TOOTH REPLACEMENT (IMPLANT) REQUEST
PRIOR AUTHORIZATION ATTACHMENT

CLIENT NAME: ____ CLIENT ID: ____________________________

CLIENT DOB: _____/_______/_______ CLIENT CURRENT PHONE #: (________)__________-_______________
Month Day Year

REQUESTING DENTIST: ____

REQUESTING DENTIST'S PHONE #: (_______)________-_________ NPI: ______________________________

1. TOOTH NUMBER(S) TO BE REPLACED _______ ______ _______ _______ ______ _______ _______

2. CONDITION OF NEIGHBORING TEETH
   ____

3. WAS THE TOOTH/TEETH TO BE REPLACED LOST DUE TO:
   ______CONGENITALLY MISSING
   ______LOSS DUE TO TRAUMA (DATE OF ACCIDENT __________________)
   ______LOSS DUE TO ABNORMAL PATHOLOGY NOT RELATED TO PERIODONTAL DISEASE OR CARIOUS LESIONS

   DESCRIBE CIRCUMSTANCES: ____

4. TREATMENT BEING REQUESTED- INCLUDE CODES____
   ____
   ____

5. DOES THIS CLIENT CURRENTLY HAVE ANY TYPE OF REPLACEMENT IN PLACE? _____YES _____NO

6. IF YES, WHAT IS CURRENTLY IN PLACE? ____

7. IS THIS CLIENT FREE OF GINGIVITIS? ______YES ______NO PERIODONTAL DISEASE _____YES _____NO

8. IS THIS CLIENT FREE OF TOBACCO USE? _____YES ______NO

9. IF NO, HAS THIS CLIENT BEEN REFERRED TO THE WYOMING QUIT LINE (1-800-784-8669)?_______________

SIGNATURE OF PROVIDER____ DATE__________________________

THIS FORM IS TO BE INCLUDED WITH A PRIOR AUTHORIZATION REQUEST FORM.

A COMPLETE COPY OF THE CLIENT'S CLINICAL RECORDS MUST BE INCLUDED WITH THIS REQUEST FORM. THE PROVIDER SHOULD ALSO PROVIDE ANY ADDITIONAL DOCUMENTATION TO SUBSTANTIATE THIS REQUEST INCLUDING ORAL HYGIENE REPORTS AND PROGRESS NOTES. PLEASE SEND THIS REQUEST TO THE ADDRESS BELOW.

Wyoming Medicaid
Attn: Medical Policy
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