CareOregon Dental Flexible Services

Last updated: March 2025

Funding Request Form & Submission Guidance

Flexible services are health-related, non-State plan services intended to improve care delivery and member health. They are cost effective alternatives to traditional services and are likely to effectively treat or prevent the dental health condition. Flexible services are unable to be reported in the conventional manner using CPT, CDT or HCPCS codes.

CareOregon Dental supports flexible services funds to be used for the benefit of members to promote dental health, prevent dental decompensation and divert from higher levels of dental care.

Eligibility requirements

To apply for CareOregon Dental flexible services all the following must be true:

1. Patient is a current CareOregon Dental member
2. Item/service is not otherwise Medicaid reimbursable (i.e. No CDT code)
3. No other funding source is available to cover the cost of the item/service
4. Item/service is clearly related to treatment goal and documented in the member's chart
5. Member has not received a flexible services item/service within the last calendar year

How to apply for services

1. Ensure eligibility
2. Complete the CareOregon Dental Flexible Services Funding Request Form
3. Fax completed forms to: ATTN: HRSFlex at 503-416-4728 or mail to: ATTN: Social Determinants, CareOregon, 315 SW Fifth Ave, Portland, OR 97204

CareOregon Dental will review your request and will make a determination within 10 business days.

- The provider will receive the outcome letter via email
- The member will receive a hardcopy outcome letter in the mail
- If approved, the member will receive the item in the mail

CareOregon Dental will supply approved items that meet criteria directly to the member through the mail. Examples of common oral health flexible services items are electric toothbrushes, water flossers, fluoride rinse and dry mouth products. Providers are authorized to request these items for CareOregon Dental members if dentally appropriate and documented in a chart note.
A completed request form shall be provided to CareOregon Dental.

For assistance, contact a member of CareOregon Dental's Dental Access Team at **DentalAccessTeam@careoregon.org** or 503-416-1444.

CareOregon Dental Flexible Services Funding Request Form

Date (mm/dd/yyyy) _____

CCO:

health share
Health Share of Oregon

Columbia Pacific CCO™
Part of the CareOregon Family

*****Incomplete request forms will be returned to the provider*****

Member information

Last name: _____ First name: _____

Medicaid ID: _____ Member DOB: _____

Mailing address: _____ Phone: _____

Dental diagnosis: _____

Additional diagnosis: _____

Requesting party information

Requesting provider: _____ Clinic: Please select clinic

Email: _____ Phone: _____

Requested flexible service item/service: Electric toothbrush-Child Sonicare

Other: _____

Request details and information

The Agency/Provider acknowledges the use of these alternative funding resources as a last resort. What other sources of funding did you consider? If none, please explain why.

- Third party resources
- Agency/provider existing programs
- Community partners

Explanation:

Check category in which this purchase applies.

- Training/education for oral health
- Improvement/management self-help or self-care activities
- Products related to oral health home/living environment
- Products for improvements for oral health

Other (describe) _____

Request details and information — continued

How does this item/service support the member's oral health treatment plan?

What type of health coaching has been provided to the member regarding this item or service?

What is the sustainability plan once this item/service is paid for? What is the follow up?

Individual completing form: _____

Signature: _____

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