



# **Nevada Office of HIV**

## **Ryan White Part B**

### **Ryan White Dental Insurance Enrollment Primer**

#### **Scope of Coverage**

Directly applicable to Ryan White Part B (RWPB). Funding and program management is directly housed in the State of Nevada Office of HIV through the Health Resources and Services Administration (HRSA) service category Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals.

#### **Purpose of Primer**

To assist with correct and secure submission of client dental insurance enrollment forms from subrecipients to the State of Nevada Office of HIV. This document will serve as a step-by-step instruction guide for uploading confidential client enrollment forms to a secure website so the Office of HIV can enroll these clients with Liberty Dental, the provider of our dental program insurance.

#### **Background**

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/ Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use Ryan White HIV/AIDS Program (RWHAP) funds for standalone dental insurance premium assistance, a RWHAP Part B recipient must implement a methodology that incorporates the following requirement:

- RWHAP Part B recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.



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#### Process

**Step 1.** Eligibility Specialists will fill out the Dental Insurance Enrollment Form as part of the Universal Eligibility packet for those clients enrolling in dental coverage. Please view the Sample Demographic Field below then view the Form Requirements in order to correctly complete step 1 of the Dental Form.

Current Ryan White Eligibility	Start Date: 01/01/2019	End Date: 06/01/2019
Eligibility Specialist Name: SARA SMITH		Direct Phone Number: (775)-123-4567
Client Legal Last Name: COOK	Client Legal First Name: JOHN	Gender: MALE
URN: JHCO0102831U	<b>Emergency Dental Request (see above note):</b> <input type="checkbox"/> Yes	
Date of Birth: 01/02/1983	Phone Number: (775)-456-7890	
Language Preference: <input checked="" type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	SSN or TIN*: 000-00-0000	
Home Address: 123 WATER DR.	City: RENO	State: NV Zip: 89512
Mailing Address** (if different than home): 456 AIR LANE	City: RENO	State: NV Zip: 89511

*Each category must be filled in except, when applicable, the Emergency Dental Request. Please fill this category in only if it is an emergency request. The SSN or TIN category will be used for verification of other health benefits. This category may be left open if the client does not have an SSN or TIN.*

#### Dental Form Requirements

Field Name	Requirement	Format
Start Date	Yes	00/00/0000 (month/day/year)
End Date	Yes	00/00/0000 (month/day/year)
Eligibility Specialist Name	Yes	First & Last Name
Direct Phone Number	Yes	(area code)-000-0000 ext. 0000
Client Legal Last Name	Yes	All Caps
Client Legal First Name	Yes	All Caps
Gender	Yes	All Caps
URN	Yes	All Caps
Emergency Dental Request	No	Check Box if Needed
Date of Birth	Yes	00/00/0000 (month/day/year)
Phone Number	Yes	(area code)-000-0000 ext. 0000
Language Preference	Yes	Check Box
SSN or TIN*	Yes, if client has one	SSN: 000-00-0000 TIN: 00-00000000



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Home Address	Yes	All Caps
City	Yes	All Caps
State	Yes	All Caps
Zip	Yes	00000
Mailing Address	Yes	All Caps
City	Yes	All Caps
State	Yes	All Caps
Zip	Yes	00000

*Step 2.* In order to complete step 2 of the Dental Form the client must read the form, check the boxes and sign the form.

Please check **all boxes below** showing that you understand **and agree to** the following program requirements:

- ☐ I understand that in order to receive dental services I will complete my annual certification and re-certification in the time frame established by the Ryan White Program in order to remain eligible for dental services.
- ☐ I understand that in order to receive dental services I must have one dental prevention service every six months.
- ☐ I understand that failure to receive one dental prevention service every six months may lead to discontinuation of dental services.
- ☐ I fully understand that by completing this form, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Medication Assistance Program.
- ☐ I understand this information will be kept confidential but will be used by staff to review my eligibility for this program.

Client Signature:

Date:

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*Step 3.* The form must be included with the eligibility documents in CAREWare.

***Now that the Dental Form is complete please follow the below steps to properly send the form electronically to the Office of HIV for processing:***

The subrecipient will designate a lead case manager and a backup, who will be responsible for uploading dental enrollment form. To request access to upload dental forms the subrecipient must email [rwidental@health.nv.gov](mailto:rwidental@health.nv.gov) requesting access to the secure site for the lead case manager and backup.

Once access has been provided, dental forms must be uploaded to <https://dpbhsftp.nv.gov/EFTClient/Account/Login.htm> and into the subrecipient's folder. Once the form has been uploaded, an email must be sent to [rwidental@health.nv.gov](mailto:rwidental@health.nv.gov) notifying us that there is a new file in the folder. This should be done on a daily/as needed basis.



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Uploading dental form for enrollment to the State secure SFTP site:

1. Go to <https://dpbhsftp.nv.gov/EFTClient/Account/Login.htm> (the Edge browser is recommended).

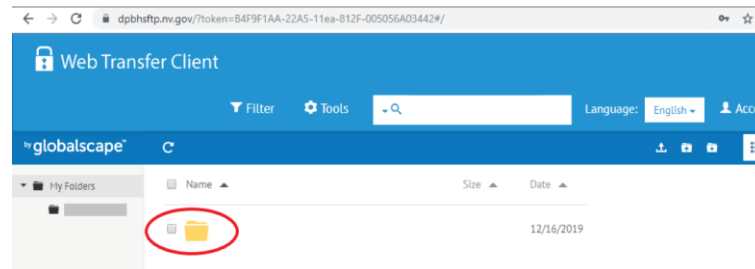
globalscape<sup>TM</sup>  
securely connected

Log in

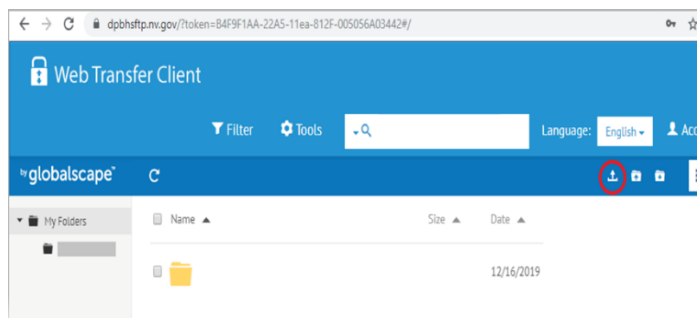
Username:  [Forgot Username](#)

Password:

2. Add your username and password given to you by the Office of HIV and login.
3. Open your folder.



4. Click the upload icon (bar with arrow on top) on the darker blue band across the webpage.



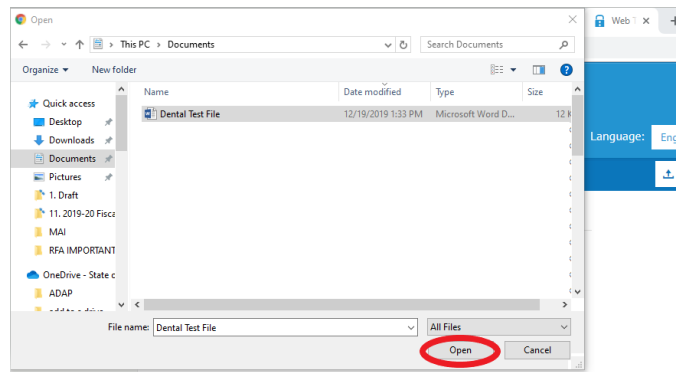


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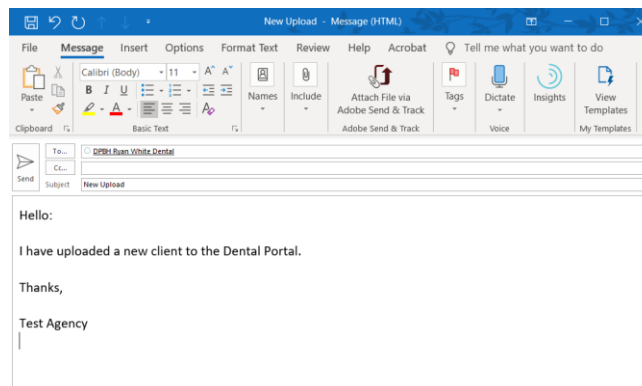
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5. Your computer documents page will open. Select the document you want to upload. Click “Open”. Document has now been uploaded.



6. Send email to [rwidental@health.nv.gov](mailto:rwidental@health.nv.gov) notifying us of the upload.



If you have any questions, please email [rwidental@health.nv.gov](mailto:rwidental@health.nv.gov) or call Grants & Projects Trainee (Contractor) at 775/684-4260 or Program Officer I at 775/684-5882.