

## Denture Prior Authorization Request Form for individuals under age 21/Pregnant Women

(Effective 09/16/2015)

**1. Patient Information:**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Patient Medicaid I.D. Number: \_\_\_\_\_

Restorative Treatment Completed to Date (check one - N/A only if edentulous):  Yes  No  N/A  
Oral Hygiene (check one - N/A only if edentulous):  Good  Fair  Poor  N/A

**2. Denture Information:** (Please answer ALL questions A-F)

A. Is patient edentulous on maxillary arch?  
 yes. If yes, estimated number of years edentulous: \_\_\_\_\_  
 no. If no, please indicate all remaining maxillary teeth by number: \_\_\_\_\_

B. Is patient edentulous on mandibular arch?  
 yes. If yes, estimated number of years edentulous: \_\_\_\_\_  
 no. If no, please indicate all remaining mandibular teeth by number: \_\_\_\_\_

C. Existing denture(s)?  yes - go to question D  
 no - go to question E

D. Please provide a brief description of the existing denture(s):  
Upper denture:  yes.....type: \_\_\_\_\_  
approximate age of denture: \_\_\_\_\_  
condition of denture: \_\_\_\_\_  
frequency of use: \_\_\_\_\_

no  
Lower denture:  yes.....type: \_\_\_\_\_  
approximate age of denture: \_\_\_\_\_  
condition of denture: \_\_\_\_\_  
frequency of use: \_\_\_\_\_

no

E. Do you expect the patient to tolerate and successfully adjust to the proposed treatment?  yes  no

F. Based on the patient's denture history, do you expect the patient to wear the proposed denture(s) on a regular basis?  yes  
 no  n/a

**3. Medical Information:**

Medical Condition(s) making the requested denture(s) a medical necessity: \_\_\_\_\_

**4. Additional Information:**

**5. Proposed Treatment:**

Complete Denture:	<input type="checkbox"/> Maxillary (#D5110)	<input type="checkbox"/> Mandibular (#D5120)	
Immediate Denture:	<input type="checkbox"/> Maxillary (#D5130)	<input type="checkbox"/> Mandibular (#D5140)	
Resin-Based Partial:	<input type="checkbox"/> Maxillary (#D5211)	<input type="checkbox"/> Mandibular (#D5212)	
Cast Partial Denture:	<input type="checkbox"/> Maxillary (#D5213)	<input type="checkbox"/> Mandibular (#D5214)	
Flexible Base Partial:	<input type="checkbox"/> Maxillary (#D5225)	<input type="checkbox"/> Mandibular (#D5226)	<input type="checkbox"/> HD Modifier For Pregnancy
Overdenture:	<input type="checkbox"/> Maxillary (#D5860)	<input type="checkbox"/> Mandibular (#D5860)	Due Date/Date of Delivery: _____
Laboratory Reline:	<input type="checkbox"/> Maxillary (#D5750)	<input type="checkbox"/> Mandibular (#D5751)	
Laboratory Rebase:	<input type="checkbox"/> Maxillary (#D5710)	<input type="checkbox"/> Mandibular (#D5711)	
Pediatric Partial, fixed	<input type="checkbox"/> Maxillary (#D6985)	<input type="checkbox"/> Mandibular (#D6985)	

**6. Requesting Provider Information:**

Provider Name/Practice Name: \_\_\_\_\_  
Medicaid Individual and Group Provider Number(s): \_\_\_\_\_  
Office Contact Number: \_\_\_\_\_  
Provider signature: \_\_\_\_\_  
Date Submitted: \_\_\_\_\_