IHCP Prior Review and Authorization Dental Request Form Instructions

Field	Description
Requesting provider NPI (or IHCP Provider ID) Name Telephone Taxonomy Service location ZIP Code + 4 Mail-to provider NPI (or IHCP Provider ID) Name Telephone Taxonomy Service location ZIP Code + 4	Enter the requesting or rendering provider's NPI (or, for atypical providers, IHCP Provider ID), name, telephone number, taxonomy, and service location ZIP Code + 4. The taxonomy is used to establish a one-to-one match with the NPI entered. If the requesting provider is not enrolled, the PA form will be returned to the provider. **A valid NPI or Provider ID is required.** The provider's copy of the *Indiana Prior Review and Authorization Dental Request Decision* letter is sent to the address that corresponds to the requesting provider NPI/Provider ID in this field, unless a separate mail-to provider is identified on the form. If the requesting provider does not have a valid service location on file, a PA decision letter will not be generated. If the mail-to provider fields are completed in conjunction with the requesting provider information that has a valid service location, the address on file for the mail-to provider NPI/Provider ID will be selected as the mailing address for the PA decision letter, instead of the address on file for the requesting provider NPI/Provider ID.
Member name Member address IHCP Member ID Member date of birth	Enter the name, address, IHCP Member ID (also known as RID) and date of birth for the member who is to receive the requested service.
Dates of service, Start	Enter the requested start date for the service. (For continued services, the start date must be the day after the previous authorization end date.)
Dates of service, Stop	Enter the requested stop date for the service.
Requested service, Procedure code	Enter the requested service code, such as Current Procedural Terminology (CPT®[1]), Current Dental Terminology (CDT®[1]), HCPCS, revenue, or NDC.
Requested service, Description	Enter a short description (or include an attachment) of the requested service and like services provided by other payers.
Place of service	Enter the requested place of service.
Units	Enter the number of units desired. Units are equal to days, months, or items, whichever is applicable.
Dollars	Enter the estimated or known IHCP cost of the service. **Required for home health services, DME, and pharmacy requests.**
Caseworker Telephone	Enter the caseworker's name and telephone number.
MCE/590/FFS	Select the appropriate member plan, if applicable: • For managed care, select **MCE**. • For the 590 program, select **590**. • For fee-for-service plans, select **FFS**.
Is member employed?	Select **YES** or **NO**.

[1] *Current Dental Terminology. CDT copyright 2016 American Dental Association. All rights reserved.*
[1] *Current Procedural Terminology. CPT copyright 2016 American Medical Association. All rights reserved.*

Field	Description
Circumstances (place/type)	Enter employment information, if applicable.
Is member in job training?	Select **YES** or **NO**.
Type of job training	Enter training information, if applicable.
Dental Treatment Plan	
1. Endodontics	Indicate on the chart the tooth or teeth to be treated by root canal therapy (1-32).
2. Periodontics	Briefly summarize the periodontal condition.
3. Does the member have missing teeth?	Select **YES** or **NO**. If yes, indicate which teeth are missing with a checkmark (✓) on the diagram provided.
4. Partial dentures	Use the diagram to indicate the teeth involved. A. Date or dates of extractions of missing teeth. B. Which teeth are to be extracted (tooth #)? C. Which teeth are to be replaced (tooth #)? D. Brief description of materials and design of partial. E. Is member wearing partials now? (**YES** or **NO**) Age of present partials.
5. Dentures	Check one or both: Full upper denture, full lower denture. A. How long edentulous? B. Is member wearing dentures now? (**YES** or **NO**) Age of present dentures. C. Is the member physically and psychologically able to wear and maintain the prostheses? (**YES** or **NO**) D. Can the member's existing dentures be relined or repaired to extend their useful life? (**YES** or **NO**)
6. Describe treatment if different from above	Describe any treatment to be provided that was not listed previously on this form.
7. Is the member on parenteral/enteral nutritional supplements?	Check **YES** or **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.
8. Brief dental/medical history	Enter pertinent information known to the provider about the member's dental and medical history.
Signature of requesting dentist	The authorized provider, as listed in the *Provider Types Allowed to Submit PA Requests* section of the *Prior Authorization* provider reference module, must sign the form. Signature stamps can be used.
Date of submission	Enter the date the form was actually submitted.