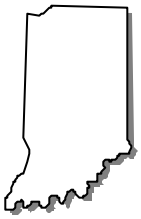
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

B T 2 0 0 2 5 0 S E P T E M B E R 1 6 , 2 0 0 2

To: All Indiana Health Coverage Programs Dentists and Dental Clinics

Subject: End-dating and Limitations of Dental Codes

Note: The prior authorization (PA) payment methodology, and maximum fees information in this bulletin may vary for providers rendering services to members enrolled in the risk-based managed care (RBMC) delivery system.

Overview

The Indiana Health Coverage Programs (IHCP) has completed an entire review of dental services and has determined that certain codes will be bundled, limited, or end-dated. In addition, dentures and partials will no longer be provided to members who are on enteral/parenteral nutritional supplements, and the rates for dentures and partials will be reduced. The Dental Advisory Panel (DAP) and other members of the dental community assisted in providing input for these changes to the IHCP dental program. These changes are being made in response to the need to provide quality dental care for all members recognizing that costs must be contained due to a growing budget deficit.

Bundled Codes

Prophylaxis and Fluoride Provided on Same Date of Service

The 2002 CDT-3 update provided questions and answers regarding billing for certain codes. Specifically, the update referenced that billing for prophylaxis and fluoride on the same day should be billed with D1201, topical application of fluoride (including prophylaxis)-child. Effective November 1, 2002, D1120, prophylaxis-child and D1203, topical application of fluoride (prophylaxis not included)-child will not be separately reimbursed on the same date of service. Nor will D1110, prophylaxis-adult and D1204, topical application of fluoride (prophylaxis not included) – adult, be separately reimbursed. Providers must bill D1201 for children up to age 12 and D1205 for children from age 13 up to age 21 when fluoride and prophylaxis are provided on the same day.

Limited and Deleted Codes

The code listed in Table 1 will be limited as specified effective November 1, 2002.

Table 1 - Dental Codes With Revised Limits and Restrictions

Procedure Code	Description
D1351	Sealant - Eliminate coverage for tooth numbers 7 and 10. Sealants are covered for tooth numbers 2, 3, 4, 5, 12,13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31 for those under 21 years of age only.

The codes listed in Table 2 will be end-dated effective November 1, 2002.

Table 2 - Dental Codes End-dated

Procedure Code	Description
D0460	Pulp vitality tests
D0472	Accession of tissue, gross examination, preparation, and transmission of written report
D0473	Accession of tissue, gross and microscopic examination, preparation, and transmission of written report
D0474	Accession of tissue, gross and microscopic examination, preparation, including the preparation and transmission of written report
D0480	Processing and interpretation of cytologic smears
D2210	Silicate cement - per restoration
D4220	Gingival curettage per quadrant, per report
D4920	Unscheduled dressing change (by someone other than treating dentist)
D5410	Adjust complete dentures - maxillary
D5411	Adjust complete dentures - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D5710	Rebase complete maxillary denture
D5720	Rebase maxillary partial denture
D5953	Speech aid prosthesis, adult
D5986	Fluoride gel carrier
D7291	Transseptal fiberotomy, by report
D7340	Vestibuloplasty - ridge extension (secondary epithelization)
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7830	Manipulation under anesthesia
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7880	Occlusal orthotic device, by report
D7920	Skin graft (identify defect covered, location, and type of graft)
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure

(Continued)

Table 2 - Dental Codes End-dated

Procedure Code	Description
D7970	Excision of hyperplastic tissue - per arch
D7971	Excision of pericoronal gingiva
D7990	Emergency tracheotomy
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9240	Hospital call
D9440	Office visit - after regularly scheduled hours
D9630	Other drugs and/or medicaments, by report, replace with NDC codes on pharmacy claim form
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth
D9940	Occlusal guard, by report
D9951	Occlusal adjustment - limited
D9952	Occlusal adjustment - complete

The codes in Table 2 will be end-dated by the IHCP and will not be available for use after November 1, 2002. Any use of these codes after that date will result in a denial of the code for edit 4013, non-covered service for date of service.

Reduction in Rates for Dentures and Partials

The rates of reimbursement for dentures and partials will be reduced to the amounts in Table 3 effective November 1, 2002. These codes all require PA and must be used for members 21 years of age and older. No change is being made to the rate of reimbursement for repairs and relines. Repairs and relines require PA and are only approved to extend the useful life of a prosthesis that is at least six years old.

Table 3 - Rates of Reimbursement for Dentures and Partials

Procedure Code	Description	Rates of Reimbursement
D5110	Complete Denture - Maxillary	$391.25
D5120	Complete Denture - Mandibular	$394.13
D5130	Immediate Denture - Maxillary	$391.25
D5140	Immediate Denture - Mandibular	$394.13
D5211	Maxillary Partial Denture - Resin Base	$328.00
D5212	Mandibular Partial Denture - Resin Base	$333.00
D5213	Maxillary Partial Denture, cast metal framework with resin denture base	$328.00
D5214	Mandibular Partial Denture, cast metal framework with resin denture base	$333.00

Note: Several dentists have raised the question of whether they must provide dentures to IHCP members at these reduced rates. They believe the product they must purchase to be able to provide dentures at these lower rates will not be of the same quality that they currently provide to their private pay patients. Dentists who share this belief may refer their patients who need dentures/partials to a dentist who wants to continue providing dentures/partials for IHCP patients.

Dentures and Partials for Members on Nutritional Supplements

Effective October 15, 2002, providers must use the revised PA form attached to this bulletin when submitting a PA request for dentures, partials, repairs, or relines. A question has been added to the form regarding whether the member is on parenteral/enteral nutritional supplements. If the response is yes, dentures and partials will not be approved unless the dentist submits a plan of care with the PA request that indicates that dentures or partials are needed to wean the member from the nutritional supplements.

D9630, Other Drugs and/or Medicaments by Report

Effective November 1, 2002, dentists who dispense legend (prescription) drugs, for example Peridex, from their office must bill for these drugs using National Drug Codes (NDC) on the *Indiana Family and Social Services Administration (IFSSA) Drug Claim Form*. Non-legend drugs, over-the-counter (OTC) drugs, and medical supplies, provided by the dentist's office are not reimbursable and **cannot be submitted** on the *IFSSA Drug Claim Form*.

Use of the NDC on the pharmacy claim form enables the OMPP to collect rebates from manufacturers. A copy of the pharmacy claim form is attached to this bulletin. Providers should follow the directions in this bulletin to correctly complete the pharmacy claim form.

Coverage of Physician Dispensed Medications

The IHCP covers all Federal Drug Administration (FDA)-approved legend drugs from rebating manufacturers **except** the following:

- Anorectics or any agent used to promote weight loss
- Drugs when prescribed solely or primarily for cosmetic purposes
- Fertility enhancement drugs
- Topical Minoxidil preparations

All covered legend drugs provided to an IHCP member require a prescriber order or prescription and a corresponding prescription number assigned by the dentist's office. This prescription number must be documented in the member's chart and entered on the *IFSSA Drug Claim Form*. Detailed billing requirements regarding the Prescription Number are included in the *Step-By-Step Instructions on How to Complete the IFSSA Drug Claim Form* section of this bulletin. Within this requirement, however, various factors influence the prescribing and the type of records the pharmacist must maintain. The *IHCP Provider Manual, Chapter 4, Provider Eligibility and Responsibilities* specifies general requirements for record keeping by providers.

Use of the National Drug Code, Health Related Item, and Universal Product Code

All legend drugs have an assigned NDC number that can be billed using the appropriate NDCs on the *IFSSA Drug Claim Form.* Legend drugs that do not have an NDC, Health Related Item (HRI) code, or Universal Product Code (UPC) are not covered by the IHCP. **This is a federal mandate**. Refer to the *IHCP Provider Manual, Appendix A, 405 IAC 5-24* for additional information. When billing the program for a covered service, it is essential that the NDC, HRI code, or UPC that is billed is taken from the package dispensed, or the package from which items are dispensed. It is never appropriate to bill with an NDC, HRI code, or UPC other than what appears on the package except as allowed by the exceptions listed in the *IHCP Provider Manual, Chapter 9*.

An NDC number is a 11-character code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations. An NDC number is composed of the following three distinct sub-categories:

- Labeler code – five digits
- Product number – four digits
- Package size – two digits

Review of Drug Rebate Program

Federal law requires that, for a legend or non-legend drug to be covered by state Medicaid programs, the manufacturer must have a drug rebate agreement in effect with the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). Manufacturers that have entered into a rebate agreement with the federal government have a unique five-digit labeler code that identifies the drug manufacturer. Prescribing practitioners must refer to the *IHCP Provider Manual, Chapter 9, Appendix G: Federal Rebate Program, Table G.1*, to determine if the drug manufacturer is participating in the Federal Drug Rebate Program. If the manufacturer does not appear in the listing, the program does not reimburse the drug.

Reimbursement Methodology for Medications Billed on the *IFSSA Drug Claim Form*

When billing the program for any covered service, the prescribing provider only submits the usual and customary charge (UCC) for the covered service. A prescribing practitioner is entitled to IHCP reimbursement for covered legend drugs at *the lower of*:

- The product's estimated acquisition cost (EAC) multiplied by the units billed as of the dispense date. EAC is currently defined as the Average Wholesale Price (AWP) of the billed item, less 10 percent. The drug database vendor provides AWP data to the fiscal agent on a monthly basis.
- The product's Federal Upper Limit (FUL), if applicable, multiplied by the units billed, as of the dispense date.
- The provider's submitted charge, which represents the UCC for the product to the general public, as of the dispense date.

Helpful Hints Regarding Units of Service

When billing for a unit that is a fraction of a whole unit, round up to the nearest whole number of the total supply dispensed. For example, a tube of 3.5 of gms should be billed as 4 gms. If three tubes of 3.5 gms, totaling 10.5 gms are dispensed, 11 gms should be billed.

When submitting claims for physician dispensed medications, units are billed as:

- Each, ea
- Gram, gm
- Milliliter, ml

A complete description of how to bill each type of unit can be found in the *IHCP Provider Manual, Chapter 9*. Billing the appropriate unit of service ensures correct reimbursement.

Step-By-Step Instructions on How to Complete the *IFSSA Drug Claim Form*

All fields of the *IFSSA Drug Claim Form* are required **except** fields 08 and 19, which are **required, if applicable**. Table 3 describes each field by referencing the field locator number, which is found in the lower left corner of each field on the form. A hard copy IFSSA Drug Claim Form follows this section. This form can also be obtained on the Web site or by writing to the following address:

EDS Forms Request
P.O. Box 7263
Indianapolis, IN 46207-7263

The following are two key field locators on the *IFSSA Drug Claim Form* that require special consideration.

- **Field Locator 06:** PRESCRIBER ID NUMBER: Enter the prescriber license number. IHCP claims require the eight-digit, prescriber medical license number on all claims submitted for physician dispensed legend drugs. This is a required field locator that must be completed to obtain reimbursement. Failure to complete this field locator will result in the denial of the claim.
- **Field Locator 12:** PRESCRIPTION NUMBER: Enter the prescription number. All legend drugs dispensed to IHCP members must have a prescription number. This is a required field locator, that accommodates 10 alphanumeric characters. The prescription number is assigned by the dispensing provider and must be on the *IFSSA Drug Claim Form* and in the member's medical record. Failure to enter a prescription number will result in the denial of the claim.

Table 4 provides a description of all field locators on the *IFSAA Drug Claim Form.*

Table 4 - IFSSA Drug Claim Form Explanation

Field Locator	Explanation
01	**PROVIDER NUMBER**. Enter the appropriate provider number. **Required**.
02	**LOC**: Enter the appropriate location code. Required. **TELEPHONE NUMBER**: Enter the telephone number of the dispensing provider. While this field is optional, the information is important should the provider need to be contacted about the claim.

(Continued)

Table 4 - IFSSA Drug Claim Form Explanation

Field Locator	Explanation	
03	**TOTAL AMOUNT BILLED**: Enter the sum of all the amounts billed from all lines on the IFSSA Drug Claim Form. **Required.**	
04	**PATIENT'S NAME: LAST, FIRST**: Enter the last name and first name of the member. **Required**.	
05	**RID NO**.: Enter the 12-digit member identification number. **Required.**	
06	**PRESCRIBER ID NUMBER**: Enter the prescriber license number. The prescriber is not required to be an enrolled IHCP provider for the provider to be reimbursed by the IHCP for a drug claim. **Required**. For assistance in obtaining the prescriber license number: • *Call the prescriber* • *Contact the Health Professions Bureau* • *Call the EDS Customer Assistance Unit, or refer to* The IHCP Provider Manual, Chapter 1	
07	**EMERG**: Emergency indicator; valid values are Y for yes and N for no. **Required**.	
08	**PREG**: Pregnancy indicator; valid value is P for yes. Leave this field blank for no. **Required, if applicable**	
09	**N.F. PAT**.: Nursing facility indicator; valid values are Y for yes and N for no. **Required**.	
10	**BRAND**: BMN indicator. **Required.** Valid program values are:	
	Program Value	
	0	No product selection indicated This value is used when the prescriber has prescribed either by brand name or generic name, signed either on the DAW or may substitute line, but has not properly indicated **BMN**. This value is also used for brand name products that are not generically available and for prescriptions prescribed generically, whether or not BMN was indicated by the prescriber. This value is the only value used for covered OTC drugs, and is reported by providers for all such prescriptions.
	5	Substitution Allowed; Brand Name Dispensed as a Generic In some instances, providers can purchase brand name drugs at a reduced price that allows them to dispense the brand name drug instead of the generic and the brand name is no more costly to the program than the generic. Use of this value does not punish a provider when the brand name drug is **not more costly to the program than the generic.**
	6	Override This value drives pricing for those drugs that are generically available and subject to FULs. This value is reported only when **BMN** or DAW is properly indicated on the prescription for a brand name drug that is generically available and substitutable in accordance with the law and Medicaid policy. Pharmacy providers can receive the brand name price for drugs dispensed to Package C members if the prescriber indicates DAW or BMN and the pharmacist indicates the DAW code of **6** on the claim form.
	8	Substitution Allowed; Generic Drug Not Available in Marketplace This value is allowed when a generic substitution is not available in the marketplace.

(Continued)

Table 4 - IFSSA Drug Claim Form Explanation

Field Locator	Explanation
11	**REFILL**: Refill indicator. If this is an original prescription, enter **00**. If this is a prescription refill, indicate the number of the refill. Valid values in the two-digit field are **00** to **99**. **Required.**
12	**PRESCRIPTION NUMBER**: Enter the prescription number. Field accommodates 10 alphanumeric characters. **Required**.
13	**DATE PRESCRIBED**: Enter the date prescribed in a MMDDYY format. **Required.**
14	**DATE DISPENSED**: Enter the date dispensed in a MMDDYY format. **Required.**
15	**NDC NUMBER**: Enter the NDC, HRI code, or UPC of the item dispensed. The code number must be in the proper configuration. Refer to the *IHCP Provider Manual, Chapter 9, Section 3, National Drug Code (NDC), Health Related Item (HRI) Code, and Universal Product Code (UPC) Configurations.* This field accommodates 11 numeric characters. **Required.** A provider must enter the specific NDC, HRI code, or UPC of the item being dispensed when billing IHCP for a deductible or coinsurance amount that is not reimbursed by another insurance source. The deductible or coinsurance amount is the portion of a covered service not reimbursed by the plan. These amounts are billed to the IHCP. Refer to the section titled, Pharmacy Coverage and Reimbursement in this chapter for instructions concerning how to bill IHCP for other payer copays.
16	**QUANTITY**: Indicate the quantity of the item or drug dispensed using the appropriate unit of measurement such as, ea, gm, or ml. **Required**.
17	**DAYS** : Indicate the approximate number of DS for the quantity of the drug dispensed. Field accommodates three numeric characters, capable of 999 days. **Required**.
18	**CHARGE**: Enter the amount charged for the prescription dispensed. **Required**.
19	**3RD PTY PAID**: Providers are not required to bill pharmacy claims to private insurance companies prior to submitting to IHCP. If a provider elects to bill another insurance company first, enter any payment received from the insurance company in field 19. If payments from multiple insurance companies are received, combine the amounts from each insurance company and enter the total amount in field 19. **Required, if applicable**. If another insurance company is billed, but paid zero ($0), enter *0* in field 19. Refer to The *IHCP Provider Manual, Chapter 9, Section 2, Pharmacy Coverage and Reimbursement* for instructions concerning how to bill when only a copay is required under the insurance plan. Pharmacy claims for dates of service equal to the spenddown effective date **are not** submitted via POS. These claims must be submitted electronically or on paper with the DPW Form 8A attached. Electronic claims submitted without a DPW Form 8A attached generate a CCF to the provider. The provider must attach the DPW Form 8A to the CCF and return it to EDS for processing.
20	**PROVIDER NAME AND ADDRESS**: Enter the provider name and address. The address entered in this field must correspond to the location code entered in field 02. **Required**.
21	**SIGNATURE OF PROVIDER OR REPRESENTATIVE**: Read the statement on the form positioned above the signature line and sign the claim form. The provider or an authorized person who is designated by the agency or organization must sign and date the claim. A signature stamp is acceptable, however, a typed signature is not acceptable. **Required**.
22	**DATE BILLED**: Enter the date the claim was completed. **Required**.

PLEASE PRINT CLEARLY

Indiana Family and Social Services Administration

DRUG CLAIM FORM

Provider Number 01	02	Telephone Number	Total Amount Billed 03

0	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
1	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
2	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
3	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
4	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
5	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
6	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
7	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
8	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	
9	PATIENT'S NAME: LAST, FIRST 04		RID NO. 05	PRESCRIBER'S I.D. NUMBER 06		EMERG 07	PREG 08	N.F.PAT. 09		BRAND 10	REFILL 11
	PRESCRIPTION NUMBER 12	DATE PRESC 13	DATE DISP 14	NDC NUMBER 15	QTY 16	DAYS 17		CHARGE 18		3RD PTY PAID 19	

Provider's Name and Address
☐ 20

This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements or documents, or concealment of material fact may be prosecuted under applicable Federal or State laws.

I, the undersigned, being aware of restricted funds in the Medicaid Program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of
Provider or Representative
☐ 21

Date Billed
22

Figure 1 - Indiana Family and Social Services Administration Drug Claim Form

[redacted]

INDIANA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Provider # _____ Phone _____ RID NO._____ DOB _____
Name: _____ Name: _____
Address: _____ Address: _____
City/State/Zip _____ City/State/Zip _____

DATES OF SERVICE START MMDDCCYY	STOP MMDDCCYY	SERVICE CODE **REQUIRED**	REQUESTED SERVICE	PLACE OF SERVICE	UNITS	DOLLARS

Caseworker_____ Phone_____ 590 Program ( )
Is Member Employed? YES _____ NO _____ Circumstances (Place/Type):_____
Is Member in Job Training? YES _____ NO _____ Type of Job Training_____
Dental Treatment Plan

- Endodontics – Indicate on diagram below the tooth/teeth to be treated by root canal therapy.
  1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
  32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
- Periodontics – Evaluate the periodontal condition
  _____
  _____
- Partial dentures (use chart to right to indicate teeth involved)

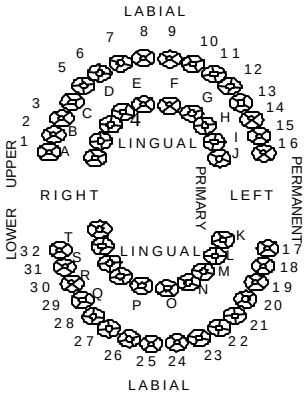
A. Date or dates of extractions of missing teeth. _____
_____
B. Which teeth (use tooth number) are to be extracted?_____
C. Which teeth (use tooth number) are to be replaced?_____
D. Brief description of materials and design of partial._____
_____
E. Is member wearing partials now? YES ___ NO ___ Age of present partials____

- Dentures (check one or both): Full upper denture _____ Full lower denture _____

A. How long edentulous_____
B. Is member wearing dentures now? YES __ NO __ Age of present dentures____

- Describe treatment if different from above:
  _____
  _____
  _____
  _____
- Is the member on parenteral/enteral nutritional supplements? YES____ NO____
  If YES, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines, and repairs will be denied.

Does the Member have missing teeth? YES___ NO___
If YES please indicate missing teeth with an X.



Brief Dental/Medical History:_____
_____
_____

Signature of Requesting Dentist _____ Date of Submission: _____
(original signature required) The above sections must be completed or the request will be rejected.

Health Care Excel
Prior Authorization Department
P.O. Box 531520
Indianapolis, IN 46253-1520

EDS-9-06-94 / PAU-8002EDS-9-06-94 / PAU-8002

Figure 2 - Revised Dental PA Form

Other Information

Questions about this bulletin may be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. Questions regarding the PA change in this bulletin may be directed to HCE at 1-800-457-4518.

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