State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 19 No. 57 **November 2009**

To: Federally Qualified Health Centers – **For Action**

Subject: Prior Authorization and Billing Procedures for Dental Encounter Visits Associated with Dental Services that require prior authorization

Purpose: To notify providers that Division of Medical Assistance and Health Services (DMAHS) has made revisions to prior authorization and claim submission protocols for the dental encounter code (D0120-22) when it is associated with prior authorized dental procedure codes. **(This replaces Newsletter Vol.18, No.16)**

Action: Effective October 2009

Prior Authorizations (see attachment A):

- Every prior authorization (PA) request must include the dental procedure code(s) and total number of encounters (D0120-22) needed to complete the service.
- When requesting prior authorization for root canals and/or crowns, one 2-part prior authorization form is needed for each tooth and should include all services needed to restore that tooth (see attachment A-1)
- Maxillary (upper) and mandibular (lower) denture(s) can be requested on the same PA with the requested number of encounter visits (see attachment A-2)
- If the dental service(s) is/are denied or modified, the dental encounter visit(s) will also be denied or the number of units may be modified.

Prior authorizations submitted without the associated dental encounter visit(s) will be returned for correction

Dental Claims – electronic or paper (see attachment B):

- The claim submitted for the first date of service must have:
  Prior authorization number in the upper right corner
  The dental procedure code(s)
  The dental encounter code
  See attachments B-1 (a) and B-1 (b);
- The subsequent claims must have the prior authorization number and only the dental encounter code. DO NOT SUBMIT THE ASSOCIATED DENTAL PROCEDURE CODES ON THE SUBSEQUENT CLAIMS. *See attachments B-2(a) and B-2(b);*
- Subsequent dental encounters can be billed for multiple visits on the same claim form or on separate claim forms and must have the correct prior authorization number for the respective dental services and dental encounter visits as approved.

If you have any questions regarding this information, please call 1-800-776-6334 for assistance.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE
Attachments A-1 & 2

PRIOR AUTHORIZATIONS

1 - Prior Authorization to include all encounter visits associated with the requested dental services.*

2 - Prior Authorization per tooth for all dental services and all encounter visits needed for these services on one PA.*

*ALL prior authorizations shall include all needed films and/or documentation.

Recommended number of dental encounters for dental procedures:

Crowns	Up to 3
Endodontics	Up to 5, based on tooth type
One Denture*	Up to 6
Two Dentures*	Up to 8
Denture Repairs (lab)	Up to 2 visits
Occlusal Guards	Up to 2 visits

*Partial or Complete

DENTAL PRIOR AUTHORIZATION
Attachment A-1

PA# 1100123456

1. Recipient's Last Name: DOE — First Name: JANE — MI: L
2. Recipient's Street Address: 326 MAIN STREET — Telephone Number: 2019993333
3. HSP (MEDICAID) Case No.: 4830000912
4. Person No.: 02
5. Date of Birth: 020136
6. Sex: ☐ Male ☒ Female

City: ANYTOWN — State: NJ — ZIP Code: 07871

7. Other Dental Insurance or Liability Coverage? ☐ YES ☒ NO
If YES, attach copy of Decline Notice or Explanation of Payment from Carrier
Carrier Codes ___, ___, ___,
No Fault Auto Coverage ☐ YES ☐ NO

8. Was patient's illness connected with employment? ☐ YES ☒ NO
If Yes, give Name and Address of Employer here
Did injury result from an automobile accident? ☐ YES ☒ NO

9. Was this service performed as a result of an EPSDT Program Referral? ☐ YES ☒ NO

10. Existing or previous Dentures? ☐ YES ☒ NO

	PARTIAL	FULL	DATE INSERTED
Mx			
Md			

11. Date of Initial Impressions
Maxillary ________________
Mandibular ________________
(Dentures, Appliances, Space Maintainers, Etc.)

12. **PROVIDER OF SERVICE INFORMATION**

Telephone Number: 2019891211

Medicaid Provider Number (Enter only when not printed below): 1234567

Names and Address

HAPPY FAMILY HEALTH CARE CENTER
29 CENTER PLACE
ANYTOWN NJ 07871

13. Number of X-rays
Pretreatment: 16
Post-treatment: ______

14. Is this a referral? ☐ YES ☒ NO
NAME — If Yes, Referring Practitioner #:

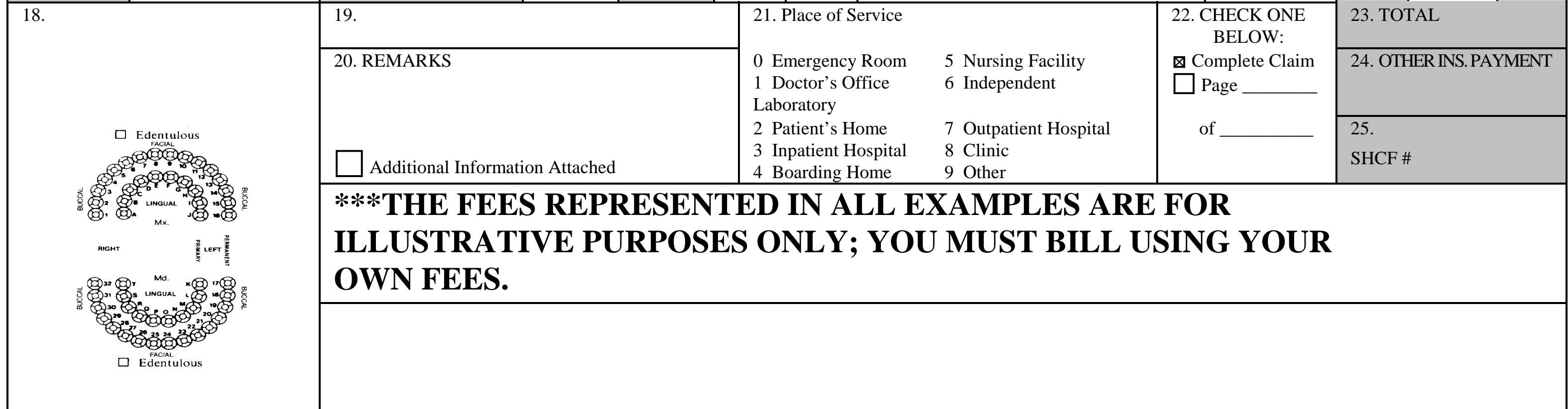
15A. Date of Initial Preparation(s) (Crowns)
Place tooth code in box.

15B. Date of Initial Treatment(s) (Endodontic)
Place tooth code in box.

16. Reviewer ID — Review Date — AGENCY USE ONLY

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 11 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A. Date of Services MO | DAY | YR	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F. Tooth Code	G. Tooth Surface	H. Description of Service	I. TOTAL FEE REQUESTED	J.	K. Place of Service	L.
	D5110		1				Complete Upper	1000.00			
	D5120		1				Complete Lower	1000.00			
	D0120-22		8				ENCOUNTERS	900.00			



18. ☐ Edentulous / ☐ Edentulous

19.

20. REMARKS
☐ Additional Information Attached

21. Place of Service
0 Emergency Room
1 Doctor's Office
2 Patient's Home
3 Inpatient Hospital
4 Boarding Home
5 Nursing Facility
6 Independent Laboratory
7 Outpatient Hospital
8 Clinic
9 Other

22. CHECK ONE BELOW:
☒ Complete Claim
☐ Page ________ of __________

23. TOTAL

24. OTHER INS. PAYMENT

25. SHCF #

*****THE FEES REPRESENTED IN ALL EXAMPLES ARE FOR ILLUSTRATIVE PURPOSES ONLY; YOU MUST BILL USING YOUR OWN FEES.**

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

DENTAL PRIOR AUTHORIZATION
Attachment A-2

PA# 1100123789

1. Recipient's Last Name: DOE — First Name: JOHN — MI: L
2. Recipient's Street Address: 326 MAIN STREET — Telephone Number: 2019993333
3. HSP (MEDICAID) Case No.: 4830000912
4. Person No.: 01
5. Date of Birth: 020135
6. Sex: ☒ Male ☐ Female

City: ANYTOWN — State: NJ — ZIP Code: 07871

7. Other Dental Insurance or Liability Coverage? ☐ YES ☒ NO
If YES, attach copy of Decline Notice or Explanation of Payment from Carrier
Carrier Codes ___, ___, ___,
No Fault Auto Coverage ☐ YES ☐ NO

8. Was patient's illness connected with employment? ☐ YES ☒ NO
If Yes, give Name and Address of Employer here
Did injury result from an automobile accident? ☐ YES ☒ NO

9. Was this service performed as a result of an EPSDT Program Referral? ☐ YES ☒ NO

10. Existing or previous Dentures? ☐ YES ☒ NO

	PARTIAL	FULL	DATE INSERTED
Mx			
Md			

11. Date of Initial Impressions
Maxillary ___________
Mandibular ___________
(Dentures, Appliances, Space Maintainers, Etc.)

12. **PROVIDER OF SERVICE INFORMATION**
Telephone Number: 2019891211
Medicaid Provider Number (Enter only when not printed below): 1234567
Names and Address:
HAPPY FAMILY HEALTH CARE CENTER
29 CENTER PLACE
ANYTOWN NJ 07871

13. Number of X-rays
Pretreatment: 16
Post-treatment:

14. Is this a referral? ☐ YES ☒ NO
NAME — If Yes, Referring Practitioner #:

15A. Date of Initial Preparation(s) (Crowns)
Place tooth code in box.

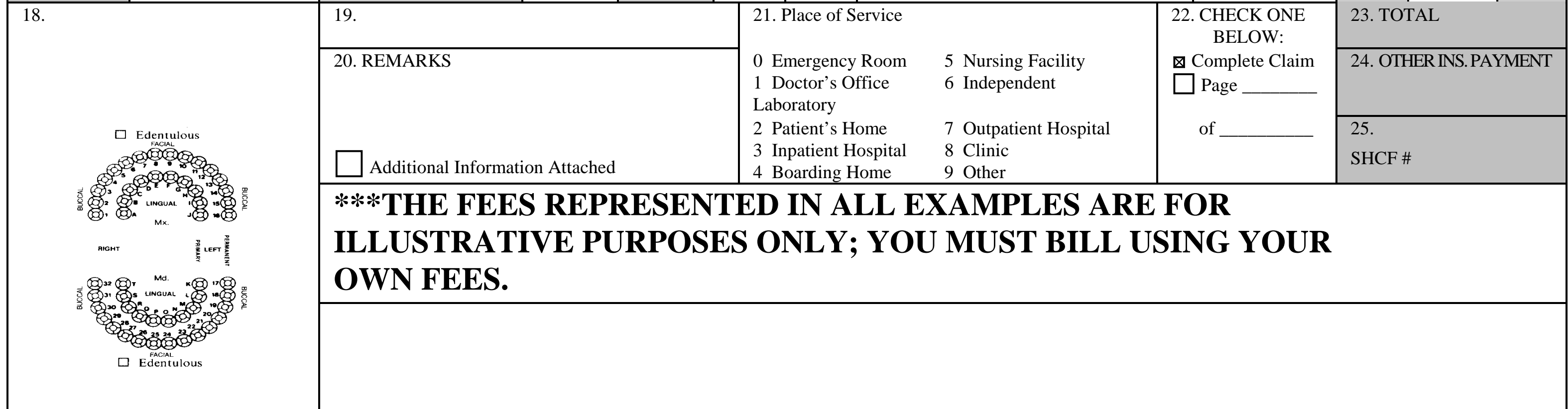
15B. Date of Initial Treatment(s) (Endodontic)
Place tooth code in box.

16. Reviewer ID — Review Date

AGENCY USE ONLY

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 11 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A. Date of Services MO / DAY / YR	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F. Tooth Code	G. Tooth Surface	H. Description of Service	I. TOTAL FEE REQUESTED	J.	K. Place of Service	L.
	D3320		1		12		RCT	500.00			
	D2954		1		12		Post & Core	100.00			
	D2752		1		12		Crown PFM	600.00			
	D0120-22		6				ENCOUNTERS	1200.00			


18.
☐ Edentulous
☐ Edentulous

19.

20. REMARKS
☐ Additional Information Attached

21. Place of Service
0 Emergency Room
1 Doctor's Office
2 Patient's Home
3 Inpatient Hospital
4 Boarding Home
5 Nursing Facility
6 Independent Laboratory
7 Outpatient Hospital
8 Clinic
9 Other

22. CHECK ONE BELOW:
☒ Complete Claim
☐ Page ________ of ________

23. TOTAL

24. OTHER INS. PAYMENT

25. SHCF #

*****THE FEES REPRESENTED IN ALL EXAMPLES ARE FOR ILLUSTRATIVE PURPOSES ONLY; YOU MUST BILL USING YOUR OWN FEES.**

Attachments B - 1 & 2

DENTAL CLAIMS

1 – Request for the first encounter visit and the associated dental procedure code with the PA number noted.

2 – Request for subsequent encounter visits associated with the dental service and the PA number. DO NOT REPORT the dental procedure code on your subsequent claims for this service.

The fees indicated in the “Total Fee Requested” section of Field 17-I on the attachments are only examples; YOUR FEES should be indicated when submitting your prior authorization request/claim.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

DENTAL CLAIM
ATTACHMENT B-1(a)

PA# 1100123456

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address	Telephone Number
DOE	JANE	R	326 MAIN STREET	2019993333

3. HSP (MEDICAID) Case No.	4. Person No.	5. Date of Birth	6. Sex	City	State	ZIP Code
4830000912	02	020136	☐ Male ☒ Female	ANYTOWN	NJ	07871

7. Other Dental Insurance or Liability Coverage? ☐ YES ☒ NO
If YES, attach copy of Decline Notice or Explanation of Payment from Carrier
Carrier Codes ___, ___, ___,
No Fault Auto Coverage ☐ YES ☐ NO

8. Was patient's illness connected with employment? ☐ YES ☒ NO
If Yes, give Name and Address of Employer here
Did injury result from an automobile accident? ☐ YES ☒ NO

9. Was this service performed as a result of an EPSDT Program Referral? ☐ YES ☒ NO

10. Existing or previous Dentures? ☐ YES ☒ NO

	PARTIAL	FULL	DATE INSERTED
Mx			
Md			

11. Date of Initial Impressions
Maxillary __________________
Mandibular __________________
(Dentures, Appliances, Space Maintainers, Etc.)

13. Number of X-rays
Pretreatment ________
Post-treatment ________

14. Is this a referral? ☐ YES ☒ NO
NAME
If Yes, Referring Practitioner #:

12. **PROVIDER OF SERVICE INFORMATION**

Telephone Number
2019891211

Medicaid Provider Number
(Enter only when not printed below)
1234567

Names and Address

HAPPY FAMILY HEALTH CARE CENTER
29 CENTER PLACE
ANYTOWN NJ 07871

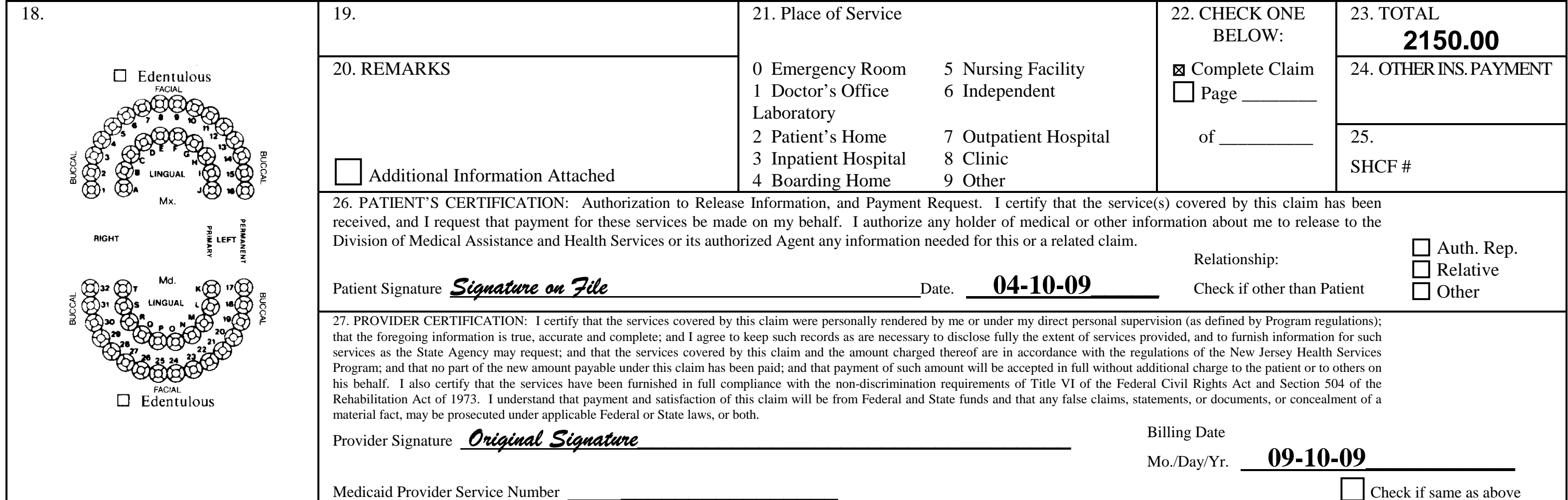
15A. Date of Initial Preparation(s) (Crowns)
Place tooth code in box.

15B. Date of Initial Treatment(s) (Endodontic)
Place tooth code in box.

16. Reviewer ID | Review Date | AGENCY USE ONLY

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 11 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A. Date of Services MO | DAY | YR	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F. Tooth Code	G. Tooth Surface	H. Description of Service	I. TOTAL FEE REQUESTED	J.	K. Place of Service	L.
090909	D0120-22		1				ENCOUNTER	150.00		8	
090909	D5110		1				COMPLETE UPPER	1000.00		8	
090909	D5120		1				COMPLETE LOWER	1000.00		8	



18.
☐ Edentulous

☐ Edentulous

19.

20. REMARKS
☐ Additional Information Attached

21. Place of Service
0 Emergency Room
1 Doctor's Office
2 Patient's Home
3 Inpatient Hospital
4 Boarding Home
5 Nursing Facility
6 Independent Laboratory
7 Outpatient Hospital
8 Clinic
9 Other

22. CHECK ONE BELOW:
☒ Complete Claim
☐ Page ________ of __________

23. TOTAL
2150.00

24. OTHER INS. PAYMENT

25.
SHCF #

26. PATIENT'S CERTIFICATION: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agent any information needed for this or a related claim.

Patient Signature *Signature on File* Date. 04-10-09

Relationship:
Check if other than Patient
☐ Auth. Rep.
☐ Relative
☐ Other

27. PROVIDER CERTIFICATION: I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State Agency may request; and that the services covered by this claim and the amount charged thereof are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the new amount payable under this claim has been paid; and that payment of such amount will be accepted in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

Provider Signature *Original Signature*

Billing Date
Mo./Day/Yr. 09-10-09

Medicaid Provider Service Number ____________

☐ Check if same as above

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

DENTAL CLAIM
ATTACHMENT B-2(a)

PA# 1100123789

1. Recipient's Last Name: DOE | First Name: JOHN | MI: L
2. Recipient's Street Address: 326 MAIN STREET | Telephone Number: 2019993333
3. HSP (MEDICAID) Case No.: 4830000912 | 4. Person No.: 01 | 5. Date of Birth: 020135 | 6. Sex: ☒ Male ☐ Female
City: ANYTOWN | State: NJ | ZIP Code: 07871

7. Other Dental Insurance or Liability Coverage? ☐ YES ☒ NO
If YES, attach copy of Decline Notice or Explanation of Payment from Carrier
Carrier Codes ___, ___, ___,
No Fault Auto Coverage ☐ YES ☐ NO

8. Was patient's illness connected with employment? ☐ YES ☒ NO
If Yes, give Name and Address of Employer here
Did injury result from an automobile accident? ☐ YES ☒ NO

9. Was this service performed as a result of an EPSDT Program Referral? ☐ YES ☒ NO

10. Existing or previous Dentures? ☐ YES ☒ NO

	PARTIAL	FULL	DATE INSERTED
Mx			
Ml			

11. Date of Initial Impressions
Maxillary ________
Mandibular ________
(Dentures, Appliances, Space Maintainers, Etc.)

12. **PROVIDER OF SERVICE INFORMATION**
Telephone Number: 2019891211
Medicaid Provider Number (Enter only when not printed below): 1234567
Names and Address:
HAPPY FAMILY HEALTH CARE CENTER
29 CENTER PLACE
ANYTOWN NJ 07871

13. Number of X-rays
Pretreatment ____
Post-treatment ____

14. Is this a referral? ☐ YES ☒ NO
NAME | If Yes, Referring Practitioner #:

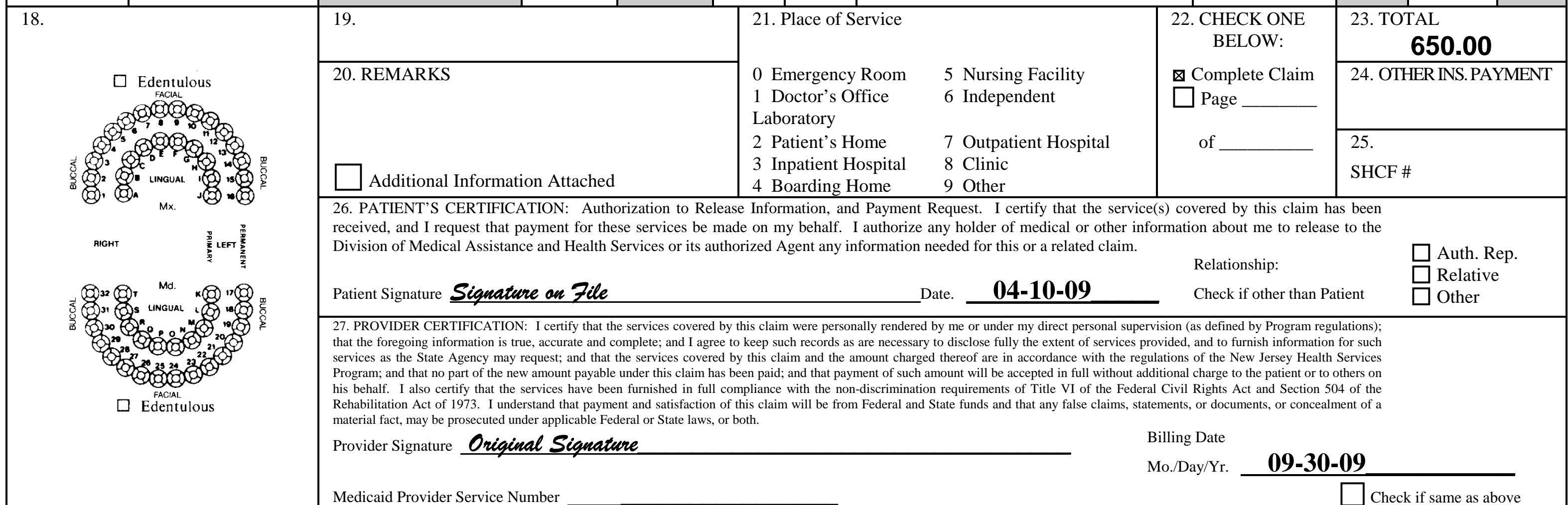
15A. Date of Initial Preparation(s) (Crowns)
Place tooth code in box.

15B. Date of Initial Treatment(s) (Endodontic)
Place tooth code in box.

16. Reviewer ID | Review Date | AGENCY USE ONLY

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 11 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A. Date of Services MO | DAY | YR	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F. Tooth Code	G. Tooth Surface	H. Description of Service	I. TOTAL FEE REQUESTED	J.	K. Place of Service	L.
090809	D3320		1		12		RCT	500.00		8	
090809	D0120-22		1				ENCOUNTER	150.00		8	



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☐ Edentulous

☐ Edentulous

19.

20. REMARKS
☐ Additional Information Attached

21. Place of Service
0 Emergency Room
1 Doctor's Office
2 Patient's Home
3 Inpatient Hospital
4 Boarding Home
5 Nursing Facility
6 Independent Laboratory
7 Outpatient Hospital
8 Clinic
9 Other

22. CHECK ONE BELOW:
☒ Complete Claim
☐ Page ____ of ____

23. TOTAL 650.00
24. OTHER INS. PAYMENT
25. SHCF #

26. PATIENT'S CERTIFICATION: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agent any information needed for this or a related claim.

Patient Signature *Signature on File* Date. 04-10-09

Relationship: Check if other than Patient ☐ Auth. Rep. ☐ Relative ☐ Other

27. PROVIDER CERTIFICATION: I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State Agency may request; and that the services covered by this claim and the amount charged therefor are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the new amount payable under this claim has been paid; and that payment of such amount will be accepted in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

Provider Signature *Original Signature*

Billing Date Mo./Day/Yr. 09-30-09

Medicaid Provider Service Number ________ ☐ Check if same as above

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

DENTAL CLAIM
ATTACHMENT B-1(b)

PA# 1100123456

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address	Telephone Number
DOE	JANE	R	326 MAIN STREET	2019993333

3. HSP (MEDICAID) Case No.	4. Person No.	5. Date of Birth	6. Sex	City	State	ZIP Code
4830000912	02	020136	☐ Male ☒ Female	ANYTOWN	NJ	07871

7. Other Dental Insurance or Liability Coverage? ☐ YES ☒ NO
If YES, attach copy of Decline Notice or Explanation of Payment from Carrier

Carrier Codes ___, ___, ___,
No Fault Auto Coverage ☐ YES ☐ NO

8. Was patient's illness connected with employment? ☐ YES ☒ NO
If Yes, give Name and Address of Employer here
Did injury result from an automobile accident? ☐ YES ☒ NO

9. Was this service performed as a result of an EPSDT Program Referral? ☐ YES ☒ NO

10. Existing or previous Dentures? ☐ YES ☒ NO

	PARTIAL	FULL	DATE INSERTED
Mx			
Md			

11. Date of Initial Impressions
Maxillary ___________
Mandibular ___________
(Dentures, Appliances, Space Maintainers, Etc.)

12. **PROVIDER OF SERVICE INFORMATION**

Telephone Number
2019891211

Medicaid Provider Number
(Enter only when not printed below)
1234567

Names and Address

HAPPY FAMILY HEALTH CARE CENTER
29 CENTER PLACE
ANYTOWN NJ 07871

13. Number of X-rays
Pretreatment ______
Post-treatment ______

14. Is this a referral? ☐ YES ☒ NO
NAME
If Yes, Referring Practitioner #:

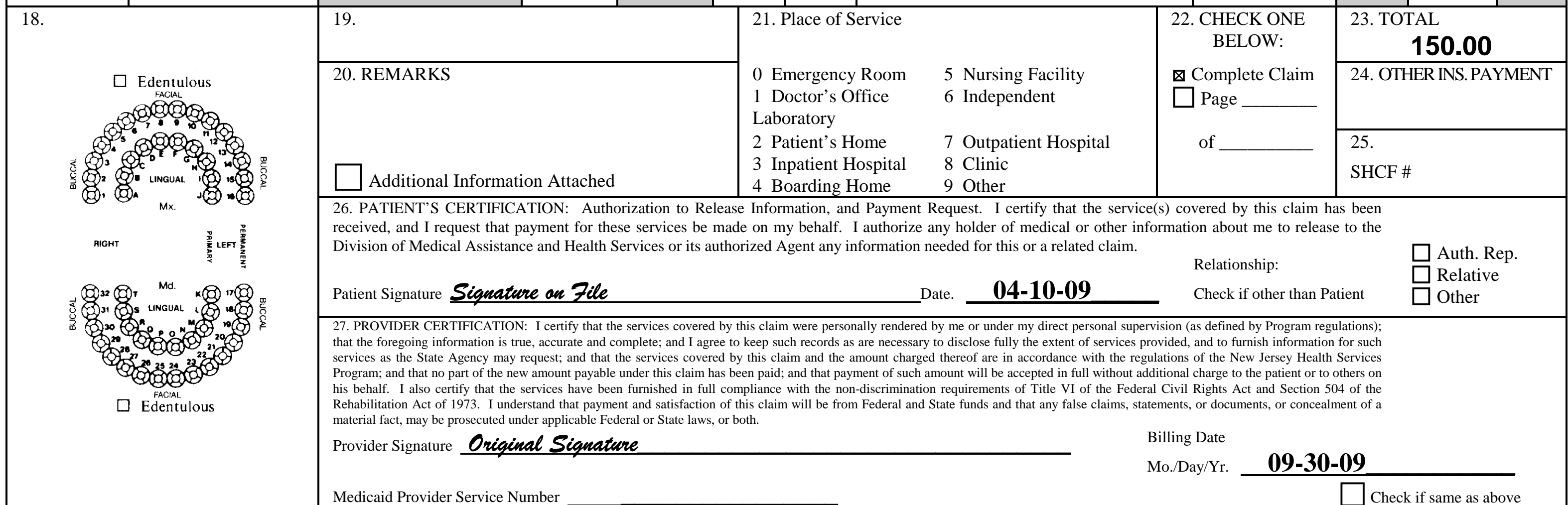
15A. Date of Initial Preparation(s) (Crowns)
Place tooth code in box.

15B. Date of Initial Treatment(s) (Endodontic)
Place tooth code in box.

16. Reviewer ID | Review Date | AGENCY USE ONLY

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 11 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A. Date of Services MO | DAY | YR	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F. Tooth Code	G. Tooth Surface	H. Description of Service	I. TOTAL FEE REQUESTED	J.	K. Place of Service	L.
092909	D0120-22		1				ENCOUNTER	150.00		8	



18.
☐ Edentulous
☐ Edentulous

19.

20. REMARKS
☐ Additional Information Attached

21. Place of Service
0 Emergency Room
1 Doctor's Office
2 Patient's Home
3 Inpatient Hospital
4 Boarding Home
5 Nursing Facility
6 Independent Laboratory
7 Outpatient Hospital
8 Clinic
9 Other

22. CHECK ONE BELOW:
☒ Complete Claim
☐ Page _______ of _________

23. TOTAL
150.00

24. OTHER INS. PAYMENT

25.
SHCF #

26. PATIENT'S CERTIFICATION: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agent any information needed for this or a related claim.

Patient Signature *Signature on File* Date. 04-10-09

Relationship:
Check if other than Patient
☐ Auth. Rep.
☐ Relative
☐ Other

27. PROVIDER CERTIFICATION: I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State Agency may request; and that the services covered by this claim and the amount charged thereof are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the new amount payable under this claim has been paid; and that payment of such amount will be accepted in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

Provider Signature *Original Signature*

Billing Date
Mo./Day/Yr. 09-30-09

Medicaid Provider Service Number ______________
☐ Check if same as above

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

DENTAL CLAIM
ATTACHMENT B-2 (b)

PA# *1100123789*

1. Recipient's Last Name	First Name	MI	2. Recipient's Street Address	Telephone Number
DOE	JOHN	L	326 MAIN STREET	2019993333

3. HSP (MEDICAID) Case No.	4. Person No.	5. Date of Birth	6. Sex	City	State	ZIP Code
4830000912	01	020135	☒ Male ☐ Female	ANYTOWN	NJ	07871

7. Other Dental Insurance or Liability Coverage? ☐ YES ☒ NO
If YES, attach copy of Decline Notice or Explanation of Payment from Carrier

Carrier Codes ___, ___, ___,

No Fault Auto Coverage ☐ YES ☐ NO

8. Was patient's illness connected with employment? ☐ YES ☒ NO
If Yes, give Name and Address of Employer here
Did injury result from an automobile accident? ☐ YES ☒ NO

9. Was this service performed as a result of an EPSDT Program Referral? ☐ YES ☒ NO

10. Existing or previous Dentures? ☐ YES ☒ NO

	PARTIAL	FULL	DATE INSERTED
Mx			
Md			

11. Date of Initial Impressions
Maxillary ________________
Mandibular ________________
(Dentures, Appliances, Space Maintainers, Etc.)

13. Number of X-rays
Pretreatment ________
Post-treatment ________

14. Is this a referral? ☐ YES ☒ NO
NAME
If Yes, Referring Practitioner #:

12. **PROVIDER OF SERVICE INFORMATION**

Telephone Number
2019891211

Medicaid Provider Number
(Enter only when not printed below)
1234567

Names and Address

HAPPY FAMILY HEALTH CARE CENTER
29 CENTER PLACE
ANYTOWN NJ 07871

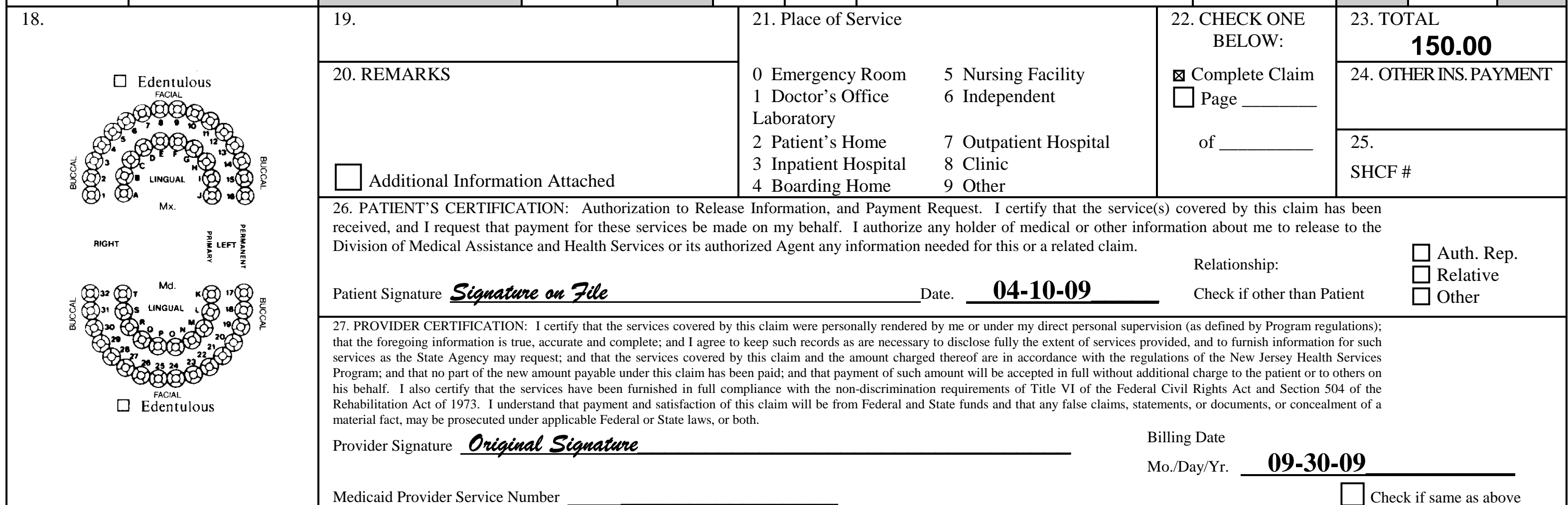
15A. Date of Initial Preparation(s) (Crowns)
Place tooth code in box.

15B. Date of Initial Treatment(s) (Endodontic)
Place tooth code in box.

16. Reviewer ID | Review Date | AGENCY USE ONLY

17. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 11 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A. Date of Services MO | DAY | YR	B. PROCEDURE & MODIFIER CODE REQUESTED	C. PROCEDURE & MODIFIER CODE APPROVED	D. Units Requested	E. Units Approved	F. Tooth Code	G. Tooth Surface	H. Description of Service	I. TOTAL FEE REQUESTED	J.	K. Place of Service	L.
092309	D0120-22		1				ENCOUNTER	150.00		8	



18.
☐ Edentulous
FACIAL
BUCCAL LINGUAL BUCCAL
Mx.
RIGHT PRIMARY PERMANENT LEFT
Md.
BUCCAL LINGUAL BUCCAL
FACIAL
☐ Edentulous

19.

20. REMARKS

☐ Additional Information Attached

21. Place of Service
0 Emergency Room
1 Doctor's Office
2 Patient's Home
3 Inpatient Hospital
4 Boarding Home
5 Nursing Facility
6 Independent Laboratory
7 Outpatient Hospital
8 Clinic
9 Other

22. CHECK ONE BELOW:
☒ Complete Claim
☐ Page ________ of __________

23. TOTAL
150.00

24. OTHER INS. PAYMENT

25.
SHCF #

26. PATIENT'S CERTIFICATION: Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agent any information needed for this or a related claim.

Patient Signature *Signature on File* Date. 04-10-09

Relationship:
Check if other than Patient
☐ Auth. Rep.
☐ Relative
☐ Other

27. PROVIDER CERTIFICATION: I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State Agency may request; and that the services covered by this claim and the amount charged thereof are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the new amount payable under this claim has been paid; and that payment of such amount will be accepted in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws, or both.

Provider Signature *Original Signature*

Billing Date
Mo./Day/Yr. 09-30-09

Medicaid Provider Service Number ______

☐ Check if same as above