Indiana Health Coverage Programs

Dental Prior Authorization Request Form

	Requesting provider	Mail-to provider (If different)
Requesting provider NPI (or IHCP Provider ID)		
Name		
Telephone		
Taxonomy		
Service location ZIP Code + 4		

Member name _____ Member address _____

IHCP Member ID _____ Member date of birth _____

Dates of service		Requested service		Place of service	Units	Dollars
Start MMDDCCYY	Stop MMDDCCYY	Procedure code **REQUIRED**	Description			

Caseworker _____ Telephone _____ MCE ◯ 590 ◯ FFS ◯

Is member employed? ◯ Yes ◯ No Circumstances (place/type) _____

Is member in job training? ◯ Yes ◯ No Type of job training _____

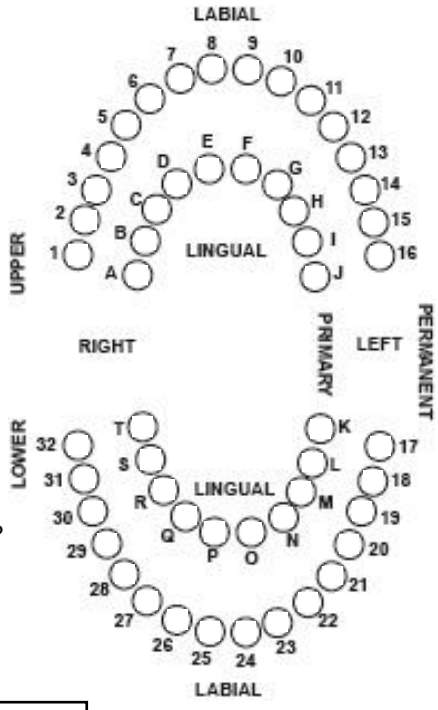
Dental treatment plan

1. Endodontics – Indicate on chart 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	
17		18		19		20		21		22		23		24		25		26		27		28		29		30		31		32	

2. Periodontics – Evaluate the periodontal condition: _____

3. Does the member have missing teeth? ◯ Yes ◯ No
   If YES, please indicate missing teeth with check marks (in diagram at right).



4. Partial dentures
   A. Date or dates of extractions of missing teeth _____
   B. Which teeth are to be extracted? (List tooth numbers.) _____
   C. Which teeth are to be replaced? (List tooth numbers.) _____
   D. Brief description of materials and design of partial

   E. Is the member wearing partials now? ◯ Yes ◯ 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 ◯ No Age of present dentures _____
   C. Is the member physically and psychologically able to wear and maintain the prostheses?
      ◯ Yes ◯ No
   D. Can the member's existing dentures be relined or repaired to extend their useful life?
      ◯ Yes ◯ No

6. Describe treatment if different from above:

7. 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.

8. Brief dental/medical history:

Signature of requesting dentist *Date of submission*

(Original signature or signature stamp required.)

The above sections must be completed, or the request will be rejected.

See the *IHCP Quick Reference Guide* for information about where to mail this form.