



## Dental Wellness Plan Wraparound Payment Request

Federally Qualified Health Center (FQHC)

Quarterly Reconciliation Worksheet

(Due 30 days from end of previous quarter)

Provider Name: \_\_\_\_\_

NPI #: \_\_\_\_\_ Provider Type (circle one): FQHC / IHS

MCO Name: \_\_\_\_\_ Reconciliation Quarter Ending: \_\_\_\_\_

1	2	3	4	5	6
Number 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 Provider

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 III, Section E, Procedure Codes and Nomenclature.
2. List all dollar amounts normally expected to be received by the FQHC from the plan for the services provided in box 1. (Note: These amounts exclude any subcapitation arrangements to the FQHC). 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 FQHC for the reconciliation quarter indicated.
7. Include an Excel spreadsheet containing supporting claims detail. The claims detail must consist of the following columns: Patient Name, Medicaid ID #, Date of Service, CDT Code(s), Amount Billed, and Amount Paid by the MCO. Click [here](#) to download the template (470-5419) for claims detail.

*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: \_\_\_\_\_

Email this completed form and the supporting claims data in Excel to [costaudit@dhs.state.ia.us](mailto:costaudit@dhs.state.ia.us).