Clear Form

Minnesota Department of **Human Services**

DHS-3538-ENG 8-11

Minnesota Health Care Programs (MHCP)

Dental Implants Authorization Form

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for Dental Implants. Fax this form with any additional or required documentation to the medical review agent.

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

Provider Information

REQUESTING PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )
REFERRING PROVIDER NAME	NPI/UMPI

Dental Implant Criteria

The criteria in subitems (1) to (3) must be met to receive payment for dental implants and related services:

1) There must be bone and tooth loss that compromises chewing or breathing.
2) The implants must be medically necessary and cost-effective.
3) A complete treatment plan, including prosthesis and all related services, must be approved prior to the start of treatment.

MHCP does not cover treatment deemed to be cosmetic or for aesthetic reasons. Dental implants usually require lengthy treatment. It is recommended that the provider discuss the expected eligibility period with the family and the county human services agency before initiating treatment. This will clarify the eligibility policies and help reduce denial of payment, due to subsequent ineligibility.

DIAGNOSIS ICD-9 CODE	DESCRIPTION
Does recipient have a mental health disability? ☐ Yes ☐ No	IF YES, DESCRIBE
List all requested services in the complete treatment plan.	
Does the recipient have bone loss? ☐ Yes ☐ No	IF YES, DESCRIBE

Does the recipient have tooth loss? ☐ Yes ☐ No	IF YES, DESCRIBE
If yes, does this loss compromise chewing? ☐ Yes ☐ No	IF YES, DESCRIBE
If yes, does this loss compromise breathing? ☐ Yes ☐ No	IF YES, DESCRIBE
Smoker? ☐ Yes ☐ No	
Periodontal disease? ☐ Yes ☐ No	IF YES, DESCRIBE
Dental caries? ☐ Yes ☐ No	IF YES, DESCRIBE
Bone density problem? ☐ Yes ☐ No	IF YES, DESCRIBE
Metabolic problem? ☐ Yes ☐ No	IF YES, DESCRIBE
Diabetes? ☐ Yes ☐ No	IF YES, COMPLICATIONS
Eradiated bone? ☐ Yes ☐ No	IF YES, REASON
Occlusal guards? ☐ Yes ☐ No	IF YES, DESCRIBE
Graft? ☐ Yes ☐ No	IF YES, REASON
Generally good health? ☐ Yes ☐ No	DESCRIBE
Generally good oral health? ☐ Yes ☐ No	DESCRIBE
Good anatomy (good facial/jaw structure)? ☐ Yes ☐ No	DESCRIBE
Speech impediment? ☐ Yes ☐ No	IF YES, DESCRIBE
Describe recipient's nutritional status.	
Does the recipient have severe atrophy of the mandible with inability to function with conventional dentures? ☐ Yes ☐ No	IF YES, DESCRIBE
Has the recipient tried conventional dentures? ☐ Yes ☐ No	IF YES, WHY DIDN'T THEY WORK?
	IF NO, WHY WERE DENTURES NOT TRIED?

Does the recipient have skeletal deformities (e.g., Arthorgryposis, ectodermal dysplasis, partial anodontia, Cleidocranial dysplasia) that prevent ability to function with conventional dentures? ☐ Yes ☐ No	IF YES, DESCRIBE
Are one or more arches involved? ☐ Yes ☐ No	IF YES, DESCRIBE
Has the recipient had cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone? ☐ Yes ☐ No	IF YES, DESCRIBE
Has the recipient experienced accidental loss of anterior teeth secondary to acute trauma? ☐ Yes ☐ No	IF YES, DESCRIBE

Have other treatments been tried to correct this problem?

REASON FOR FAILURE

Documentation Requirements	FULL MOUTH X-RAYS (attach)	MODEL	FULL MOUTH PERIODONTAL CHARTING
	REFERRAL SOURCE	CLEARANCE FROM PERIODONTIST	CLINIC RECORD DOCUMENTATION ATTACHED

Does the recipient understand the risks and complications for implant surgery?

Describe the recipient's oral hygiene habits.

Describe the aftercare plan for the dental implants and who will be providing the care.

Is the recipient or caregiver able to perform follow-up care to maintain the implants?

Describe the recipient's ability to successfully provide the aftercare of the dental implants.

SIGNATURE OF REQUESTING PROVIDER	DATE