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

Title Page

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

13 CSR 70-55.010 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 of Medical Services 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.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State at the headquarters of the agency and is available to any interested person at a cost established by state law.

(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 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, D5820W8, 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 relines;

(F) Denture Duplication and Relines. Duplication of a partial or full denture is a covered service. Relines of a partial or full denture, either chair-side or laboratory, is covered. Duplication 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. Dental care 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 radiographic evidence of root surface caries secondary to gingival recession. For recipients ages five through twenty-five (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 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 Medicaid 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. Medically necessary orthodontic appliances for interceptive and etal 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) 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, D5820W8, 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 relines;

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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.


**MISSOURI MEDICAID PROGRAM**

**DENTAL CLAIM**

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

<table>
<thead>
<tr>
<th>1. RECIPIENT NAME (LAST, FIRST, MIDDLE/INITIAL)</th>
<th>2. SEX</th>
<th>3. DATE OF BIRTH (DAY, MONTH, YEAR)</th>
<th>4. MEDICARE IDENTIFICATION NUMBER</th>
<th>5. NEW APPROVAL</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td>NO</td>
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</tbody>
</table>

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 3B.
   - YES, BUT NOT APPLICABLE TO THIS CLAIM.

8. POLICY NUMBER:

9. MEDICAL BILLING ADDRESS (APPROX LABEL HERE):

10. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY OR INJURY?

   - NO
   - YES

11. IS TREATMENT A RESULT OF OTHER ACCIDENT?

   - NO
   - YES

12. DENTIST SOC. SEC. NO. OR TIN:

13. DENTIST LC. NUMBER:

14. IF PROPSISIS IS THIS INITIAL PLACEMENT?

   - NO
   - YES

15. DATE OF PRIOR PLACEMENT:

16. DOES PATIENT HAVE A COMPLAINT OR INTEREST IN TREATMENT PLAN?

   - NO
   - YES

17. THIS PATIENT REFERRED BY:

18. MEDICARE PROVIDER NO.

19. PRIMARY DIAGNOSIS:

20. SECONDARY DIAGNOSIS:

21. IF PROPSISIS, GIVE NAME AND ADDRESS OF SUPPLYING LABORATORY:

22. PRIOR AUTHORIZATION NUMBER:

23. PATIENT ACCOUNT NUMBER:

24. P.D.O.T. REFERRAL:

25. IDENTIFY MISSING TEETH WITH ‘X’:

26. EXAMINATION AND TREATMENT PLAN:

   - LIST OF TOOTH NO. OR LETTER, SURFACE CODE, DESCRIPTION OF SERVICE INCLUDING TOOTH PROPERTIES, MATERIALS USED, ETC.
   - DATE SERVICE PERFORMED
   - DENTAL CODE
   - CHARGE

27. REMARKS:

28. PROVIDER CERTIFICATION:

29. LESS AMOUNT PAID OR OTHER AMOUNT:

30. NET CHARGES:

31. POSSIBLE CHILD ABUSE: }

**CODE OF STATE REGULATIONS** *(1/5/93)*

Roy D. Blunt
Secretary of State
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
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.

### GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1. INITIAL/CHANGE</td>
<td>2. NAME (LAST, FIRST, MIDDLE)</td>
</tr>
<tr>
<td>3. DATE OF BIRTH</td>
<td>4. ADDRESS (STREET, CITY, STATE, ZIP CODE)</td>
</tr>
<tr>
<td>5. MEDICAID NUMBER</td>
<td>6. DIAGNOSIS CODE</td>
</tr>
<tr>
<td>7. DIAGNOSIS DESCRIPTION</td>
<td>9. NAME &amp; ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE</td>
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### HCY (EPSDT) SERVICE REQUEST

<table>
<thead>
<tr>
<th>Field</th>
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<tr>
<td>10. DATE OF HCY SCREEN</td>
<td>11. SCREENING FULL INTERPERIODIC PARTIAL</td>
</tr>
<tr>
<td>12. TYPE OF PARTIAL HCY SCREEN</td>
<td>13. SCREENING PROVIDER NAME</td>
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<tr>
<td>14. PROVIDER NUMBER</td>
<td>15. TELEPHONE NUMBER</td>
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### SERVICE INFORMATION

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<td>16. REF NO.</td>
<td>17. TYPE SERV.</td>
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<td>18. PROCEDURE CODE</td>
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<td>20. THROUGH</td>
<td>21. DESCRIPTION OF SERVICE/ITEM</td>
</tr>
<tr>
<td>22. UNITS</td>
<td>23. AMOUNT TO BE CHARGED</td>
</tr>
<tr>
<td>24. AMOUNT ALLOWED IF PRICED BY REPORT</td>
<td>25. APPL DENIED</td>
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### PROVIDER

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. PROVIDER NAME (APPLY LABEL HERE)</td>
<td>30. TELEPHONE</td>
</tr>
<tr>
<td>26. ADDRESS</td>
<td>31. ADDRESS</td>
</tr>
<tr>
<td>27. MEDICAID PROVIDER NUMBER</td>
<td>32. DATE DISABILITY BEGAN</td>
</tr>
<tr>
<td>28. SIGNATURE</td>
<td>33. PERIOD OF MEDICAL NEED IN MONTHS</td>
</tr>
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</table>

### V. PRESCRIBING/PERFORMING PRACTITIONER

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. NAME</td>
<td>34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER</td>
</tr>
<tr>
<td>35. SIGNATURE</td>
<td>36. DATE</td>
</tr>
</tbody>
</table>

### VI. FOR STATE OFFICE USE ONLY

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

**CODE OF STATE REGULATIONS**

(1/5/93) Roy D. Blunt
Secretary of State
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 diagnostic 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/yyyy format).
20. Through Date — Enter the date that services will terminate if authorization is approved (mm/dd/yyyy 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.

(Use 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/yyyy format. (Signature stamps are not acceptable)

VI. FOR STATE OFFICE USE ONLY

Approved or denied 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.

Roy D. Blunt (1/5/93) CODE OF STATE REGULATIONS
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.