Request Date: _____

Review Type: ☐ **Admission** ☐ **Retrospective**

Please see instructions on page 5 for Admission or Retrospective review types.

RECIPIENT INFORMATION

Recipient Name: Last, First, Middle

_____

Date of Birth: ☐☐/☐☐/☐☐

If Medicaid eligibility is retroactive,

please enter start date of service: ☐☐/☐☐/☐☐

Medicaid ID #: ☐☐☐☐☐☐☐☐☐☐

Sex: ☐ Age: ☐☐☐

Date of First Visit/Evaluation: ☐☐/☐☐/☐☐

REQUESTOR INFORMATION

Requestor's Name:

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Ext. ☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

email: _____

REQUESTING DENTIST

Dentist's Name: Last, First, Middle

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

Medicaid #: ☐☐☐☐☐☐☐☐☐
(Required)

NPI: ☐☐☐☐☐☐☐☐☐☐

REFERRING DENTIST

Dentist's Name: Last, First, Middle

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

Medicaid #: ☐☐☐☐☐☐☐☐☐

NPI: ☐☐☐☐☐☐☐☐☐☐

DIAGNOSIS

Diagnosis codes are not required for dental services, however they may assist in the review process.

Diagnosis Code: _____

Description: _____

Diagnosis Identified Date: ☐☐/☐☐/☐☐

Diagnosis Code: _____

Description: _____

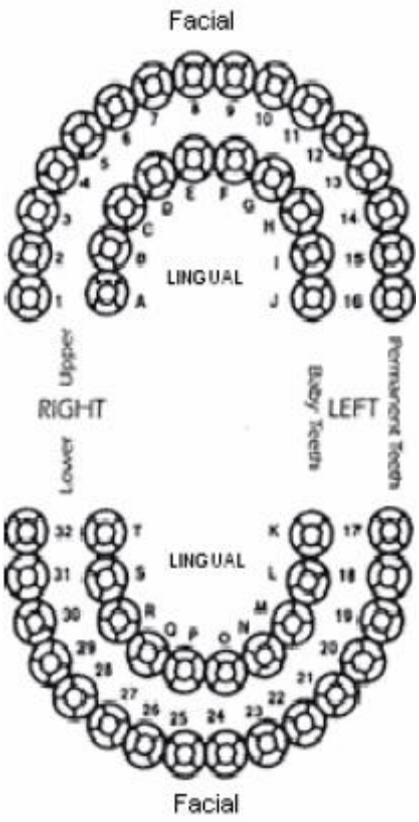
Diagnosis Identified Date: ☐☐/☐☐/☐☐

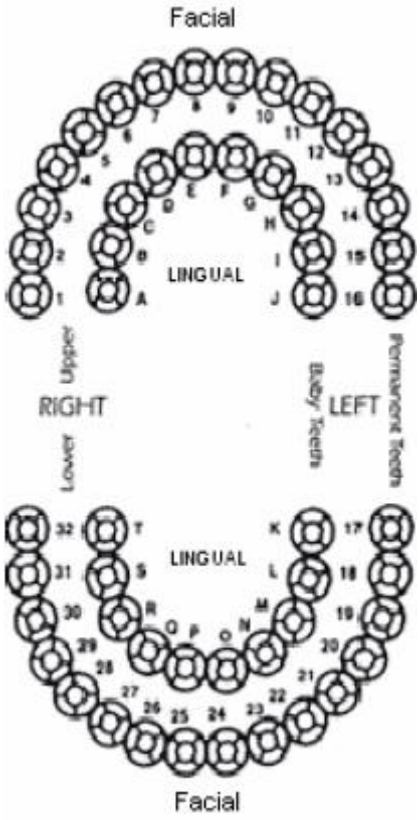
CDT™ CODE(S)	DESCRIPTION(S)	START DATE	THRU DATE
		Please see instructions on page 5 for Start Date and Thru Date.	
D5211	Upper Partial – Resin Base	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐
D5212	Lower Partial – Resin Base	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐

Medicaid ID Number: ☐☐☐☐☐☐☐☐☐☐	Recipient Last/First/Middle Name:

CDT™ CODE(S)	DESCRIPTION(S)	START DATE	THRU DATE
D5213	Maxillary Partial Denture	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐
D5214	Mandibular Partial Denture	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐
D5820	Interim Partial Denture	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐
D6985	Pediatric Partial Denture	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐
D5110	Complete Denture -Maxillary	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐
D5120	Complete Denture -Mandibular	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐

Please place an X on the chart below to indicate which missing teeth are being replaced by a partial denture.



Medicaid ID Number: ☐☐☐☐☐☐☐☐☐☐	**Recipient Last/First/Middle Name:**
Is this request for: **___ New Denture** **___ Replacement Denture** **___ Upper Denture** **___ Lower Denture** **If a Replacement Denture:** **Record previous date of placement (if known):** ☐☐/☐☐/☐☐ **Specify why it must be replaced, indicate if it can currently be used, and why it is the most cost effective and clinically appropriate treatment option for recipient's dental needs.**	**Response:**
If this request is for an upper partial, please indicate the missing maxillary (upper) teeth on the chart to the right. **If the request is for a lower partial, please indicate the missing mandibular (lower) teeth on the chart to the right.**	 **Response:**

Does the patient have congenitally missing teeth?

- **Yes**
- **No**

Does the patient have a full upper or lower denture?

- **Yes**
- **No**

Patient's oral hygiene?

- **Poor**
- **Fair**
- **Good**

Clinical Summary Information- prior treatment history, current treatment plan and other pertinent information, etc:

Florida Agency for Health Care Administration Disclaimer Statement

eQHealth Solutions certification determination does not guarantee Medicaid payment for services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid Program.

Requesting Provider Attestation Statement

I hereby attest that, as a dental services provider or provider representative, an order for dental services has been received for the recipient. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) dentist. A dental provider who knowingly or willfully makes or causes to be made any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be subject to the application of sanctions, which include, but are not limited to, fines, suspensions, and termination. In addition, the provider may be prosecuted under federal and/or state criminal laws and may be subject to civil monetary penalties and/or fine.

Printed Name: _____

Signature: _____

Date: _____

SUPPORTING DOCUMENTATION:

The following documentation is not required but may be submitted.

Please only submit dental radiographs when they are specifically requested by eQHealth.

Type of Review Request	Recommended Documentation
All Types of Review Request	Please provide any documentation that is not included in the review request form that supports the medically necessity of the requested services.
Radiographs (x-rays)	Submission with the request is recommended.

INSTRUCTIONS FOR COMPLETION OF CDT™ SERVICE CODES START AND THRU DATES:

Admission Review
Recipient eligible for Medicaid on anticipated start date. Enter the start date of care and the anticipated date of delivery of the partials as the through date.

Retrospective Review
Recipient did not have Medicaid eligibility at the time the services were started and completed. Enter the actual dates of service and units.