

Dental Wellness Plan and Hawki Petition for Exception to Policy (ETP)

Delta Dental of Iowa

An exception to policy (ETP) is for an item or service that is not covered by the Department of Human Services (DHS). The criteria for granting an exception to policy can be found in 441 Iowa Administrative Code 1.8(2). Criteria includes:

- Is there an extreme need for an item or service?
- Are there exceptional circumstances that justify an exception to policy?
- Would an exception to policy result in net savings to the state?
- Have all other possible sources been exhausted?
- What is the cost to the state and are there funds in the DHS budget?

Instructions:

You may complete the Petition for Exception to Policy form or you may write a letter that explains the situation.

- Enter the name and address of the person who is filing out the form.
- List the member's name, Medicaid ID, and birth date for the member you are requesting the ETP for.
- Provide a description of what dental services the member needs and explain why they are needed.
- Include cost and proposed savings.
- Explain what has been tried in the past for this member.
- Complete a Prior Authorization for the services you are requesting.

The process after you file an ETP is outlined below:

1. The ETP form or a letter is received by Delta Dental.
2. Delta Dental clinical and administrative team reviews the ETP.
3. If approved by Delta Dental, a request is sent from DDIA to Department of Human Services (DHS) Director to receive approval.
4. If the DHS approves, DDIA will send a letter to the provider and DWP or Hawki member.
5. If the ETP is not approved by DDIA or DHS, DDIA will send a letter to the provider and the DWP member.

Petition for Exception to Policy (ETP)
Delta Dental of Iowa
Dental Wellness Plan (DWP) and Hawki

To submit a request for an exception to policy, please fill out the following information and send to:

Delta Dental of Iowa
 Government Programs ETP
 9040 Northpark Drive
 Johnston, IA 50131

Information about person filling out the form			
Name of the person requesting the ETP:	Phone number:	Date of Request:	
Company or Office Name:		Email Address:	
Address:	City:	State:	Zip:

Information about the DWP or Hawki member who is on the ETP		
Name of the DWP Member:	Medicaid ID:	Birthdate:
Describe your ETP request: (be specific)		
Why are you requesting an ETP?		
What is the time period you are request the ETP to cover (ex. one month, six months)? The time period cannot exceed one year.		
What is the date you would like the ETP to start?		
Have you tried any other service before requesting an ETP? If yes, please describe the service.		