Dental Benefit Management Program Reporting

**Report Information**

Report Number: 133

Report Name: Provider Satisfaction Survey Report

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Subject Matter: Informatics

Document Type: Free Form Template

# Free Form

Template

**Information to be completed by the Dental Plan**

MCE ID: [Dental Plan ID]

MCE Name: [Dental Plan Name}

MCE Contact:

MCE Contact Email:

Report Period Start Date:

Report Period End Date:

Submission Date of Report:

*(This plan can be submitted in any format. However, this document must be completed and submitted with the required plan)*

**Definitions and Instructions:**

The Dental Plan shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims preprocessing, and utilization management processes.

The Dental Plan shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due one-hundred and twenty (120) days after the end of the contract year.

**RFP Reference: Provider Satisfaction Surveys**