

DENTAL SERVICE PRIOR AUTHORIZATION REQUEST

STATE OF MONTANA - SOCIAL and REHABILITATION SERVICES

FOR USE BY DENTISTS/DENTURISTS

PLEASE TYPE OR PRINT

FORM NO. MA-4PA

NAME & ADDRESS OF PROVIDER OF SERVICES		NPI	MAIL TO: MONTANA MEDICAID DEPT. MA-4 P.O. BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958		
PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YEAR	INDIVIDUAL NUMBER
		M S F X			

SURFACE NO.	TOOTH NUMBER	PROCEDURE NUMBER	DESCRIPTION OF SERVICE	EXPECTED DATE OF SERVICE	NO. SVCS.	CHARGES	APPROVAL	
							YES	NO
1								
2								
3								
4								
5								
6								
7								
8								

	REASON FOR REQUESTED PROSTHESIS/SIGNS AND SYMPTOMS	PROSTHESIS (COMPLETE ONLY IF BEING REQUESTED)	
		DATE INSERTION OF LAST PROSTHESIS MO. DAY YEAR	TYPE OF LAST PROSTHESIS
		DATE OF LAST EXTRACTION MO. DAY YEAR	TYPE OF PROSTHESIS REQUESTED
			IS THIS A NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE OF SERVICE IF OTHER THAN OFFICE _____
<p>If the patient chooses to use a dentist, please complete this prescription block and give the form to the patient. The patient will take the form to the dentist who will complete the rest of it and submit it for approval.</p>			
		Rx Patient Name _____	
		Signature of Prescribing Dentist _____ Date _____	

CHARTING SYMBOLS	ABBREVIATIONS	<p>Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the prosthesis is received by the recipient. Authorization is valid for 180 days from the date of approval, if the patient is eligible on the date the services are rendered.</p>
■ SURFACES TO BE FILLED / TEETH TO BE EXTRACTED x MISSING TEETH	1 - MESIAL 2 - DISTAL 3 - OCCLUSAL 4 - LINGUAL 5 - INCISAL 6 - FACIAL A - AMALGAM S - SILICATE P - PLASTIC C - CROWN G - GOLD	

FOR ORTHODONTIA REQUESTS ONLY; TO BE COMPLETED BY REQUESTING DENTIST NUMBER OF MONTHS OF SERVICE REQUESTED _____ ESTIMATED START DATE OF TREATMENT _____	CONSULTANT'S COMMENTS: _____ _____ _____ DATE: ____/____/____	ORTHODONTIA APPROVAL MONTHLY ADJUSTMENT _____ MONTHS APPROVED RETAINER SERVICE _____ MONTHS APPROVED OTHER _____
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SIGNATURE OF PROVIDER REQUESTING AUTHORIZATION _____ DATE _____	APPROVED BY _____ DATE _____
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NOTE: This form will not be returned to you. You will receive notification through the PA notification.