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

NEWSLETTER

Volume 2 No. 24

May 1992

TO: Dentists, Independent Clinics
Chief Executive Officers - Hospitals

SUBJECT: Using the Revised Dental Services Form (MC-10 (REV.9/91))

A. How to Obtain Prior Authorization

B. The Prior Authorization Process

C. How to Bill for Prior Authorized Services

D. How to Bill for Services Which Do Not Require Authorization

The Medicaid Dental Services Form (REV. 9/91), a two-ply form, serves both as a prior authorization and a claim form. Each ply has a fixed purpose. The plies are not interchangeable, i.e. they can be used only for the one intended purpose.

The top page of this two-ply form is entitled Dental Prior Authorization - MC-10 (A) (REV.9/91) - Part 1 of 2.

The second page of the two-ply form is entitled Dental Claim Form - MC-10 (REV.9/91) - Part 2 of 2.

In order to assist dental service providers in the completion and disposition of the newly revised dental services form, the Division of Medical Assistance and Health Services is issuing the following instructions. Please maintain these instructions in your files for future reference.

INSTRUCTIONS

A. How to Obtain Prior Authorization

1. When requesting prior authorization, **BOTH** plies (pages) of the Dental Form must be submitted with radiographs to:

   Dental Claims Review Unit
   Bureau of Dental Services
   CN-713
   Trenton, N. J. 08625-0713

   Do not separate the two-plies of the Dental Form when requesting prior authorization.

2. Fill in white areas only. **DO NOT** write in shaded areas.

3. Enter only one (1) dental service per line, i.e., a maximum of only eleven (11) claim detail lines for each Dental Services Claim Form.

4. Items 1 through 15B. Complete all recipient and provider information; answer all questions as appropriate.

5. Item 17B. Enter correct five (5) digit procedure code. Select codes from Subchapter 3 of the Medicaid Dental Services Manual. See Exhibit PA-1. Neither the CPT-4 codes nor HCFA codes (D Series) can be accepted.

6. Item 17D. Enter the number of units of service requested. Most procedure codes are limited to one (1) unit of service. For exceptions, see Exhibit A (attached).

7. Item 17F. Enter the Tooth Code, when appropriate. The only entries should be 01 to 32, or A to T. In the case of a supernumerary tooth, the designation SN should be used. Item 17F should never have more than one tooth code entered. When billing for a service not specific to a single tooth number, no entry is to be made.

8. Item 17G. Enter Tooth Surface designation, when appropriate, only as follows:

M - Mesial	L - Lingual
D - Distal	I - Incisal
O - Occlusal	B - Buccal (Facial)

   <u>F</u> - For Facial is not acceptable at this time.

   See #9 below.

9. The tooth code and tooth surface fields on the Dental Form should have only those designations noted in #7 and #8 above. Entries such as 00, UR, UL, LR, and LL as well as MX, MD and EXT will cause the claim to reject from the system. These designations should be entered in Descript ion of Service only (Field 17H).

10. Item 17H. Enter Description of Service. Here, enter a quadrant designation (UR,UL,LR,or LL), an arch designation (MX or MD), (U or L), type of service (crown- CR, filling-AM or composite-COMP), and/or other descriptive data. As noted in #9 above, do not enter this data in the Tooth Code or Tooth Surface fields (17F,17G).

11. Item 17I. Enter total fee requested using dollars, decimal and cents. The dollar sign is not required. For example: 7.00, 201.00, 595.00, etc. Please be advised that failure to enter the charge showing both dollars and cents will result in incorrect payments. For example: $25 charge is to be entered as 25.00 on the Claim Form. Coding this charge as 25. or 25-- will result in the significant underpayment of your claim.

12. Item 18. Complete charting. As a minimum, chart missing teeth and teeth to be extracted.

13. The prior authorization request should NOT be signed by either the recipient (patient) or the provider of service (dentist). The signatures are required ONLY when billing on the MC-10, Page 2 of 2.

14. Prior authorization requests should NEVER be sent to Unisys/Paramax.

15. Radiographs should NEVER be sent to Unisys/Paramax.

16. Do not write notes or comments on the Prior Authorization form except in Items 19 and/or 20. Attach additional comments on an extra sheet of paper, if you wish to give the Dental Consultant more information.

B. <u>The Prior Authorization Process</u>

1. Following receipt of the prior authorization request at the Dental Claim Review Unit, it will be reviewed and services may be authorized, modified or denied.

2. The top copy (Dental Prior Authorization - MC-10(A) - Part 1 of 2) will be removed and sent by the Dental Unit to Unisys/Paramax, where the information will be entered into the Prior Authorization Module. This will generate a letter

from Unisys/Paramax notifying the dentist officially of the status of each detail line (service) for which prior authorization was requested.

Concurrently, the Dental Claims Review Unit will return to the dentist the second ply (Dental Claim-Part 2 of 2) with the appropriate action in the status column (17L), with the radiographs attached.

Occasionally, a request for prior authorization may be suspended for further review by the State or for correction by the provider. Please follow the instructions on the Prior Authorization Correction Form, which is generated by Unisys/Paramax, and forward the form as directed.

C. How to Bill for Prior Authorized Services

1. Item 17A. - Following completion of any of the services which required prior authorization, enter all dates of service in month, day, and year sequence, using six digits, e.g., February 9, 1992, should be entered as 02/09/92. DO NOT use ditto marks, lines, arrows, or the words, "same as above". Draw a line through any services for which a claim has already been submitted for payment, and also, for those services which have been prior authorized, but not yet completed.

2. Enter the Place of Service on each line in Item 17K, using the information found in Item 21, e.g., the doctor's office is 1.

3. Make certain the prior authorization number is entered in the upper right hand corner of the page. This is found on the original Prior Authorization or on page 2 of the Notification Letter (FD-360) received from Unisys/Paramax.

4. Item 22. Check "complete claim" or "page information", e.g., 1 of 2 (See Exhibits B-1, B-2, B-3)

5. Item 23. Total each page separately and enter the total charge in this field.

6. Item 26. Upon completion of treatment, have the patient sign and date the Claim Form. If the patient is not available, and you have the patient's "signature on file", enter "Patient signature on File" on the dental claim. Another alternative is to sign "Patient not available", and have either the doctor or the office manager sign, date and note his or her title.

7. Item 27. All submissions for payment "shall be manually signed by the patient's treating dentist. The form may be completed by an employee for the signature of the treating dentist, but the treating dentist shall be responsible for the accuracy of all information contained on the form. In the event the patient is treated by more than one dentist in a multi-dentist practice, the duty to verify the accuracy of the information on the form and to manually sign the form shall be that of the designated dentist of record pursuant to N.J.A.C. 13:30-8.17" (Board of Dentistry Statutes and Regulations - N.J.A.C. 13:30-8.10).

   The statement about signatures does not apply "to an electronic method for claims submission. In that case, the treating dentist (or dentist of record if one is so designated pursuant to N.J.A.C. 13:30-8.17) shall review and manually sign a written confirmation of the accuracy of the claim data no less frequently than every three months. The dentist shall keep copies of such written confirmation on file for a period of seven years." (N.J.A.C. 13:30-8.10(e)).

   "Any dentist who verifies claim data ...... is responsible for all of the claim data submitted as if it were submitted and a form manually signed on an individual claim basis." (N.J.A.C. 13:30-8.10 (F)).

D. How to Bill for Services Which Do Not Require Authorization

1. Basically, the process is the same as billing for Prior Authorized Services (see C. above), however, no Prior Authorization number is required.

2. Discard the Prior Authorization page (Part 1 of 2) using the Dental Claim ONLY (Part 2 of 2). A photocopy of the Dental Claim (Part 2 of 2) may also be used.

3. The Prior Authorization page CANNOT be accepted for billing purposes.

4. Attached are sample Dental Claim Forms (Exhibits B-1, B-2, and B-3) filled out for submission for payment. Study them carefully and use as a guide when billing.

5. The Dental Claim or a photocopy thereof must have the original signature of the dentist when submitted for payment (See C.7 above). An original signature, or an approved alternative (See C.6 above) for the patient's signature must also appear on the Dental Claim.

Any Dental provider not having **Subchapter 3. (HCPCS Procedure Codes)**, may contact Unisys/Paramax at 1-800-776-6334 for a copy.

If you have questions regarding this Newsletter and its attachments, please contact Archie H. Bell, D.D.S., Chief, Bureau of Dental Services, CN-713, Trenton, N.J. 08625-0713 or contact him by telephone at 1-609-588-7136 or 1-800-782-0181.

Attachments:

Exhibit A
Exhibit PA-1
Exhibit B-1
Exhibit B-2
Exhibit B-3

Exhibit A

Units of Service

The following codes are the only codes where more than one (1) unit can be requested.

00230	Additional periapical and/or bitewing radiograph(s) 1 to 14 units (dependent upon age)
00240	Occlusal radiograph(s) - 1 or 2 units
00260	Additional extraoral radiograph(s) - 1 or 2 units
00470	Diagnostic casts - 1 or 2 units
00471	Diagnostic photographs - 1 to 8 units
Y2115	Tooth processed to Arch Bar, per tooth - 1 to 6 units
02951	Pin retention - 1 to 3 units
03411	Apicoectomy, additional roots - 1 to 2 units
03411 22	Apico/Endo, additional roots - 1 to 2 units
03430	Retrograde Filling(s) - 1 to 3 units
04210	Gingivectomy, per quadrant - 1 to 4 units
04220	Gingival curettage, per quadrant - 1 to 4 units
04260	Osseous Surgery, per quadrant - 1 to 4 units
04320	Provisional Splinting, Intracoronal, per tooth - 1 to 14 units
04321	Provisional Splinting, Extracoronal, per tooth - 1 to 14 units
04341	Periodontal scaling, etc., per quadrant - 1 to 4 units
Y2505	Immediate replacement, anterior teeth on partial denture - 1 to 6 units (List teeth numbers in Description of Service)

05520, 05640	Repair, additional tooth replacement - 1 to 6 units (List teeth numbers in Description of Service)
Y2510	Repair, additional clasp - 1 to 3 units (List teeth numbers in Description of Service)
07310, 07320	Alveoplasty, per quadrant - 1 to 4 units
07340, 07350	Vestibuloplasty, per quadrant - 1 to 4 units
07470	Removal of exostosis, per quadrant - 1 to 4 units
09220 22	Special anesthesia, basic - 4 units
09220 52	Special anesthesia, time - 1 to 8 units
09910	Application of Desensitizing Medicaments, per tooth - 1 to 14 units
09920	Behavior management, time - 1 to 8 units
09951	Occlusal adjustment, limited, per tooth - 1 to 3 units
09951 22	Occlusal adjustment, per quadrant - 1 to 4 units

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

"EXHIBIT B-2"
DENTAL CLAIM

PA# ____________

1. Recipient's Last Name: RECIPIENT — First Name: Shesa — MI: B.
2. Recipient's Street Address: 123 Rut Street — Telephone Number: 609 555-1111
3. HSP (MEDICAID) Case No.: 0 1 2 3 4 5 6 7 8 9 — 4. Person No.: 2 0 — 5. Date of Birth: 02 15 80 — 6. Sex: ☐ Male ☒ Female
City: Anytown, — State: N.J. — ZIP Code: 08519

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 or injury connected with employment? ☐ Yes XX No
If Yes, give Name and Address of Employer here
Did injury result from an automobile accident? ☐ Yes XX No

9. Was this service performed as a result of an EPSDT Program Referral? ☐ Yes XX 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: (609) 584-0200
Medicaid Provider Number (Enter only when not printed below): 1234567
Name and Address:
Michael Horton, D.D.S.
123 Blank Street
Anytown, N.J. 08619

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

14. Is this a Referral? ☐ Yes XX 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. CLAIM SERVICES DETAIL (MAXIMUM OF 11 SERVICES) — GRAY SHADED AREA FOR DIVISION USE ONLY

A. Dates of Service (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.
02/21/92	Y2965		1				Orthodontic Exam	6.00		1	
02/21/92	Y2975		1				Salzmann Assessment	6.00		1	
02/21/92	00470		2				Diagnostic Models	23.00		1	
02/21/92	00340-22		1				Cephalogram/Tracing	15.00		1	
02/21/92	00330		1				Panorex	10.00		1	
02/21/92	00471		5				5 Slides/Photos	5.00		1	
02/28/92	Y2910		1				Appliances	178.00		1	
03/15/92	Y2920		1				Monthly Adjustment	40.00		1	

18. ☐ Edentulous (Facial, Buccal, Lingual, Mx., Md., Right, Left) ☐ Edentulous

19.

20. REMARKS
Salzmann Attached (27 Points)
☐ 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
XX Complete Claim
☐ Page ___ Of ___

23. TOTAL 283.00

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 ____
Relationship (Check if other than Patient): ☐ Auth. Rep. ☐ Recipient ☐ 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 net 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 rendered 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: Michael Horton DDS — Billing Date Mo. Day Yr.: 03-20-92
Medicaid Provider Service Number ____ ☒ Check if same as above

MC-10 (REV. 9/91) — CLAIM FORM — Medicaid Part 2 of 2

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

"EXHIBIT B-3"

DENTAL CLAIM

PA#

1. Recipient's Last Name: RECIPIENT — First Name: Shesa — MI: B.
2. Recipient's Street Address: 123 Rut Street — Telephone Number: 609 555-1111
3. HSP (MEDICAID) Case No.: 0 1 2 3 4 5 6 7 8 9 — 4. Person No.: 2 0 — 5. Date of Birth: 02 15 80 — 6. Sex: ☐ Male ☒ Female
City: Anytown, — State: N.J. — ZIP Code: 08619

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 or injury 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: (609) 584-0200
Medicaid Provider Number (Enter only when not printed below): 1234567
Name and Address:
Michael Horton, D.D.S.
123 Blank Street
Anytown, N.J. 08619

13. Number of X-rays
Pre-treatment
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.

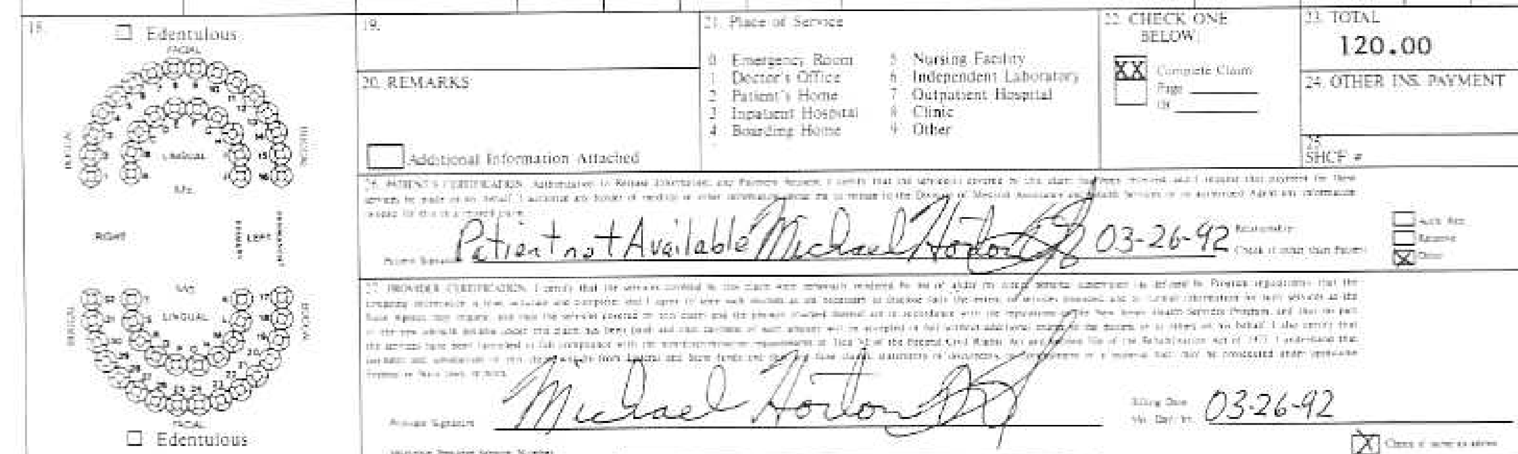
15B. Date of Initial Treatment(s) (Endodontic) Place tooth code in box.

16. Reviewer ID — Review Date

AGENCY USE ONLY

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

A. Dates of Service 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.
04/06/92	Y2920		1				Monthly Adjustment	40.00		1	
05/07/92	Y2920		1				Monthly Adjustment	40.00		1	
06/06/92	Y2920		1				Monthly Adjustment	40.00		1	



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: 120.00

24. OTHER INS. PAYMENT

25. SHCF #

26. PATIENT'S CERTIFICATION. Authorization to Release Information and Payment Request.

Patient Signature: Patient not Available Michael Horton DDS 03-26-92
Relationship (Check if other than Patient): ☐ Auth Rep ☐ Relative ☒ Other

27. PROVIDER CERTIFICATION.

Provider Signature: Michael Horton DDS
Billing Date Mo. Day Yr.: 03-26-92
☒ Check if same as above
Medicaid Provider Service Number

MC-10 (REV. 9/91) — CLAIM FORM — Medicaid Part 2 of 2

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

"EXHIBIT B-1"
DENTAL CLAIM

PA# 11-87654321

1. Recipient's Last Name: RECIPIENT — First Name: Ima — MI: B.
2. Recipient's Street Address: 123 Rut Street — Telephone Number: 609 555-1111
City: Anytown — State: NJ — ZIP Code: 08619
3. HSP (MEDICAID) Case No.: 0 1 2 3 4 5 6 7 8 9 — 4. Person No.: 0 1 — 5. Date of Birth: 02 15 61 — 6. Sex: ☐ Male ☒ Female
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 or injury 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.	X		04/01/82
Md.			

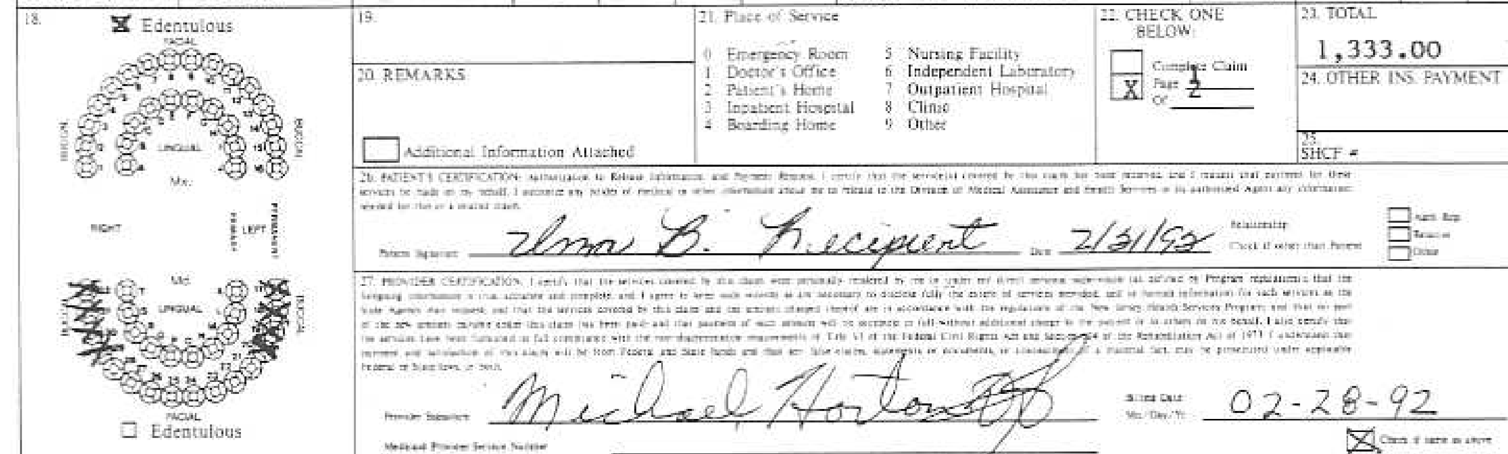
11. Date of Initial Impressions — Maxillary: 01/03/92 — Mandibular: (Dentures, Appliances, Space Maintainers, Etc.)

12. PROVIDER OF SERVICE INFORMATION
Telephone Number: (609) 584-0200
Medicaid Provider Number (Enter only when not printed below): 1234567
Name and Address:
Michael Horton, D.D.S.
123 Blank Street
Anytown, N.J. 98619

13. Number of X-rays — Pre-treatment: 10 — Post-treatment:
14. Is this a Referral? ☐ Yes ☒ No — If Yes, Referring Practitioner #: NAME
15A. Date of Initial Preparation(s) (Crowns) Place tooth code in box.
15B. Date of Initial Treatment(s) (Endodontic) Place tooth code in box. 28 01/06/92
16. Reviewer ID — Review Date — AGENCY USE ONLY

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

A. Dates of Service 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.
12/03/91	00110		1				Examination	30,00		1	
12/03/91	00220		1				First Xray	5.00		1	
12/03/91	00230		9				9 Add. Xrays	18.00		1	
01/08/92	07110		1		5		Extraction	25.00		1	
01/08/92	07210		1		11		Surgical Ext.	35.00		1	
01/15/92	02335		1		24	MIDL	Composite	75.00		1	
02/03/92	03320		1		28		Root Canal	195.00		1	
01/02/92	04341		2				LR/LL Perio Scaling & RP	150.00		1	
02/21/92	05110		1				Complete Denture-MAX	395.00		1	
02/21/92	Y2515 YU		1				Denture ID	10.00		1	
02/21/92	05214		1				Cast PL Denture	395.00		1	



18. ☒ Edentulous (Mx.) — ☐ Edentulous (Md.)
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 2 Of
23. TOTAL: 1,333.00
24. OTHER INS. PAYMENT
25. SHCF #
26. PATIENT'S CERTIFICATION — Patient Signature: Ima B. Recipient — Date: 2/21/92
27. PROVIDER CERTIFICATION — Provider Signature: Michael Horton — Billed Date Mo/Day/Yr: 02-28-92
Medicaid Provider Service Number — ☒ Check if same as above

MC-10 (REV. 9/91) — CLAIM FORM — Medicaid Part 2 of 2

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

"Exhibit PA-1"

DENTAL PRIOR AUTHORIZATION

PA# 11 00604352

1. Recipient's Last Name: RECIPIENT, First Name: Ura MI: A.
2. Recipient's Street Address: 123 Rut Street
Telephone Number: 609) 555-1111
3. HSP (MEDICAID) Case No.: 9 8 7 6 5 4 3 2 1 0
4. Person No.: 0 1
5. Date of Birth: 062441
6. Sex: ☐ Male ☒ Female
City: Anytown, NJ State ZIP Code: 08619

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 State Coverage ☐ Yes ☐ No

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

9. Was this service performed as a result of an EPSDT Program Referral? ☐ Yes XX 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: (609) 584-0200

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

Name and Address:
Michael Horton, D.D.S.
123 Blank Street
Anytown, N.J. 98619

13. Number of X-rays
Pretreatment: 7 + 1
Post-treatment: ______

14. Is this a Referral? ☐ Yes XX 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.	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. FEE APPROVED	K.	L. Status
	00110		1				Examination	30.00			
	00240		1				1 Occlusal Xray	10.00			
	00220		1				First Xray PA	5.00			
	00230		6				6 Additional Xrays	12.00			
	05110		1				Complete Max Dent.	395.00			
	Y2515YU		1				Max. Denture ID	10.00			
	02751		1		28		Crown - PFM	325.00			
	02150		1		19	MO	Amalgam	50.00