

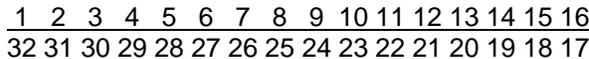
ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

<p>Section I – Must be completed by a Medicaid provider.</p> <p>Requesting NPI or License # _____</p> <p>Phone () _____</p> <p>Name _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Medicaid Provider NPI # _____</p>	<p>Section II</p> <p>Medicaid Recipient Identification Number _____ (13-digit RID number is required)</p> <p>Name as shown in Medicaid system _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Telephone Number () _____</p>
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	DATES OF SERVICE	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
	START CCYYMMDD			
	STOP CCYYMMDD			
<p>PLACE OF SERVICE (Circle one)</p> <p>11 = DENTAL OFFICE</p> <p>22 = OUTPATIENT HOSPITAL</p> <p>21 = INPATIENT HOSPITAL</p>				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.



2. Detailed description of condition or reason for the treatment:

3. Brief Dental/Medical History:

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist _____ Date of Submission _____

FORWARD TO: HPES, P.O. Box 244032, Montgomery, AL 36124-4032 or HPES 301 Technacenter Dr., Montgomery AL 36117