



Iowa Department of Human Services

Dental Wellness Plan Wraparound Payment Request

Federally Qualified Health Center
 Quarterly Reconciliation Worksheet
 (Due 30 days from end of previous quarter)

Name of Federally Qualified Health Center:

Reconciliation Quarter Ending:

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|------------------------|------------------------|-----------------------------------|--|---------------------------------|
| # of Medicaid Dental Wellness Plan Encounters or Visits | Expected Plan Payments | Subcapitation Payments | Estimated Payments to Be Received | Medicaid Regular Encounter or per Visit Payments | Difference Reimbursable to FQHC |
| | | | | | |

1. Enter the number of daily encounters or visits for Medicaid members receiving Dental Wellness Plan benefits. These encounters must follow the encounter rules as indicated in the Federally Qualified Health Center Provider Manual, Chapter E, Section V, Procedure Codes and Nomenclature, or rules for counting visits as indicated in the Rural Health Clinic Provider Manual Chapter III, Section E, Procedure Codes and Billing.
2. List all dollar amounts normally expected to be received by the federally qualified health center or rural health clinic from the plan for the services provided in box 1. (Note: These amounts exclude any subcapitation arrangements to the federally qualified health center or rural health clinic.) If any payments are made over and above the general capitation payments, these must be included here.
3. List all dollar amounts of contractual, risk based capitation payments made on behalf of the plan (for Delta Wellness members) for the provision of care that is NOT separately reimbursed either by encounter, visit, or fee schedule.
4. Add together the total amounts from boxes 2 and 3.
5. Multiply the actual Medicaid encounter rate or per-visit interim rate times the number of encounters or visits reported in box 1.
6. Subtract box 5 from box 4. This amount represents the wraparound payment that the Medicaid program will reimburse to the federally qualified health center or rural health clinic for the reconciliation quarter indicated.

I attest that this information is correct and complete to the best of my knowledge and that the calculations are supported by records maintained at our facility. Any adjustments or amendments to this report will be made within seven days of the original submission of this document.

Signature:

Date:

Return to: Iowa Medicaid Enterprise – Provider Cost Audit Unit, PO Box 36450, Des Moines, IA 50315, or Fax: (515) 725-1353