NC DMA SUPPLEMENT TO DENTAL PRIOR APPROVAL FORM

FULL DENTURE / PARTIAL DENTURE REQUEST

This form must accompany any prior approval request for full or partial dentures to be delivered in a long-term care facility (e.g., skilled nursing facility, intermediate care facility, adult care home).

1. PATIENT'S NAME LAST FIRST MIDDLE	2. BIRTHDATE (MM/DD/CCYY)	3. SEX	4. PATIENT'S MEDICAID ID NUMBER

II. THIS PORTION TO BE COMPLETED BY FACILITY STAFF

5.FACILITY / ADDRESS / TELEPHONE NUMBER

6. ATTENDING PHYSICIAN / TELEPHONE NUMBER	7. RELATIVE NAME / ADDRESS / TELEPHONE NUMBER
8. DIAGNOSIS / PRIMARY / SECONDARY	9. MEDICATIONS

PATIENT INFORMATION (Describe briefly)

Level of disorientation: _____ Personal care assistance: _____

Type of diet: _____ Activities/Social: _____

Can patient communicate needs? _____

Prognosis: _____

Comments: _____

_____

_____

Completed by: _____ Title: _____ Date: _____

III. THIS PORTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN

STATEMENT: IN MY OPINION THIS PATIENT IS ABLE TO TOLERATE DENTURES. THIS PATIENT DESIRES DENTURES. THIS PATIENT NEEDS DENTURES FOR AN IMPROVED QUALITY OF LIFE.

_____ _____

Attending Physician Date

IV. THIS PORTION TO BE COMPLETED BY THE ATTENDING DENTIST

STATEMENT: BASED ON ORAL EXAMINATION FINDINGS AND AN EVALUATION OF THIS PATIENT'S POTENTIAL TO UTILIZE DENTURES IT IS MY OPINION THAT DENTURES SHOULD BE PROVIDED. I WILL PROVIDE POST-OPERATIVE CARE FOLLOWING DENTURE INSERTION TO THE PATIENT AS NEEDED IN ACCORDANCE WITH MEDICAID GUIDELINES.

_____ _____

Attending Dentist Date

Fax this form to CSC at: (855) 710-1964