United Healthcare | Dental Benefit Providers

Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

Justification of Need for Replacement Prosthesis Form

NEW YORK STATE DEPARTMENT OF HEALTH - Bureau of Dental Review

Provider Name:_____ NPI:_____

Member Name:_____CIN:_____ Age:_____

ADDRESS BOTH ARCHES - COMPLETE EACH APPROPRIATE SECTION

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1. Reason for replacement of existing maxillary appliance: ___worn/broken teeth ___loose ___broken base/framework, ___extraction of additional teeth ___lost ___stolen ___other

2. Reason for replacement of existing mandibular appliance: ___worn/broken teeth ___loose___broken base/framework, ___extraction of additional teeth ___lost ___stolen ___other

_____

3. If lost, provide explanation of circumstances:

_____.

4. If stolen, provide copy of police report (if available) or a statement containing a detailed explanation of circumstances of the theft. Please indicate which document you are submitting with this form below:

_____ Police Report

_____Statement of circumstances

5. Required field for Partial Dentures:

Maxillary Arch: teeth being replaced:_____, teeth being clasped:_____.

Mandibular Arch: teeth being replaced:_____, teeth being clasped:_____.

6. Has the member requested replacement dentures previously? ___Yes ___No

6a. If yes, is this request being made within eight (8) years of the member's prior request for replacement dentures? __ Yes ___No

6b. If yes, provide an explanation of the preventative measures instituted by the member/caretaker to alleviate this member's need for further replacements:

_____

_____

7. Additional comments pertaining to treatment plan:_____

_____

Provider signature:_____ Date:_____