Medicare Advantage Dental Discount

Frequently asked questions

Starting Jan. 1, 2027, members enrolled in eligible UnitedHealthcare Medicare Advantage plans can save on dental care through the UnitedHealthcare Dental Savings Network (PPO6).

How the Medicare Advantage dental discount works

Eligible UnitedHealthcare Medicare Advantage members receive reduced rates on dental services from participating Dental Savings Network (PPO6) providers. This is a discount offering – not insurance – and members pay providers directly.

What this means for you

- Verify the member's eligibility and enrollment on **UHCdental.com**
- Determine services based on your diagnosis and the member's clinical needs
- Apply your contracted PPO6 network rate
- Collect payment directly from the member

Benefit verification, prior authorization, plan limitations and claim submission do not apply.

Frequently asked questions

What is the Medicare Advantage Dental Discount?

It's a dental discount offering -- not insurance -- available to eligible UnitedHealthcare Medicare Advantage members in Arizona, Kansas, Maine, Massachusetts, Mississippi, Missouri, New Jersey, New Mexico, Oregon, Texas, Virginia and West Virginia.

Which network does this discount offering use?

The discount offering uses the Dental Savings Network (PPO6). Providers must participate in PPO6 for members to receive the network rate.

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How do I identify an eligible member?

UnitedHealthcare Medicare Advantage members will present their member ID card. Sign in to **UHCdental.com** to verify the member's eligibility and enrollment.





Members with one of the following contract IDs on their ID card are eligible for the Medicare Advantage Dental Discount:

H0609-054-000	H2406-096-000	H5253-119-000	H8768-040-000
H2001-153-000	H2406-097-000	H8211-006-000	H8768-055-002
H2406-076-000	H3805-048-000	H8768-023-000	H8768-058-000
H2406-091-000	H4514-007-000	H8768-034-00	H8768-059-000

Do I need to verify benefits or obtain prior authorization before providing services?

No. Determine services based on your diagnosis and the member's clinical needs. Benefit verification, prior authorization and plan limitations do not apply.

Which fee schedule should our office use?

Use the PPO6 network fee schedule. If your office needs a copy, contact your Provider Relations Advocate or call Provider Services at **800-822-5353**.

Do members have deductibles, maximums or frequency limitations?

No. Deductibles, annual maximums and frequency limitations do not apply.

Can a member have both a dental rider and access to the dental discount?

Yes. Members may have both the dental rider and access to the dental discount. However, the rider benefit and the discount offering cannot both be applied to the same dental service at the same time.

How should our office collect payment?

Members pay your office directly for services at the applicable PPO6 network rate.

Should our office submit a claim?

No. Claims are not accepted or required. You may provide the member with an itemized statement or receipt for their records.

Which services are eligible for the network rate?

Most dental services are available at the applicable PPO6 network rate.

Can members receive the PPO6 network rate from a non-participating provider?

No. Members receive the PPO6 network rate only from participating PPO6 providers.



Questions?

Contact your Provider Relations Advocate or call Provider Services at **800-822-5353**.

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