



**DMMA PRIOR AUTHORIZATION REQUEST
FOR GENERAL DENTAL TREATMENT PLAN**

Prior Authorization for the following dental procedure is requested as follows:

Instructions: Complete all relevant fields. The DMMA dental policy may also require the submission of x-rays or other supporting documentation. Please check the dental policy guidelines at www.dmap.state.de.us and attach documentation as necessary.

Medicaid/DHCP Eligible Child: _____

Medicaid/DHCP ID Number: _____

Patient DOB: _____

Diagnosis: _____

Procedure(s) to be performed (CDT code): _____

Tentative Treatment Date: _____

Related Tooth/Quadrant/Arch: _____ Missing Teeth: _____

Radiographs Submitted: NONE PANOREX PERIAPICAL BITEWING FMX PHOTO

Radiograph Mount: _____ Bump up _____ Bump down

Initial Restoration: Yes No

How old is the existing restoration: _____

Fee: _____ Additional Remarks: _____

I understand that the service must be medically necessary and directly related to the treatment plan in order for this request to be approved. I also understand that the child must be eligible for Medicaid (and under age 21) or the Delaware Healthy Children Program (and under age 19) on the date the service, and that where other third party coverage of dental care exists it must be billed prior to the submission of a claim to DMMA. Approval of the prior authorization request is therefore not a guarantee of payment.

Billing Provider Name

Date

Performing Provider Name

Provider Phone Number

Provider Billing NPI Number

Provider Fax Number

Please email to gabrielle.hilliard@state.de.us
Attention: Dental PA Unit

Or Mail to: Dental PA Unit
Division of Medicaid & Medical Assistance
P.O. Box 906
New Castle, DE 19720