
CHAPTER 16: DENTAL SERVICES

APPENDIX G: PRIOR AUTHORIZATION CHECKLIST**PAGE(S) 2**

**Check List for Use Prior to Mailing a Medicaid Dental Prior Authorization Request
(Print or copy this page for your convenience)**

The information provided below will help you prevent errors frequently made when completing a Medicaid dental prior authorization (PA) request. For complete dental prior authorization guidelines, see the Prior Authorization section for the dental services program that applies.

- ☐ Are you using the 2006 American Dental Association (ADA) Claim Form when submitting a request to Medicaid for dental prior authorization? (Only this version is accepted.)
- ☐ Have you provided two identical copies of each ADA claim form being submitted?
- ☐ Has any information been placed in the upper right-hand corner of the claim (above the box labeled "Primary Subscriber Information")? (This area is for Medicaid use only and must be left blank.)
- ☐ Are you certain that the claim form is properly completed with provider name, group, and individual provider number, current provider address and phone number, recipient name and date of birth, etc.? (Each claim form submitted for dental prior authorization should be fully completed using the ADA Claim Form instructions within this chapter. If a service has not been delivered at the time of the request, leave the date of service blank. If a service has already been delivered, enter the correct date of service on the claim form.)
- ☐ Have you grouped together on the first lines of the claim form all services requiring prior authorization?
(Procedures that will be rendered and do not require prior authorization should be listed on the ADA claim form after those services requiring prior authorization so that the reviewer understands the full treatment plan.)
- ☐ Have you provided an explanation or reason for treatment in the remarks section of the claim form if the reason is not obvious from the radiographs? (Be certain to include the remarks on the same ADA claim form in which the treatment is being requested.)
- ☐ Have you included bitewing radiographs and any other required radiographs?
- ☐ Are the radiographs mounted so that each individual film is readily viewable and does the doctor's name, patient's name, and the date of the films appear on the mounting? (Radiographs MUST be mounted and MUST contain the identified information.)
- ☐ Are the mounted radiographs on the top of the EPSDT Dental Program the Adult Denture Program claims?

(The mounted radiographs MUST be on the top of the claim for prior authorization for these programs.)

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- ☐ Have you submitted the panoramic radiograph, if one has been taken, along with the request for post authorization of the radiograph and included any additional services requiring prior authorization on the same claim form?
- ☐ Have you stapled all pages (and the mounted radiographs) for a single recipient with a SINGLE staple in the upper left-hand corner? (Using a single staple will expedite the request. Paper clips should be not used.)
- ☐ Have you separated the dental prior authorization requests by program type (EPSDT Dental Program, and Adult Denture Program and placed each program type in a separate package/envelope?
- ☐ **Are you mailing to Louisiana Department of Health Medicaid Dental Program, P.O. Box 91030, Baton Rouge, LA 70821-9030?**

NOTE: It is the dental provider's responsibility to obtain a dental PA on behalf of the recipient. If a dental provider has not received a PA decision (or other related correspondence from the Dental Medicaid Unit) within 25 days from the date of submission, it is the provider's responsibility to contact the Medicaid Dental PA Unit to inquire on the status of the PA request. The provider should NEVER instruct the recipient to contact Medicaid regarding the dental PA request.