MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Supplemental Dental Prior Authorization Form

(to be completed and submitted with PA-1 form)

Member Information

Last name	First name	MI	Member ID no.

Full and Partial Dentures

	Upper/Date	Lower/Date
1. Are these ☐ replacement or ☐ first dentures?	_____	_____
2. If replacement, what year were dentures provided?	_____	_____
3. How long has the patient been without dentures?	_____ (yrs)	_____ (yrs)

4. If dentures have been lost or stolen or are missing, or must be changed or replaced due to a medical or surgical condition, please describe below.

_____

_____

5. If partial is requested, indicate the following by tooth number:

Upper teeth to be extracted: _____ replaced: _____ clasped: _____

Lower teeth to be extracted: _____ replaced: _____ clasped: _____

Nursing Facility Patients Only:

6. Did the patient request dentures? ☐ yes ☐ no

If not, name the person who did: _____ Relation to patient: _____

7. Can the existing dentures be relined or repaired? ☐ yes ☐ no

8. Explain why you believe this patient will adjust to new dentures: _____

_____

Root-Canal Therapy, Crown, and Bridge

	Tooth Number	Service Code	Crown Required?	
1. List the codes that describe the services to be provided and the applicable tooth numbers. Indicate whether the tooth will require a crown.			☐ yes	☐ no
			☐ yes	☐ no
			☐ yes	☐ no
			☐ yes	☐ no

2. For post and crown, include date of root-canal therapy and prior-authorization number, if any.

Date: _____ Prior-authorization number: _____

Dentist's Name	Date	Dentist's Provider Number

The dentist named above has examined this member for services and verified the medical necessity of these services and the accuracy of the information on this form.