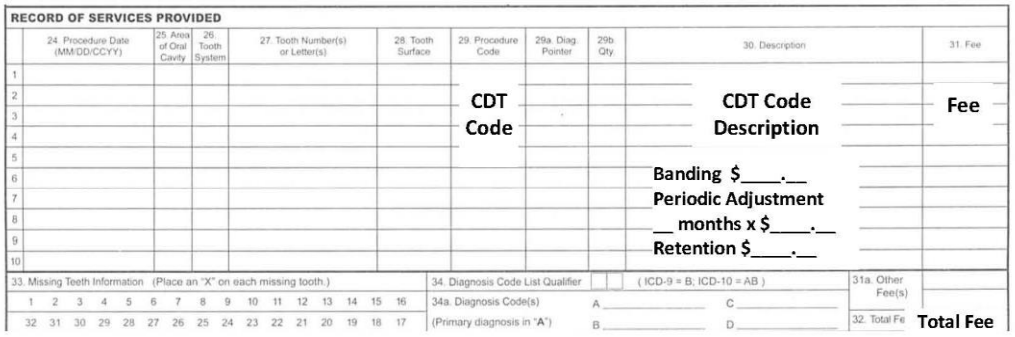
Instructions for Submitting Dental Prior Authorization Requests Using the 2012 ADA Dental Form

May 14, 2019

Prior Authorization (PA) form instructions

The following table provides requirements for submitting dental prior authorization requests to Nevada Medicaid. Fields marked with an asterisk are required when requesting PA. As a reminder, all prior authorization requests are to be submitted to Nevada Medicaid via the Electronic Verification System (EVS) secure Provider Web Portal.

Field	Requirement	Field name and instructions
1*	**Required**	**PA instructions:** Check *request for predetermination/preauthorization*. **Retrospective authorization is not available for non-emergency dental services. In the case of an emergency, a retrospective request may be submitted the next business day after service is rendered.**
12*	**Required**	**Subscriber/Policyholder name (Last, First, Middle Initial, Suffix), Address, City, State, and ZIP Code:** Enter the recipient's full name and complete address.
15*	**Required**	**Policyholder/Subscriber identifier (SSN or ID#):** Enter the recipient's 11-digit recipient ID as it appears on their Medicaid card.
27*	**Conditional**	**Tooth number(s) or letter(s):** When the procedure directly involves a tooth or range of teeth, enter tooth number(s) 1-32 for permanent dentition, 51-82 for supernumerary teeth, A-T for primary dentition or AS-TS for primary supernumerary teeth. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. When reporting a range of teeth, use a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4, 7-10, 22-27), or use commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). To report a quadrant, enter UL, UR, LL or LR.
28*	**Conditional**	**Tooth surface:** When applicable, enter a tooth surface code. The following single letter codes are used to identify surfaces: *B* for Buccal, *D* for Distal, *F* for Facial, *I* for Incisal, *L* for Lingual, *M* for Mesial and *O* for Occulusal.
29*	**Required**	**Procedure code:** Enter the appropriate procedure code for the service provided. Refer to the *Code on Dental Procedures and Nomenclature* book that was in effect on the Procedure Date entered in Item 24. **PA instructions:** Enter the procedure code of the requested service.
29b*	**Required**	**Quantity:** Enter the number of times (01-99) the procedure identified in Field 29 is delivered to the patient on the date of service shown in Field 24. The default value is "01."

Field	Requirement	Field name and instructions
30	**Conditional**	**PA instructions:** To request orthodontic services, enter a price breakdown in the Description column as described/shown below: • *Banding*, followed by your usual and customary charge for banding • *Periodic Adjustment*, the number of months in the treatment, x (the multiplication sign), and your usual and customary charge per visit. • *Retention*, followed by your total charge for retainers. 
31*	**Required**	**Fee:** Enter your usual and customary charge for each procedure.
33*	**Required**	Missing Teeth Information. **PA instructions:** Field 33 is required when requesting prior authorization.
35	**Conditional**	**PA instructions:** Describe the medical necessity for the procedure.
38*	**Required**	**PA instructions:** Specify where the services will be performed.
40	**Conditional**	Is treatment for orthodontics? **PA instructions:** If the request is for orthodontics, check *Yes*. Otherwise, check *No*.
41	**Conditional**	Date appliance placed (MM/DD/YYYY) **PA instructions:** When orthodontic treatment was initiated by another dentist or orthodontist, enter the date the appliance was placed.
42	**Conditional**	Months of treatment remaining **PA instructions:** When orthodontic treatment was initiated by another dentist or orthodontist, enter the number of months of treatment remaining.
43	**Conditional**	Replacement of prosthesis? **PA instructions:** Check *Yes* if requesting replacement for an existing prosthesis. Otherwise, check *No*.

Field	Requirement	Field name and instructions
44	**Conditional**	Date prior placement (MM/DD/YYYY) **PA instructions:** If requesting a replacement for an existing prosthesis, enter the date of prior placement.
45	**Conditional**	**Treatment resulting from**: If treatment/services were provided as a result of an occupational illness/injury, auto accident or other accident, check the appropriate box and complete Item 46.
46	**Conditional**	**Date of accident (MM/DD/YYYY):** Enter the date on which the accident noted in Item 45 occurred.
48*	**Required**	**Address, City, State, ZIP Code:** Enter the name and address of the billing provider. **The full, 9-digit ZIP code is required to process the claim.**
53*	**Required**	**Certification:** The provider who rendered the service(s) must sign and date this field. Rubber-stamped and electronic signatures are acceptable. The provider's license number is not required in this field.
54*	**Required**	**NPI (National Provider Identifier):** Enter the NPI of the servicing provider.