Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
www.mass.gov/dma

MassHealth
Dental Bulletin 30
December 2003

TO: Dental Providers Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: **Supplemental Dental Prior Authorization Form**

Background

The Division has revised the Supplemental Dental Prior Authorization Form (DEN-1) in an effort to simplify the prior-authorization process.

Phasing in and Obtaining the New Form

A copy of the revised form DEN-1 is attached. Please note: the Division will continue to use and distribute the previous version of DEN-1 (Rev. 08/02) until its supply of the form is exhausted. To obtain supplies of the form, by mail or fax a written request to the following address or fax number.

MassHealth
Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: 617-576-4087

DEN-1 (Rev. 12/03) is also available on the Division's Web site at www.mahealthweb.com.

Important Documentation

Please note that providers are responsible for all information submitted for both prior authorization (PA) and furnished services. Providers must document that they have examined the member and reviewed and verified the accuracy of the information provided on the PA form.

Electronic Options

In the near future, the Division will offer providers the option to submit a request for PA via APAS (Automated Prior Authorization System). The Division provides more information about this new technology and its capability to include submitting and tracking requests on-line at www.masshealth-apas.com.

Questions

If you have questions about this bulletin, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

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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.