Iowa Department of Human Services

Dental Wellness Plan Wraparound Payment Request

Federally Qualified Health Center (FQHC)
Quarterly Reconciliation Worksheet
(Due 60 days from end of previous quarter)

Provider Name:_____

NPI #:_____ Provider Type:_____

MCO Name:_____ Reconciliation Quarter Ending:_____

1	2	3	4	5	6
Number of Medicaid Dental Wellness Plan Encounters	Payments from MCO and Other Sources	Payments from Subcapitation Contracts	Total Payments Received	Expected Medicaid Fee for Service Amount	Wraparound Payment Requested

1. Enter the number of daily encounters 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 received by the FQHC from the MCO and Other Sources for the services provided in box 1.
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. The total of the amounts from boxes 2 and 3.
5. Multiply the most recently set Medicaid interim encounter rate in effect by the number of encounters reported in box 1.
6. Subtract box 4 from box 5. This amount represents the potential wraparound payment (pending review) 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, Paid Date, CDT Code(s), Amount Billed, Amount Paid by the MCO, Amount Paid by Other Source, and Adjusted Claims information. 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:

Submit this completed form and the Wraparound Supporting Claims Detail, IME Form 470-5419, in Excel to IME Provider Cost Audit & Rate Setting Unit using the Iowa Medicaid Portal Access (IMPA) System.