**Denture Evaluation Tool**

(Effective 7/1/2023)

**Members that may be eligible for dentures include: individuals under age 21, pregnant members, and members who are participating in the Department of Aging and Independent Living Developmental Disability Services (DDS) Waiver Program or the Department of Mental Health Community Rehabilitation and Treatment (CRT) Waiver Program.**

**See** [**fee schedule**](http://www.vtmedicaid.com/#/feeSchedule) **for prior authorization requirements.**

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

1. **Denture Information:** (Please answer **ALL** questions) Criteria is located on page 2.

A. List all remaining maxillary teeth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_none.

B. List all remaining mandibular teeth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_none.

*\*Please submit electronically FMX or pan of any remaining teeth*

C. Pre-existing Upper denture?: [ ]  yes: full partial in use needs repair/reline needs replacement

 *\*Please circle* [ ]  no

 Pre-existing Lower denture?: [ ]  yes: full partial in use needs repair/reline needs replacement

 *\*Please circle* [ ]  no

D. New Full denture if no repairable full denture exists and:

 \_\_\_\_\_ Maxilla is edentulous

 \_\_\_\_\_ Mandible is edentulous

 \_\_\_\_\_ All remaining teeth in noted arch must be removed as non-restorable

E. If partial denture is requested (*please circle)*: Maxillary Mandibular Both

 \_\_\_\_\_ Maxilla is missing at least one of the following # 5 6 7 8 9 10 11 12 (circle which)

 \_\_\_\_\_ Mandible is missing at least one of the following # 22 23 24 25 26 27 (circle which)

 \_\_\_\_\_ What teeth, if any, will be removed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

F. Do you expect the patient to tolerate and successfully wear the proposed prosthesis [ ]  yes [ ]  no

G. Could pre-existing prostheses be made serviceable by repair, reline, rebase, alteration? [ ]  yes [ ]  no

 If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any Medical Condition(s) making the requested denture(s) a medical necessity?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. **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)

Overdenture: [ ]  Maxillary (#D5863) [ ]  Mandibular (#D5864)

 **[ ]  HD Modifier for Pregnancy Due Date/Date of Delivery:\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Requesting Provider Information:**

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

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

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

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

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

 **CRITERIA FOR ADULT DENTURE FABRICATION for eligible members aged 21 and over**

DVHA criteria for full and partial dentures are based on restoration of function, ability to bite, ability to chew and ability to speak.

DVHA supplies the least expensive appropriate health service available. Therefore, provision of cast frame vs flexible base vs acrylic base will include consideration of number of missing teeth, pattern of tooth loss and expected stability during function.

DVHA does not pay additional fees for precision attachments, ball and socket attachments, magnetic retention. Program does cover customary cast and wrought clasps.

Partial dentures will not be approved if only posterior teeth are missing, yet there exists an opposable pair of posterior teeth on both left and right that serve as functional occlusal stops. Posterior teeth defined as numbers 2-3-4-13-14-15-18-19-20-29-30-31- Wisdom teeth are not subject to replacement.