

**FORWARDHEALTH
 PRIOR AUTHORIZATION / DENTAL ATTACHMENT 1 (PA/DA1)
 CHECK BOX FORMAT**

The requested identifying information will only be used to process the prior authorization (PA) request. Failure to supply any of the requested information may result in denial of the PA.

Member Identification Number		Billing Provider's National Provider Identifier (NPI)		Rendering Provider's NPI
CATEGORY	PROCEDURE CODES (Check All That Apply)	TREATMENT PLAN JUSTIFICATION (Check All That Apply)	REQUIRED DOCUMENTATION	
Diagnostic Services	<input type="checkbox"/> D0210 <input type="checkbox"/> D0330 <input type="checkbox"/> D0470 (Prior authorization only required in certain circumstances.)	<input type="checkbox"/> Frequency limitation to be exceeded (D0210 and D0330) <input type="checkbox"/> Member over age 20 (D0470) <input type="checkbox"/> Department of Health Services request <input type="checkbox"/> Date of models (MM/DD/CCYY) _____	<ul style="list-style-type: none"> • Explanation to exceed frequency limitation. • Document number and type of X-rays taken (for D0210 and D0330). 	
Restorative Services	<input type="checkbox"/> D2390 <input type="checkbox"/> D2932 <input type="checkbox"/> D2933 (For members ages 0-20, PA is <i>not</i> required.)	Tooth No. _____ <input type="checkbox"/> Tooth numbers 6-11, 22-27, D-G, supernumerary (56-61, 72-77) <input type="checkbox"/> Successful endodontic treatment <input type="checkbox"/> More than 50 percent tooth involved in trauma / caries <input type="checkbox"/> Cannot be restored with composite <input type="checkbox"/> American Association of Periodontists (AAP) I or II <input type="checkbox"/> Frequency limitation to be exceeded <input type="checkbox"/> Member over age 20	<ul style="list-style-type: none"> • One periapical X-ray. • Explanation to exceed frequency limitation. • D2933 is not allowed on teeth numbers 22-27. 	
Endodontic Services	<input type="checkbox"/> D3310 <input type="checkbox"/> D3320	Tooth No. _____ <input type="checkbox"/> Involves root canal therapy on four or more teeth (PA not required for three or fewer teeth)	All documentation listed below and a treatment plan that indicates all indicated teeth meet clinical criteria.	
	<input type="checkbox"/> D3330 (For members ages 0-20, PA is <i>not</i> required.)	Tooth No. _____ <input type="checkbox"/> AAP I or II <input type="checkbox"/> Evidence visible on radiographs that at least 50 percent of the clinical crown is intact <input type="checkbox"/> Restorative treatment completed <input type="checkbox"/> Restorative treatment in process <input type="checkbox"/> Extractions completed in last three years (Indicate tooth number, date, and reason for any extractions) _____ <hr/> <input type="checkbox"/> Pathology, describe _____ <input type="checkbox"/> Involves root canal therapy on four or more teeth (PA not required for three or fewer teeth)	<ul style="list-style-type: none"> • Full-mouth series X-rays to include bitewing X-rays. • Intra-oral charting. • Document pathology, abscesses, carious exposure, non-vital, etc. 	
Periodontic Services	<input type="checkbox"/> D4210 <input type="checkbox"/> D4211	<input type="checkbox"/> Medication-induced hyperplasia <input type="checkbox"/> Irritation from orthodontic bands <input type="checkbox"/> Hyperplasia <input type="checkbox"/> More than 25 percent crown involved <input type="checkbox"/> Other _____	<ul style="list-style-type: none"> • Periodontal charting. • Comprehensive periodontal treatment plan. • Include Area of Oral Cavity code(s) on PA/DRF: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). 	
	<input type="checkbox"/> D4341 <input type="checkbox"/> D4342	<input type="checkbox"/> Member over age 12 — pockets 4 to 6 mm <input type="checkbox"/> History of periodontal abscess <input type="checkbox"/> Early bone loss <input type="checkbox"/> Moderate bone loss <input type="checkbox"/> AAP II or III <input type="checkbox"/> Oral hygiene (choose one) — <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Full-mouth debridement completed in last 12 months. Date of service for D4355 (MM/DD/CCYY) _____	<ul style="list-style-type: none"> • Periodontal charting. • Comprehensive periodontal treatment plan. • Include Area of Oral Cavity code(s) on PA/DRF: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). 	
	<input type="checkbox"/> D4355 (For members ages 13 and older, PA is <i>not</i> required.)	<input type="checkbox"/> Excess calculus on X-ray <input type="checkbox"/> AAP I or II <input type="checkbox"/> No dental treatment in multiple years <input type="checkbox"/> Oral hygiene (choose one) — <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Member under age 13	<ul style="list-style-type: none"> • Bitewing or full mouth X-rays. • Calculus must be visible on X-rays. 	
	<input type="checkbox"/> D4910	<input type="checkbox"/> Recent history of periodontal scale / surgery <input type="checkbox"/> Oral hygiene (choose one) — <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Years requested (check one) — <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<ul style="list-style-type: none"> • Periodontal charting. • Comprehensive periodontal treatment plan. • Allowed once per 12 months. 	

Continued



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CATEGORY	PROCEDURE CODES (Check All That Apply)	TREATMENT PLAN JUSTIFICATION (Check All That Apply)	REQUIRED DOCUMENTATION
Prosthodontic Services — Complete Dentures	<input type="checkbox"/> D5110 <input type="checkbox"/> D5120	<input type="checkbox"/> Initial placement of dentures (year) Max _____ Mand _____ <input type="checkbox"/> Age of existing denture(s) (years) Max _____ Mand _____ <input type="checkbox"/> New denture request because of the following (choose all that apply) <input type="checkbox"/> Worn base / broken teeth <input type="checkbox"/> Poor fit <input type="checkbox"/> Vertical dimension <input type="checkbox"/> Date(s) last teeth extracted (MM/DD/CCYY) _____ <input type="checkbox"/> Reason for edentulation _____ <input type="checkbox"/> Lost / stolen / broken dentures <input type="checkbox"/> Reline / repair not appropriate <input type="checkbox"/> Has not worn existing dentures for more than three years <input type="checkbox"/> Edentulous more than five years without dentures <input type="checkbox"/> Additional justification _____ <input type="checkbox"/> Frequency limitation must be exceeded.	<ul style="list-style-type: none"> • New dentures limited to one per five years, per arch. • Six weeks healing period required unless special circumstances documented. • Document reasons for not wearing dentures, or for not having ever had dentures. • Submit medical documentation to support special requests. • Document loss and plan for prevention of future mishaps. • Explanation to exceed frequency limitation.
Prosthodontic Services — Partial Dentures	<input type="checkbox"/> D5211 <input type="checkbox"/> D5212 <input type="checkbox"/> D5213 <input type="checkbox"/> D5214 <input type="checkbox"/> D5225 <input type="checkbox"/> D5226 <input type="checkbox"/> D5670 <input type="checkbox"/> D5671	<input type="checkbox"/> Initial placement of dentures (year) Max _____ Mand _____ <input type="checkbox"/> Age of existing denture(s) (years) Max _____ Mand _____ <input type="checkbox"/> New denture partial request because of the following (choose all that apply) <input type="checkbox"/> Worn base / broken teeth <input type="checkbox"/> Poor fit <input type="checkbox"/> Vertical dimension <input type="checkbox"/> Date(s) last teeth extracted _____ <input type="checkbox"/> Tooth numbers extracted _____ <input type="checkbox"/> Missing at least one anterior tooth and/or has fewer than two posterior teeth in any one quadrant in occlusion with opposing arch <input type="checkbox"/> Has at least six missing teeth per arch <input type="checkbox"/> AAP I or II <input type="checkbox"/> Nonrestorable teeth have been extracted <input type="checkbox"/> Restorative procedures scheduled <input type="checkbox"/> Restorative procedures completed <input type="checkbox"/> Unusual clinical circumstances — must be documented (e.g., needed for employment) <input type="checkbox"/> Lost / stolen / broken dentures <input type="checkbox"/> Reline / repair not appropriate <input type="checkbox"/> Additional justification _____ <input type="checkbox"/> Frequency limitation must be exceeded.	<ul style="list-style-type: none"> • X-rays to show entire arch. • Periodontal charting. • New partials limited to one per five years, per arch. • Six weeks healing period required unless special circumstances documented. • Document reasons for not wearing partial dentures, or reasons for not having ever had partial dentures. • Submit medical documentation to support special requests. • Document loss and plan for prevention of future mishaps. • Explanation to exceed frequency limitation.
Prosthodontic Services — Denture Reline	<input type="checkbox"/> D5750 <input type="checkbox"/> D5751 <input type="checkbox"/> D5760 <input type="checkbox"/> D5761	<input type="checkbox"/> Loose or ill fitting <input type="checkbox"/> Tissue shrinkage or weight loss <input type="checkbox"/> Member is wearing denture <input type="checkbox"/> Age of the denture or partial _____ <input type="checkbox"/> Frequency limitation must be exceeded.	<ul style="list-style-type: none"> • Relines limited to one per three years, per arch. • Document special circumstances. • Explanation to exceed frequency limitation.
Adjunctive General Services — Anesthesia	<input type="checkbox"/> D9220 <input type="checkbox"/> D9241 <input type="checkbox"/> D9248 (Prior authorization not required for the following: <ul style="list-style-type: none"> • Services performed in a hospital or ambulatory surgery center. • Services for members ages 0-20 when performed by a pediatric dentist or oral surgeon.) 	<input type="checkbox"/> Behavior <input type="checkbox"/> Disability (describe) _____ <input type="checkbox"/> Geriatric <input type="checkbox"/> Physician consult <input type="checkbox"/> Complicated medical history _____ <input type="checkbox"/> Extensive restoration <input type="checkbox"/> Maxillofacial surgery (describe) _____ <input type="checkbox"/> Three or more extractions in more than one quadrant.	Submit medical documentation to support special circumstances.
HealthCheck Other Services	<input type="checkbox"/> D0999 <input type="checkbox"/> D2999 <input type="checkbox"/> D4999 <input type="checkbox"/> D9999	<input type="checkbox"/> Periodic oral evaluation (additional) <input type="checkbox"/> Single unit crown. Tooth number _____ <input type="checkbox"/> Surgical procedure <input type="checkbox"/> Non-surgical procedure	<ul style="list-style-type: none"> • Submit medical documentation to support special requests. • HealthCheck referral required.

Additional Comments