

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: _____

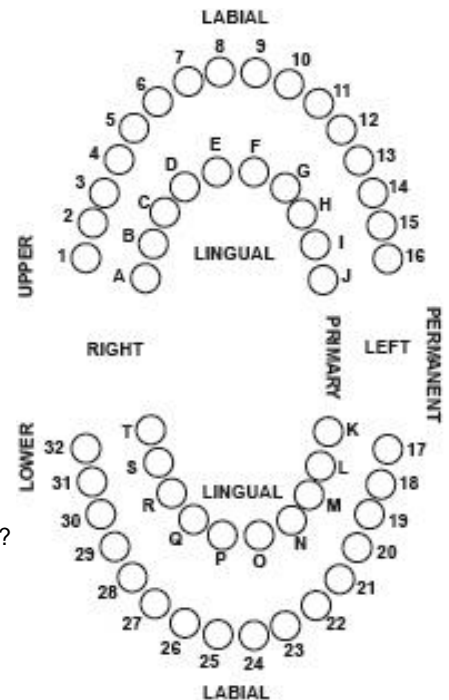
3. Does the member have missing teeth? Yes No
 If YES, please indicate missing teeth with check marks (in diagram at right).

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.