Medical Policy Review Form

Medical-Dental Procedures

Quality and Utilization Improvement Dept.	Telephone # (888)-467-0774
Medical or Dental	Fax # (952) 853-8713

PROVIDER PLEASE COMPLETE ALL SECTIONS BELOW

Member Information:	Provider Information:
Member Name:	DDS/MD:
Member ID #:	DDS Practice (Name):
DOB:	Tax ID#:
	Phone #:
	Fax #:

1. Diagnosis: _____ ICD9 DX: _____

2. Procedure/Service: _____ CDT PX: _____
   _____ CDT PX: _____
   _____ CDT PX: _____
   _____ CDT PX: _____
   _____ CDT PX: _____

3. Facility: _____ Tax ID # _____

4. Expected Date:_____

Additional Information:

_____
_____
_____
_____
_____

Please attach pertinent medical necessity for the requested procedure/service.
See below for documentation requirements.

INFORMATION REQUIRED:

For all Medical Dental Requests:
Please include a provider statement outlining the medical necessity of the procedure and the specific diagnosis. If applicable, please submit x-rays.

Accidental Dental Services:
If these services are required due to an injury you sustained that caused damage to the teeth, please submit all of the following:

1. Pre-injury radiographs
2. Post-injury radiographs
3. Date of injury
4. Details of the accident/how the injury occurred
5. Dental clinic notes describing the tooth injury; and
6. Which teeth were involved in the injury

Occlusal Orthotic Devices:
A signed provider statement indicating all of the following:

1. The specific temporomandibular (TMJ) joint disorder diagnosis;
2. The temporomandibular joint disorder (TMD) symptoms; and
3. The type of TMJ occlusal orthotic device requested.

Frenulectomy:
Documentation indicating the location of the frenulectomy (labial or lingual) and medical necessity.

Cone Beam CT Scan:
Medical necessity information (chart notes/documentation, etc.) warranting the need for this service. If applicable, please submit x-rays.

Oral Biopsy
The presumptive clinical diagnosis and the pathology report results. If applicable, please submit radiographs.

Facility/ General Anesthesia
Member information (chart notes/documentation, etc.) warranting the need for this service. Please include pertinent medical necessity information including:

- Diagnosis codes, anticipated necessary dental care and number of appointments that would be expected to complete dental care needs.
- If applicable, include documentation of:
- Previous unsuccessful attempts at dental care in the clinic setting
- Behavioral modification attempted to provide care in the clinic setting
- A disability or a medical condition that requires general anesthesia

You may attach the dental claim form to this request form.