



DEPARTMENT OF HEALTH & SOCIAL SERVICES  
DIVISION OF SOCIAL SERVICES

**MEDICAID PRIOR AUTHORIZATION REQUEST  
FOR ADULT  
ORAL AND FACIAL PROSTHETICS**

Oral and facial prosthetics are covered for Medicaid adults, age 21 or older, when determined to be medically necessary and part of a rehabilitation plan to treat an anatomical deficiency caused by disease, injury, or other diagnosed condition.

This Prior Authorization form is designed for use by the prosthetic provider who actually designs and prepares the prosthesis for fee-for-service adult Medicaid clients. Prior Approval and reimbursement will not be made to providers when the prosthesis is prepared by an outside laboratory.

Prosthetic providers treating MCO-enrolled Medicaid adults should seek approval from and bill the client's MCO directly. Prior approval for Medicaid-eligible children needing a maxillofacial prosthetic should be requested through the Medicaid Dental Program using the General Dental PA request form.

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

**Instructions:** Complete all fields.

Medicaid-eligible Adult: \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Description and History of Oral or Facial Deficiency: \_\_\_\_\_

Description of Overall Treatment Plan: \_\_\_\_\_

Procedure to be performed (CPT code): \_\_\_\_\_

Location where procedure will be performed: \_\_\_\_\_

Expected Date of Service: \_\_\_\_\_

Fee: \_\_\_\_\_

Additional Remarks: \_\_\_\_\_

I understand that the service must be medically necessary and directly related to the patient's treatment plan in order for this request to be approved. I also understand that the client must be Medicaid eligible on the date the service is performed in order to be paid by the State Medicaid Program. Other services not directly related to the provision of the prosthetic device are not covered under this request. Notification of approval or denial will be made following a medical review of this request.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider ID Number

\_\_\_\_\_  
Provider Phone Number

**Please fax to: (302) 255-4481  
Attention: Dental PA Unit**

\_\_\_\_\_  
Provider Fax Number

**Or mail to: Dental PA Unit  
Division of Social Services  
P.O. Box 906  
New Castle, DE 19720**