Information about referrals to providers for members of Maryland dental plans

Referrals to Out-of-Network Providers due to Network Inadequacy

If you need covered dental care services that are not available from a network provider—or access to a network provider would require unreasonable delay or travel—you, your provider or a representative acting on your behalf can ask for a referral to an out-of-network provider. If your request is approved, such services from the out-of-network provider will be covered at the network benefit level.

How to request a referral to an out-of-network provider

To request a referral to an out-of-network provider, call the toll-free member phone number on your dental plan ID card. If you wish to have someone else represent you for this request, please tell us and we will send you the form needed to designate a representative.

- Referral requests for dental care determinations will be made within 2 working days after receipt of the information necessary to make a determination.

Emergency cases: Please be sure to tell us if you have an emergency case where a health service is necessary to treat a condition or illness that, without medical attention, would seriously jeopardize the patient's life, health or ability to regain maximum function, or would cause the member to be in danger to self or others.

What to do if Your Request for Referral is not approved

If your request for a referral is denied and you don't agree with our decision, you, your health care provider or a representative acting on your behalf may request a grievance review. This is the process for asking us to reconsider a decision. The person who reviews your grievance will not be the person, or a subordinate of that person, who made the original decision.

A grievance request must be submitted within **180 days** from when you received the denial of your request for a referral.

To submit a grievance, please provide the following information:

- A written grievance asking us to reconsider our decision
- The specific coverage decision you would like us to review
- An explanation of why the requested service should be considered for coverage
- Any additional information that supports your position
- A copy of the denial letter we sent you

Mail or fax this information to:

Dental Appeals/Grievances
P.O. Box 30569
Salt Lake City, UT 84130-0569
Fax: 1-714-364-6266

Expedited (urgent) grievance fax: 1-714-364-6266 (please include description of urgency)

If more information is needed, we will notify you, your provider and any representative acting on your behalf within 5 working days of receiving the grievance request. For emergency cases, we will verbally inform you, your provider and any representative acting on your behalf if we need more information. If no additional information is available or is not submitted to us, a decision will be made on the available information.

The timeframe for us to review the grievance and make a decision depends on whether or not you have already received care from the provider for whom you are requesting a referral to.

- **Prospective Denial:** If you have not yet received services from the provider to whom your request for a referral was denied, we will review the grievance and give you, your provider, and any representative acting on your behalf a decision no later than **30 work days** after the date on which the grievance was submitted. With written permission from you, your health care provider, or a representative acting on your behalf, the time frame for us to respond can be extended up to 30 additional work days. Written notification of our grievance decision will be sent to you, your care provider, and any representative acting on your behalf within 5 work days after the grievance decision has been made.

  For emergency cases, where the patient's condition is such that the time needed to complete a standard grievance review could seriously jeopardize the patient's life, health or ability to regain maximum function, we will give you, your health care provider, and any representative acting on your behalf a verbal decision within **24 hours** of receipt of the grievance request. A written notice of the decision will be provided to you, your provider, and any representative acting on your behalf within 1 day after the verbal grievance decision has been communicated. If we do not provide a grievance decision within 24 hours, you, your health care provider, or a representative acting on your behalf may file an adverse decision complaint directly with the Insurance Commissioner.

- **Retrospective Denial:** If you have already received services from the provider to whom your request for referral was denied, we will review the grievance and give you, your provider, and any representative acting on your behalf a decision no later than **45 work days** from the date on which the grievance was submitted. Written notification of the grievance decision will be sent to you, your health care provider, and any representative acting on your behalf within 5 work days after the grievance decision has been made.

For questions, please call the toll-free member phone number on your dental plan ID card.

This information applies to fully insured, commercial dental plans provided by or through UnitedHealthcare Insurance Company, Dental Benefit Providers of Illinois, Inc., or their affiliates.

UnitedHealthcare®