Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 35—Dental Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 35—Dental Program

13 CSR 70-35.010 Dental Benefits and Limitations, Medicaid Program

PURPOSE: This rule describes the dental services for which the Division of Family Services shall pay when the service is provided to an eligible assistance recipient, the service is provided by a licensed dentist or licensed and certified dental specialist who has entered into an agreement for that purpose with the division and the service is listed as a covered item either in the new rule or the ***Medicaid Dental Manual*** *sponsored by the division. This rule or the* ***Medicaid Dental Manual*** *also describes the dental services which shall be paid under limitations and those which shall not be paid under present conditions.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Administration. The Missouri Medicaid dental program shall be administered by the Division of Medical Services, Department of Social Services. The dental services covered and not covered, the limitations under which services are covered and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services. Dental services covered by the Missouri Medicaid program shall include only those which are clearly shown to be medically necessary. The division reserves the right to effect changes in services, limitations and fees with proper notification to Medicaid dental providers.

(2) Provider Participation. A dentist shall be licensed by the dental board of the state in which s/he is practicing and shall have signed a participation agreement to provide dental services under the Missouri Medicaid program. An oral surgeon or other dentist specialist shall be licensed in his/her specialty area by the dental board of the state in which s/he is practicing. In those states not having a specialty licensure requirement, the dentist specialist shall be a graduate of and hold a certificate from a graduate training program in that specialty in an accredited dental school. In either case, the dental specialist shall have signed a participation agreement to provide dental services under the Missouri Medicaid program.

(3) Recipient Eligibility. The Medicaid dental provider shall ascertain the patient's Medicaid status before any service is performed. The recipient's Medicaid eligibility is determined by the Division of Family Services. The recipient's eligibility shall be verified from a current Medicaid identification card or a letter of new approval in the recipient's possession. The patient must be a Medicaid-eligible recipient under the Missouri program on the date the service is performed. The Division of Medical Services is not allowed to pay for any service to a patient who is not eligible under the Missouri Medicaid program.

(4) Prior Authorization. Prior authorization shall be required in the following two (2) cases: a) initial placement or replacement of all full dentures (upper, lower or both) and b) placement or replacement of all partial dentures. When prior authorization is required, the form provided by the Division of Medical Services or its contracted agent shall be used. The dental service shall not be started until written approval has been received. Telephone approval shall not be given. Prior authorization shall be effective for a period of one hundred twenty (120) days from the date of written approval. Prior authorization approves the medical necessity of the requested dental service. It shall not guarantee payment for that service as the patient must be a Medicaid-eligible recipient on the date the service is performed. The division reserves the right to request documentation regarding any specific request for prior authorization.

(5) Claims. The Medicaid dental provider shall submit his/her usual charge to the general public on the claim form provided by the Division of Medical Services or its contracted agent. Medicaid reimbursement for dental services is based on an established fee schedule as published in Section 19 of the Dental Manual. When a claim is reimbursed by Medicaid (or Medicare-Medicaid), no amount in addition to copayment or coinsurance amounts as specified in Section 19 of the Dental Manual shall be collected from the recipient, his/her immediate family or anyone else. The reimbursement provided by Medicaid (or Medicare-Medicaid) shall be accepted in full settlement of the dental claim. The recipient shall be responsible for any noncovered service (no reimbursement). The division reserves the right to request documentation regarding any specific dental claim.

(6) Other Source Payment. The Medicaid payment for dental services cannot duplicate or replace benefits available to the recipient from any other source, public or private. A settlement received from private insurance or litigation as the result of an accident must be used toward payment of the dental care. Medicaid shall be the last source of payment on any claim. Any payment received from a private insurance carrier or other acceptable source shall be listed on the claim form. If the settlement received is equal to or exceeds the fee which could be allowed by Medicaid, no payment shall be made by Medicaid.

(7) Dental Certification. A dental certification form as provided by the Division of Medical Services or its contracted agent shall be completed in the case of any denture, partial or full, except for those flipper-type partials identified in the *Dental Services Provider Manual*. This completed form shall be attached to the claim and the request for prior authorization.

(8) Dental Manual. *A Medicaid Dental Manual* shall be produced by the Division of Medical Services and shall be distributed to all dental providers participating in the Missouri Medicaid program. It shall contain a list of covered and noncovered services, the limitations under which services are covered and other pertinent data to supplement this rule. The Health Care Financing Administration's Common Procedure Coding System (HCPCS) Level 1, 2 or 3 procedure codes, which includes a modification of the *American Dental Association's (ADA) Code on Dental Procedures and Nomenclature* shall be used in the manual. Maximum allowable fees by the Missouri Medicaid Dental Program shall be published in provider manuals and bulletins.

(9) Services, Covered and Noncovered. The list shown in this section represents the groupings of medically necessary services covered by the Missouri Medicaid program. The *Medicaid Dental Manual* shall provide the detailed listing of procedure codes and pricing information.

(A) Anesthesia. General anesthesia administered in the office is a covered service. General anesthesia administered in the hospital for dental care is payable to the hospital. Local anesthesia is not paid under a separate procedure code and is included in the treatment fee. Nitrous oxide is not covered;

(B) Crowns, Bridges, Inlays. A crown of chrome or stainless steel is a covered item. A crown of polycarbonate material is a covered item for an anterior tooth. Crowns of other materials are not covered. Cast restorations indicated by an early periodic screening diagnosis and treatment (EPSDT) screen are covered;

(C) Full Dentures. One (1) upper full denture, one (1) lower full denture, or one (1) complete set (upper and lower) of full dentures is covered. A full denture must be constructed of acrylic material and must meet the following criteria: full arch impression, bite registration, each tooth set individually in wax, try-in of teeth set individually in wax before denture processing, insertion of the processed denture and six (6)-month follow-up adjustments, to be a covered item. Service in the case of any full denture is not completed and shall not be claimed until the denture is placed. Noncovered items include temporary full dentures, full overdentures and immediate placement full dentures;

(D) Partial Dentures. A partial denture shall replace permanent teeth and must be constructed of acrylic material to be a covered item. Service in the case of any partial denture is not completed and shall not be claimed until the denture is placed. Noncovered items include temporary partial dentures and partial overdentures. Immediate placement partial dentures are noncovered except for those flipper-type partials identified in the *Dental Services Provider Manual* under procedure codes D5820, D5820W5, D5820W6, D5820W9, D5821, D5821W5, D5821W6, D5821W9;

(E) Denture Adjustment and Repair. Denture adjustment is a covered service but not to the originating dentist of a new denture until six (6) months after the denture is placed. Repair of a broken denture may be accomplished on the same date of service as denture duplication or reline;

(F) Denture Duplication and Reline. Duplication of a partial or full denture is a covered service. Reline of a partial or full denture, either chair-side or laboratory, is covered. Duplications and relines are not covered within twelve (12) months of initial placement of an original denture. Additional denture relines or duplications are limited to once within three (3) years from the date of the last preceding reline or duplication. Denture duplication or reline may be accomplished on the same date of service as repair of a broken denture;

(G) Emergency Treatment. Emergency dental care does not require prior authorization and is covered whether performed by a licensed dentist or a licensed dentist specialist. Emergency care is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention reasonably could be expected to result in—placing the patient's health in serious jeopardy or serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Emergency care not listed in the *Medicaid Dental Manual* shall be explained on the claim. An emergency oral examination is not paid under a separate procedure code and is included in the treatment fee. Palliative treatment on the same date of service as other dental care on the same tooth is not covered. Denture dental services are not subject to emergency treatment consideration;

(H) Examinations, Visits, Consultations. An initial oral examination in the office is covered. Subsequent office medical services are covered. A professional visit to a nursing home is covered and shall include the fee for an oral examination. A professional visit to a hospital is covered and shall include the fee for an oral examination. A consultation by a dentist is a covered service and shall include the fee for an oral examination;

(I) Extractions. Extraction fees for permanent and deciduous teeth, as listed in the *Medicaid Dental Manual*, apply whether the service is performed in the office, hospital or ambulatory surgical center. Preoperative X rays involving extractions may be covered but postoperative X rays are not covered;

(J) Preventive Treatment. Fluoride treatment may be covered but is limited to the application of stannous fluoride or acid phosphate fluoride. Sodium fluoride treatments are not covered. Fluoride treatment shall include both the upper and lower arch and shall be a separate service from prophylaxis. Fluoride treatment for recipients under age twenty-one (21) is covered. Fluoride treatment for recipients age twenty-one (21) and over is limited to individuals with rampant caries, or those who are undergoing radiation therapy to head and neck, or those with diminished salivary flow, or individuals who are mentally retarded or have cemental or roof surface caries secondary to gingival recession. For recipients ages five through twenty (5–20), topical application of sealants as outlined in Section 19 of the *Medicaid Dental Manual* is covered. Dietary planning, oral hygiene instruction and training in preventive dental care are not covered;

(K) Hospital Dental Care. Dental services provided in an inpatient hospital or an outpatient hospital place of service are subject to the same general benefits and limitations applicable to all dental services and all are not selectively restricted based on place of service;

(L) Injections. Procedure codes for the injections which are covered shall be shown in Section 19 of the *Dental Manual*;

(M) Oral Surgery (or Other Qualified Dentist Specialist). Oral surgery is limited to medically necessary care. Cosmetic oral surgeries shall not be paid. Procedures as covered for a certified oral surgeon (or other qualified dentist specialist) shall be indicated in the *Medicaid Dental Manual*. A medically necessary oral surgery procedure not specifically listed in the *Medicaid Dental Manual* may be billed using the procedure code identified in the dental manual as Unspecified. The Unspecified procedure must be explained on the claim form.

(N) Orthodontic Treatment/Space Management Therapy. Medically necessary minor orthodontic appliances for interceptive and oral development as listed in the *Medicaid Dental Manual* are covered. Fixed space maintainers are covered for the premature loss of deciduous teeth. Medically necessary orthodontic treatment and space maintainers for recipients under age twenty-one (21) is covered when indicated by an EPSDT screen and prior authorized;

(O) Periodontic Treatment. A gingivectomy or gingivolplasty is allowed for epileptic patients on Dilantin therapy, or medically necessary drug-induced hyperplasia. Limited occlusal adjustment is covered when it is necessary as emergency treatment. Other periodontic procedures are not covered;

(P) Prophylaxis (Preventive). Prophylaxis may be a covered service for the upper arch, the lower arch or both arches. Prophylaxis shall be a separate service from fluoride treatment and shall include scaling and polishing of the teeth;

(Q) Pulp Treatment (Endodontic). A pulpotomy on deciduous teeth is covered and shall include complete amputation of the vital coronal nerve, with placement of a suitable drug over the remaining exposed tissue. The fee excludes final restoration. Pulp vitality tests and pulp caps are not covered;

(R) Restorations (Fillings). Fees for any restorative care listed in the *Medicaid Dental Manual* apply whether the service is performed in the office, hospital, ambulatory surgical center or nursing facility. Amalgam fillings are covered for Class I, Class II and

Class V restorations on posterior teeth. A maximum fee shall apply for any one (1) posterior tooth and shall include polishing, local anesthesia and treatment base. Silicate cement, acrylic or composite fillings are not covered for Class I and Class II restorations but are covered for Class III, Class IV and Class V restorations on anterior teeth. A maximum fee shall apply for any one (1) anterior tooth and shall include polishing, local anesthesia and treatment base. Fillings of other materials are not covered, except when a sedative filling is necessary as emergency treatment. X rays may be covered;

(S) Root Canal Therapy (Endodontic). Root canal therapy is a covered service for permanent teeth. The fee excludes final restoration but includes all in treatment X rays. Pre-operative and postoperative X rays may be reimbursed. An apicoectomy is a covered service for permanent teeth but not on the same day as a root canal. Excluding a pulpotomy, other endodontic procedures are not covered; and

(T) X rays. X rays shall not be submitted routinely with a request for prior authorization or with a claim, unless the practitioner shall have been specifically requested to submit X rays. X rays shall be taken at the discretion of the dental practitioner. Films which are not of diagnostic value shall not be claimed. X rays to be covered shall be of the intraoral type, except when a panoramic-type film is required. A preoperative full-mouth X-ray survey of permanent or deciduous teeth, or mixed dentition, is covered as described in the *Medicaid Dental Manual*. Medically necessary X rays of an edentulous mouth are covered.

(10) General Regulations. General regulations of the Missouri Medicaid program apply to the dental program.

AUTHORITY: sections 208.152, RSMo Supp. 1990, 208.153, RSMo Supp. 1991 and 208.201, RSMo Supp. 1987. This rule was previously filed as 13 CSR 40-81.040. Original rule filed Jan. 21, 1964, effective Jan. 31, 1964. Amended: Filed March 30, 1964, effective April 9, 1964. Amended: Filed April 27, 1965, effective May 7, 1965. Amended: Filed Dec. 7, 1966, effective Dec. 17, 1966. Amended: Filed Oct. 13, 1967, effective Oct. 23, 1967. Amended: Filed Jan. 22, 1968, effective Feb. 1, 1968. Amended: Filed Aug. 24, 1968, effective Sept. 3, 1968. Amended: Filed April 16, 1970, effective April 26, 1970. Amended: Filed Feb. 16, 1971, effective Feb. 26, 1971. Amended: Filed Jan. 3, 1973, effective Jan. 13, 1973. Amended: Filed Feb. 6, 1975, effective Feb. 16, 1975. Amended: Filed July 9, 1976, effective Oct. 11, 1976. Amended: Filed Feb. 7, 1977, effective May 11, 1977. Amended: Filed Nov. 14, 1977, effective Feb. 11, 1978. Emergency rescission filed June 14, 1979, effective July 31, 1979, expired Sept. 13, 1979. Emergency rule filed June 14, 1979, effective Aug. 1, 1979, expired Sept. 13, 1979. Rescinded and readopted: Filed June 14, 1979, effective Sept. 14, 1979. Emergency amendment filed April 10, 1981, effective April 20, 1981, expired July 10, 1981. Amended: Filed April 10, 1981, effective July 11, 1981. Emergency amendment filed Sept. 18, 1981, effective Oct. 1, 1981, expired Jan. 13, 1982. Amended: Filed Sept. 18, 1981, effective Jan. 14, 1982. Amended: Filed July 15, 1991, effective Nov. 30, 1991. Amended: Filed Aug. 14, 1992, effective Feb. 26, 1993.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*

MISSOURI MEDICAID PROGRAM
DENTAL CLAIM

RETURN ORIGINAL TO:
GTE DATA SERVICES
P.O. BOX 5300
JEFFERSON CITY, MO 65102

DEPARTMENT OF SOCIAL SERVICES ***(PLEASE TYPE OR PRINT)***

RECIPIENT

1. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL) | 2. SEX M F | 3. RECIPIENT BIRTHDATE MO. DAY YR. | 4. MEDICAID IDENTIFICATION NUMBER | 5. NEW APPROVAL NO ☐ YES ☐

6. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE AND PHONE NUMBER.)

7. IF THE RECIPIENT HAS OTHER INSURANCE, CHECK ONE OF THE BELOW:
☐ YES, THE AMOUNT PAID IS SHOWN IN FIELD 29. ☐ YES, BUT NOT APPLICABLE TO THIS CLAIM.
NAME OF DENTAL INSURANCE AND ADDRESS
POLICY NUMBER

PROVIDER

8. DENTIST NAME, ADDRESS AND MEDICAID PROVIDER NUMBER **(AFFIX LABEL HERE)**

9. IS TREATMENT A RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO ☐ YES ☐ | IF YES, ENTER DATE, LOCATION, AND CAUSE

10. IS TREATMENT A RESULT OF AUTO ACCIDENT? NO ☐ YES ☐

11. IS TREATMENT A RESULT OF OTHER ACCIDENT? NO ☐ YES ☐

12. DENTIST SOC. SEC. NO. OR T.I.N. | 13. DENTIST LIC. NUMBER | 14. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO ☐ YES ☐ | IF NO, STATE PAYMENT SOURCE OF PRIOR PLACEMENT | DATE OF PRIOR PLACEMENT

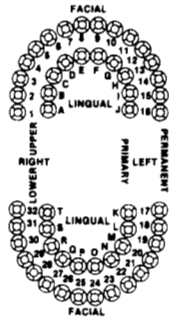
15. FIRST VISIT DATE CURRENT SERIES | 16. RADIOGRAPHS ENCLOSED? NO ☐ YES ☐ | 17. HOW MANY? | 18. DOES RECIPIENT EXHIBIT LACK OF INTEREST IN TREATMENT PLAN? NO ☐ YES ☐ | REMARKS

19. THIS PATIENT REFERRED BY: | MEDICAID PROVIDER NO. | 20. PRIMARY DIAGNOSIS | 21. SECONDARY DIAGNOSIS | 22. IF PROSTHESIS, GIVE NAME AND ADDRESS OF SUPPLYING LABORATORY

23. PRIOR AUTHORIZATION NUMBER | 24. PATIENT ACCOUNT NUMBER | 25. E.P.S.D.T. REFERRAL? NO ☐ YES ☐

SERVICES

IDENTIFY MISSING TEETH WITH "X"



FOR PARTIAL DENTURES, SHOW TEETH TO BE CLASPED AND DESIGN OF PARTIAL

SYMBOLS

MISSING TEETH "X"
RESTORABLE TEETH "0"
NON-RESTORABLE TEETH "/"
REPLACED BY DENTURES "X" (LOWER)
REPLACED BY DENTURES "X" (UPPER)
FIXED DENTURES "( )"

26. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1-34. USE CHARTING SYSTEM SHOWN. ONLY ONE TOOTH OR DESCRIPTION PER LINE. MAX. OF 13 ITEMS PER CLAIM.

LINE NO.	TOOTH # OR LETTER	SURFACE CODE	QTY	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	PLACE OF SERVICE	PROCEDURE CODE	CHARGE	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									

27. REMARKS

28. TOTAL CHARGES

29. LESS AMOUNT PAID BY OTHER INSURANCE

31. NET CHARGES

32. POSSIBLE CHILD ABUSE ☐

30. **PROVIDER CERTIFICATION**

I hereby agree to keep such records as are necessary to disclose fully the extent of the services and/or materials listed on this claim, and to furnish such information regarding any payments claimed for providing such services and/or materials as the State Department of Social Services, its designee, or the Department of Health and Human Services may request. I further agree not to charge any Medicaid Program recipient for covered services. Medicaid reimbursement for covered services will be accepted as the full and complete satisfaction of the charges. I certify that the services and/or materials listed on this claim were medically indicated and necessary to the health of the named patient and that such services were personally rendered by me or under my direction. I certify that the charges for services and/or materials listed on this claim are correct, just, unpaid, actually due according to the law and program policy and not in excess of regular charges. I certify that the services were provided in compliance with the non-discrimination provision of Title VI of the Federal Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. I certify that the information provided on this claim is true, accurate and complete. I understand that payment and satisfaction of this claim will be from federal and/or state funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and/or state law.

SIGNATURE OF PROVIDER _____ DATE _____

MO - 8802 REV. 4/88

Type of Service Code

7. Dental Services

Place of Service Codes

1. Inpatient Hospital
2. Outpatient Hospital
3. Office
4. Home
7. Nursing Home
8. Skilled Nursing Facility
9. Ambulance
0. Other Locations
A. Independent Laboratory
C. Emergency

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

RETURN TO:
GTE DATA SERVICES
P. O. BOX 5700
JEFFERSON CITY, MO
65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1. ☐ INITIAL ☐ CHANGE	PA #	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)			5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION	
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE			

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ FULL ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION (DO NOT WRITE IN SHADED AREAS) FOR STATE USE ONLY

16. REF. NO.	17. TYPE SERV	18. PROCEDURE CODE	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE ITEM	22. QTY OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF **PRESCRIBING PHYSICIAN/PRACTITIONER** | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

MO 886-0858 (9-91) MO 8809

THIS FORM IS TO BE USED FOR EPSDT (HCY) RELATED SERVICES ONLY

FIELD NUMBER AND NAME – INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Transaction Type – Check INITIAL or CHANGE. If change, enter initial prior authorization (PA) number.
2. Recipient's Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipient's current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipient's address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipient's prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening – Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. – (Reference Number) A unique designator (1-8) identifying each separate line on the request.
17. Type of Service – Enter the appropriate type of service code for each procedure code.
18. Procedure Code – Enter the procedure code(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter a specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form**.

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date – The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner – The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 8). The consultant will sign or initial the form.

DS1926

TITLE XIX MISSOURI MEDICAID PROGRAM

DENTAL CERTIFICATION FORM

This form must be completed in conjunction with all dentures either partial or full; initial or replacement, provided to any eligible Missouri recipient. Attach the completed form to the Request for Prior Authorization Form. Please be sure this form is completed in full.

Recipient's Name _____ Recipient's Birthdate _____

Recipient's Medicaid Identification Number _____

Recipient's Address _____

Dentist's Name _____

Dentist's Medicaid Provider Number _____

I certify that the recipient initiated the request for the described service(s), that providing the service(s) will be in the best interest of the recipient and that the recipient does not have any physical or mental disability or impairment which will prevent the normal use and benefit thereof.

I further certify that full absorption has taken place.

_____ _____
Signature of Dentist Date

TO BE COMPLETED ONLY IF SERVICES ARE PROVIDED IN A NURSING HOME

Name and Address of Nursing Home _____

I certify that the dentist named above, has obtained my approval to provide services in this nursing home.

_____ _____
Signature of Nursing Home Administrator Date

I certify that I initiated the request for this service.

_____ _____
Signature of Recipient Date

*If the recipient is unable to sign the form, detailed information must be included as to why the recipient was unable to sign.

MO-8816