VERMONT

Department of Vermont Health Access *Agency of Human Services*
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Denture Prior Authorization Request Form for individuals under age 21/Pregnant Women

(Effective 09/28/2017)

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 (#D5860)	☐ Mandibular (#D5860)	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: _____