**Denture Prior Authorization Request Form for individuals under age 21/Pregnant Members**

(Effective 1/1/2023)

**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: [ ]  Maxillary (#D5110) [ ]  Mandibular (#D5120)

Immediate Denture: [ ]  Maxillary (#D5130) [ ]  Mandibular (#D5140)

Resin‑Based Partial: [ ]  Maxillary (#D5211) [ ]  Mandibular (#D5212)

Cast Partial Denture: [ ]  Maxillary (#D5213) [ ]  Mandibular (#D5214)

Flexible Base Partial: [ ]  Maxillary (#D5225) [ ]  Mandibular (#D5226) [ ]  HD Modifier For Pregnancy

Overdenture: [ ]  Maxillary (#D5863) [ ]  Mandibular (#D5864) Due Date/Date of Delivery:\_\_\_\_\_\_\_\_\_\_\_\_

Laboratory Reline: [ ]  Maxillary (#D5750) [ ]  Mandibular (#D5751)

Laboratory Rebase: [ ]  Maxillary (#D5710) [ ]  Mandibular (#D5711)

Pediatric Partial, fixed [ ]  Maxillary (#D6985) [ ]  Mandibular (#D6985)

**6. Requesting Provider Information:**

Provider Name/Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Individual and Group Provider Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Submitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_