- On the left side of screen, select *Claim Upload*



- Enter *MassHealth ID #*
- Enter *D.O.B.*
- Select R*endering Provider*
- Select *Office Location*

- Select *Continue*
  *(*Please Note Claim & Prior Authorization Upload uses the same interface but will be considered a claim if there is a date of service and a prior authorization or pre-determination request if no date of service)*

Claim & Prior Authorization Upload

Please enter a patient's Member ID and Date of Birth for which you wish to submit a claim or prior authorization.

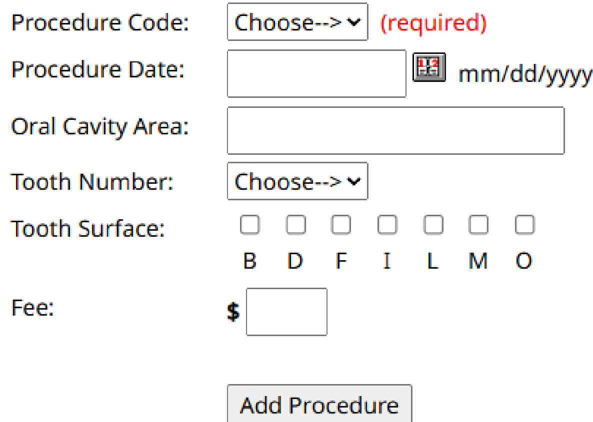
Member ID:

Date of Birth: / /

Rendering Provider NPI: Choose-->

Continue

- See *Claim and Prior Authorization Upload*
  - Add *Procedure Code*
  - Add *Procedure Date*
  - *Add Oral Cavity Area (Quadrant)*
  - Add *Tooth Number*
  - Add *Tooth Surface*
  - Fee field is optional



Step 2

ADD X-RAYS AND/OR OTHER SUPPORTING DOCUMENTATION

Select *Choose File* to navigate to the location of your X-Rays or Supporting Documentation.
(Examples of supporting documentation could include EOB from primary dental insurance or clinical documentation for retrospective review or pre-payment claim

review.)

Select *Upload File*

Upload File:

File Name: Choose File

Upload File

Step 3

INDICATE MISSING TEETH (X = MISSING, O = TO BE PULLED)

(Missing teeth field is optional)

Fill in the form and then select *Update Missing Teeth*

If the Member has no missing teeth, check here: ☐

If the Member is endentulous, check here: ☐

Otherwise, please indicate individual missing teeth or teeth to be extracted in the grids below:

PERMANENT															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PRIMARY									
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Update Missing Teeth

Step 4

REMARKS

Type in any additional remarks and select *Update Remarks*
(Examples include PA #, Unit #, facility name and address information, etc.)

Update Remarks

Step 5

SUBMIT REQUEST

The reference number will be included on the top right of the paper claim form on the next page.

Select *Submit*

Submit Request

An option to download paper forms of the claim submission for your records will appear

Please note that retrospective review requests for services that require prior authorization (PA) should be made using this Claim & Prior Authorization Upload portal function. Retrospective review will be considered for all services requiring PA except for Orthodontic services.

4. How do I check the status of a claim?

*(*Please note that the Claim Status interface includes the status of Claims, Prior Authorization, and Pre-Determination Request. A request is considered a claim if there is a date of service and a prior authorization or pre-determination request if no date of service)*

- Log into **Provider Portal** (see #1 above)
- On the left side of screen, select *Claim Status*

  Claim Status
- Enter *Member ID #* and select *Search*

  Claim Status

  Please enter a patient's Member ID, then click **Search**.

  Member ID:

  Search

See *Claim Status*

PLEASE NOTE THE FOLLOWING:

- Claims, prior authorization, and pre-determination requests will not show under the "Claim Status" function of the portal until after 4/1/2025. If the request was submitted online and a Reference number provided after submission, the request has been received.
- The Reference number can be found when selecting the option to print a copy of the request that appears on the confirmation screen after submission. The print option will generate an ADA claim form version of the request with a Reference number at the top.
- It takes about 24-48 hours for a new request to process in the system and become searchable using the "Claim Status" function

5. Clarification of the new policy regarding prepayment claim review.

- This is a new process to ensure claims align with MassHealth regulations before payment is made.
- This review includes but is not limited to:
    - member eligibility determination;
    - provider eligibility determination;
    - benefit coverage determination and/or coordination of benefit;
    - determination that the service is medically necessary and meets the applicable standards of care and is not duplicative of another service.
- When clinical review is needed for pre-payment claim review, documentation must be submitted with the claim.
- Not all procedures require clinical documentation to be submitted for pre-payment claim review.
- Providers can submit documentation before OR after providing a service:
    - **Before treatment**: To request an optional pre-determination review, to check if the proposed treatment meets coverage guidelines.
    - **With the claim**: To verify compliance with MassHealth regulations, coverage policies, and clinical guidelines.
- Providers are not required to request pre-determination before treatment.
- Pre-payment claim review and pre-determination are not prior authorization requirements.

- The MassHealth prior authorization requirements remain the same and are not changing.
- **Pre-payment claim review for crowns and core buildups:**
    - **Effective for dates of service April 1, 2025, and after**, crown and core buildup services require documentation to be submitted with the claim for clinical pre-payment review.
    - There is no new prior authorization requirement for crowns.
- **Expansion of clinical pre-payment review**:
    - **Effective for dates of service June 1, 2025, and after**, other select services will require documentation to be submitted with the claim for clinical pre-payment review
    - For more information on pre-payment claim review, refer to Section 5.00 “Claim Review” of the **Office Reference Manual**.

6. Where do I locate the Office Reference Manual (ORM)?

- The Office Reference Manual is available at **massdhp.org/orm**. The ORM is regularly updated to reflect changes in policies, procedures, and regulations, so please check back frequently for the most current information.

7. Who do I contact with additional questions, support, or service?

- Website: **massdhp.org**
- Phone: 844-MH-DENTL (844-643-3685)
- Email: providerrelations@massdhp.com
  Monday – Friday 8:00am-6:00pm EST