Description of Dental Benefits Provided Under Medicaid and the Children's Health Insurance Program (CHIP)
State: New Hampshire

Updated: 8/04/2009

The following information will identify the general categories of services available in your State. Please note that while a service may be available, you must consult with your dental provider to ensure that the service is medically necessary for your specific condition. For more specific information, please contact your State program.

State Contact: New Hampshire Healthy Kids
Telephone Number: 1-877-464-2447 or 603-228-2925.
E-mail Address:

Medicaid Program

☐ Under the Medicaid State Plan dental benefits are provided to eligible individuals under the age of 21 in compliance with the requirements of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
State Program Name:

CHIP Program

☐ CHIP Medicaid Expansion Program ONLY, i.e., offering complete oral health services under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
State Program Name:

☒ CHIP Stand-Alone/Separate Program ONLY
State Program Name: **Healthy Kids Silver**

- ☒ Dental Services Provided through State-defined benefit package
- ☐ Benchmark Equivalent Program:
  Name of :
- ☐ Optional Supplemental Dental Coverage for CHIP eligible children with private or group insurance

☐ CHIP Medicaid Expansion and Stand-Alone Program (dental services are as described above)
State Program Name:

If providing dental benefits other than as defined by EPSDT, States must complete the following:

CHIP Stand-Alone Program Dental Benefits

NOTE: Please identify any limits or other criteria using terms commonly recognized by individuals without extensive oral health terminology knowledge rather than using technical dental terminology. For example, use molar rather than posterior, or front versus anterior.

Schedule of Services

☐ State EPSDT definition
OR
☐ Nationally Recognized Standard
Name and Description: **Dental benefits are provided by Northeast Delta Dental, a not for profit organization that is affiliated with the national Delta Dental Plans Association providing dental programs in all states and territories. Benefits are limited to $600.**

Recommended Age for First Oral Health Examination:

Preventive Services:

X Cleanings

a. Recommended frequency: **once every 6 months**
b. Exceptions:

X Fluoride treatments
- a. Ages: to age 19
- b. Recommended frequency: **once every 12 months**
- c. Also provided by physicians: ☐
- d. Also provided by hygienists: ☐
- e. Exceptions:

X Sealants
- a. Ages:
- b. Recommended frequency:
- c. Exceptions:

X Oral hygiene instruction
- a. Ages:
- b. Recommended frequency:

X Space Maintainers
- **a.** Limits: **Entire benefit package is limited to $600 per person per calendar year.**
- b. Prior approval required: Y/N

Diagnostic Services:

X Dental Examinations by Dentists
- a. Recommended age of first visit:
- b. Recommended frequency:
- c. Limits**: Entire benefit package is limited to $600 per person per calendar year.**

X Dental Screens and Other Services by Hygienists
- a. Recommended frequency:
- **d.** Limits: **Entire benefit package is limited to $600 per person per calendar year.**

X X-Rays
- **e. Limits: Entire benefit package is limited to $600 per person per calendar year.**

Treatment Services:

X Fillings
1. Silver amalgam: **X**
   - **f.** Limits: **Entire benefit package is limited to $600 per person per calendar year.**
2. Tooth colored composite: **X**
   - g. Limits: **Entire benefit package is limited to $600 per person per calendar year**.

☐ Crowns/Tooth Caps
1. Stainless steel crowns: ☐
   - h. Limits: Prior approval required: ☐
2. Metal (only) crowns ☐
   - i. Limits: Prior approval required: ☐
3. Metal/Porcelain crowns: ☐
   - j. Limits: Prior approval required: ☐
4. Porcelain (only): ☐
   - k. LimitsPrior approval required: ☐

☐ Root Canals (endodontics)
1. Root canals on baby teeth (Pulpotomies): ☐
   - a. Limits:
   - b. Prior approval required: ☐

2. Root canals on permanent teeth: ☐
    a. Limits:
    b. Prior approval required: ☐

☐ Gum (periodontal) Therapy
    a. Limits:
    b. Prior approval required: ☐

☐ Dentures
    1. Partial dentures: ☐
        a. Prior approval required: ☐
    2. Complete dentures: ☐
        a. Prior approval required: ☐

☐ Retainers (orthodontic)
    a. Limits:

☐ Bridges
    a. Limits:
    b. Prior approval required: ☐

☐ Implants:
    a. Criteria:

☐ Oral Surgery
    1. Simple extractions: **X**
        l. Limits: Entire benefit package is limited to $600 per person per calendar year.
        a. Prior approval required: ☐
    2. Surgical extractions: ☐
        a. Limits:
        b. Prior approval required: ☐
    3. Care of abscesses: ☐
        a. Limits:
        b. Prior approval required: ☐
    4. Cleft palate treatment: ☐
        a. Limits:
        b. Prior approval required: ☐
    5. Cancer treatment: ☐
        b. Limits:
        c. Prior approval required: ☐
    6. Treatment of Fractures: ☐
        a. Limits:
        b. Prior approval required: ☐
    7. Biopsies: ☐
        a. Limits:
        b. Prior approval required: ☐

☐ Treatment of Jaw Joint (TMJ)
    a. Criteria:
    b. Prior approval required: ☐

☐ Braces (Orthodontia)
    a. Criteria:
    b. Prior approval required: ☐
    c. Payment if eligibility lost: ☐

☐ Emergency Room Services
    a. Identify services:
    b. Criteria:

☐ In-patient Hospital Services
    a. Criteria:
    b. Prior approval required: ☐

☐ Special Anesthesia
    a. Criteria:
    b. Prior approval required: ☐

Excluded Services

1. Identify services: