[redacted]

INDIANA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Requesting Provider # Phone: RID NO: DOB:

Mail to Provider ID: Service Location:

Name: Name:

Address: Address:

City/State/ZIP Code: City/State/ZIP Code:

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

Caseworker: Phone: MCE ◯ 590 ◯ FFS ◯

Is Member Employed? YES ◯ NO ◯ Circumstances (Place/Type):

Is Member in Job Training? YES ◯ NO ◯ Type of Job Training:

Dental Treatment Plan

1. 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 ☐

2. Periodontics – Evaluate the periodontal condition

3. 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.

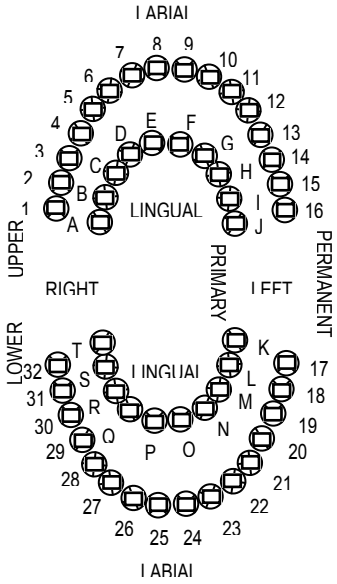
   E. Is member wearing partials now? YES ◯ NO ◯ Age of present partials

4. 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

5. Describe treatment if different from above:

6. 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 a checkmark.



Brief Dental/Medical History:

Signature of Requesting Dentist _____ Date of Submission:

(Original signature required. Signature stamps can be used.) The above sections must be completed or the request will be rejected.

Mail to: http://www.indianamedicaid.com/ihcp/ProviderServices/PAAttachmentAddresses.aspx