**2019 Florida Dental**

**Provider Satisfaction Survey**

**Florida Agency for Health Care Administration (AHCA) is interested in your satisfaction with the Florida Medicaid plans. Your responses will be kept completely confidential. If you have questions about this survey,** **please call [Survey Vendor Name] at [toll-free phone number].**

**Please be sure to fill the response circle completely. Use only black or blue ink or dark pencil to complete the survey.**

 **Correct Incorrect**

 **Mark Marks**



|  |
| --- |
| **The questions in this survey will refer to [Dental Plan Name] as "this dental plan." Please think of that dental plan as you answer the survey. Please answer all questions based on your experiences with this dental plan in the last 6 months.** |

 **1. Please indicate your type of practice. (Mark only one)**

 ⭘ General Dentistry

 ⭘ Endodontics

 ⭘ Pediatric Dentistry

 ⭘ Periodontics

 ⭘ Orthodontics

 ⭘ Oral and Maxillofacial Surgery

 ⭘ Other (Please list below)

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 **2. How many years have you been practicing dentistry?**

 ⭘ 1-5 years

 ⭘ 6-10 years

 ⭘ 11-15 years

 ⭘ 16-20 years

 ⭘ 21 years or more

 **3. How many years have you been a Medicaid provider?**

 ⭘ 1-5 years

 ⭘ 6-10 years

 ⭘ 11-15 years

 ⭘ 16-20 years

 ⭘ 21 years or more

 **4. How many years have you been in this dental plan's provider network?**

 ⭘ Less than 1 year

 ⭘ 1-5 years

 ⭘ 6-10 years

 ⭘ 11 years or more

 **5. Do you participate in any of this dental plan's provider incentive programs?**

 ⭘ Yes

 ⭘ No

 **6. Are you contracted under a value-based purchasing agreement with this dental plan?**

 ⭘ Yes

 ⭘ No

 ⭘ Don’t know

 **7. How satisfied are you with this dental plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 **8. How would you rate this dental plan compared to all other Medicaid dental plans with which you contract?**

 ⭘ Well above average

 ⭘ Somewhat above average

 ⭘ Somewhat below average

 ⭘ Well below average

 ⭘ I do not contract with other Medicaid dental plans

 **9. How satisfied are you with your ability to obtain member-level information (e.g., eligibility, benefit coverage) from this dental plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 **10. How satisfied are you with this dental plan's materials (e.g., manuals/handbooks, newsletters, policies)?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 **11. How satisfied are you with your provider relations representative (e.g., representative's ability to answer questions and resolve problems, timeliness)?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Don't know

 **12. How satisfied are you with the network of specialists (e.g., number, availability, quality) at this dental plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Don't know

 **13. How satisfied are you with the credentialing process at this dental plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Don't know

 **14. How would you rate your level of agreement with the following statements for this dental plan:**

|  | **Strongly agree** | **Agree** | **Dis-****agree** | **Strongly disagree** |
| --- | --- | --- | --- | --- |
| **Rules and procedures for service authorizations and referrals are clear in provider handbook** | ⭘ | ⭘ | ⭘ | ⭘ |
| **Standard service authorization denial notifications are sent within 7 calendar days** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Expedited service authorization denial notifications are sent within 2 business days** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **I am satisfied with the authorization process** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **I am satisfied with the authorization appeal process** | ⭘ | ⭘ | ⭘ | ⭘ |

 **15. How satisfied are you with this dental plan's performance in the following areas:**

|  | **Very satisfied** | **Satisfied** | **Dis-****satisfied** | **Very dis-****satisfied** |
| --- | --- | --- | --- | --- |
| **Claims submission process** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Assistance with claims process** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Timeliness of claims payment** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Accuracy of claims payment** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Resolution of claims payment problems or disputes** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Timeliness of the claims appeal process** | ⭘ | ⭘ | ⭘ | ⭘ |
|  **Claims denial reasons** | ⭘ | ⭘ | ⭘ | ⭘ |

 **16. How satisfied are you with the complaint resolution process related to grievances and appeals at this dental plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 ⭘ Not applicable

 **17. Have you engaged with the care management unit or staff at this dental plan more than 2 times?**

 ⭘ Yes

 ⭘ No  **🡺*Go to Question 19***

 **18. How satisfied are you with the care management services (e.g., planning, directing, and coordinating health care and utilization of medical and allied services) at this dental plan?**

 ⭘ Very satisfied

 ⭘ Satisfied

 ⭘ Dissatisfied

 ⭘ Very dissatisfied

 **19. Who is completing this survey? (Mark all that apply)**

 ⭘ Dentist

 ⭘ Office Manager

 ⭘ Administrative Staff

 ⭘ Other Clinical Staff

 ⭘ Other (Please list below)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for sharing your experience and opinions! Your answers are greatly appreciated.**

**When you are done, please use the enclosed postage-paid envelope to mail the survey to:**

**[Survey Vendor Name], [Survey Vendor Address]**