

Indiana Health Coverage Programs Dental Prior Authorization 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	<p>Enter the requesting or rendering provider's NPI (for atypical providers, enter the 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 request form will be returned to the provider. A valid NPI or Provider ID is required.</p> <p>The provider's copy of the <i>Indiana Medicaid Prior Authorization Notification</i> (PA notification 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.</p> <p>If the requesting provider does not have a valid service location on file, a PA decision letter will not be generated.</p> <p>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.</p>
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 ^{®2}), Healthcare Common Procedure Coding System (HCPCS), revenue code, or National Drug Code (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: <ul style="list-style-type: none"> • For managed care, select MCE. • For the 590 program, select 590. • For fee-for-service plans, select FFS.

¹ Current Procedural Terminology. CPT copyright 2020 American Medical Association. All rights reserved.

² Current Dental Terminology. CDT copyright 2020 American Dental Association. All rights reserved.

Field	Description
Is member employed?	Select YES or NO .
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	On the chart, indicate with a checkmark (✓) the tooth or teeth (1–32) to be treated by root canal therapy.
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	Answer questions A through E as indicated. 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 member wearing partials now? (YES or NO) Age of present partials.
5. Dentures	Check one or both: Full upper denture, Full lower denture. Answer questions A through D as indicated. 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 <i>Provider Types Allowed to Submit PA Requests</i> 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.