VERMONT

Department of Vermont Health Access *Agency of Human Services*
280 State Drive, NOB 1 South [Phone] 802-879-5903
Waterbury, VT 05671-1010 [Fax] 802-879-5963
www.dvha.vermont.gov

Dental Services Prior Authorization Request Form

(Effective 09/28/2017)

1. Patient Information:

Patient Name: _____

Date of Birth: _____ Age: _____

Patient Medicaid I.D. Number: _____

2. Treatment Request:

Procedure Code(s): _____

☐ HD Modifier: Due Date/Date of Delivery:_____

Procedure Code Description: _____

Reason for Request: _____

_____

_____

Treatment Rendered? ☐ No. ☐ Yes. If yes, Date of Service: _____

3. Attachments:

☐ None.
☐ ADA Claim Form.
☐ Radiograph(s). Specify type: _____
☐ Periodontal Charting.
☐ Other. Specify: _____

4. Provider Information:

Provider Name/Practice Name: _____

Medicaid Individual and Group Provider Number(s): _____

Office Contact Number:_____

Date Submitted: _____

I certify that my examination of this patient and his/her diagnostic materials was conducted in conformance with the Laws and Regulations of The Board of Dental Examiners of the Vermont Secretary of State Office of Professional Regulation, and that my diagnosis of his/her condition as set forth herein is accurate to the best of my professional judgment.

Provider Signature: _____

Submit this PA request and all supporting documentation to:

Department of Vermont Health Access
Clinical Operations Unit
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Waterbury, VT 05671-1010
Fax: 802-879-5963