

FORM 1
DENTAL BENEFITS MANAGEMENT RESPONSE COVER PAGE

Respondent's Name _____

Respondent's Physical Address _____

City _____ State _____ Zip Code (include 4 digit add on) _____

Respondent's Contact Person and Title _____

Phone Number & Area Code _____ FAX Number & Area Code _____

E-mail Address _____ Website Address _____

Supplier Authorized Signature

Certified This Date

Typed Name

Title

The Respondent has the capability and interest to provide (check as many as apply):

A Post-payment review Program

An administrative Utilization Management Program

A fully or partially capitated Dental Management Organization (DMO)

If the Respondent indicated interest in providing a DMO, please indicate below (check as many as apply):

Fully capitated program

Partially capitated program (explain capitation below)

Program for all SoonerCare members

Program for a targeted subset of members based on age, geographic area, health condition, etc.

(Explain targeting criteria below)

If the Respondent has capability to manage dental services and utilization, but is not interested in the programs above, please explain why and propose any alternatives:

Please provide a non-binding estimate of a price range that the Respondent's prior experience indicates might be necessary to offer the Respondent's proposed program (s). Pricing can be quoted utilizing any pricing methodologies (e.g. a fixed price, a monthly price, a PMPM price or other). If applicable identify any major drivers of pricing.

Please discuss the period of time necessary for Respondent to implement the program (s):

Please make any other comments or propose other program types that the Respondent could provide to assist OHCA in managing its dental program:

FORM 2

REFERENCE LIST FOR DENTAL MANAGEMENT PROGRAMS
(Please provide a maximum of five references and submit with your RFI Response)

REFERENCE #1

Client Name:

Client Contact for more Information (name, e-mail, phone):

Type of Organization (Medicaid, private, etc.):

Service Provided:

Annual Contract Dollar Value:

Effective Dates of Contracts:

REFERENCE #2

Client Name:

Client Contact for more Information (name, e-mail, phone):

Type of Organization (Medicaid, private, etc.):

Service Provided:

Annual Contract Dollar Value:

Effective Dates of Contracts:

REFERENCE #3

Client Name:

Client Contact for more Information (name, e-mail, phone):

Type of Organization (Medicaid, private, etc.):

Service Provided:

Annual Contract Dollar Value:

Effective Dates of Contracts:

REFERENCE #4

Client Name:

Client Contact for more Information (name, e-mail, phone):

Type of Organization (Medicaid, private, etc.):

Service Provided:

Annual Contract Dollar Value:

Effective Dates of Contracts:

REFERENCE #5

Client Name:

Client Contact for more Information (name, e-mail, phone):

Type of Organization (Medicaid, private, etc.):

Service Provided:

Annual Contract Dollar Value:

Effective Dates of Contracts: