Print

Capitol Dental Care
General Anesthesia
Approval Form

Clear Form

Office Contact Name	Email	CoverageVerified
Dentist Name	Phone	Fax
Address		
Client Name	ID #	Date of Birth
Parent/Guardian Name	Client Phone	
Address		
Medical Insurance Plan Name/ CCO	Phone	Member ID (if different than OHP)
Primary Care Physician		Primary Care Phone
Treatment Facility Name or Hospital Requested		Date(s) Requested
Patient Special Needs (i.e. interpreter, etc.)		

Clinical Information

Give a general description of the dental treatment needed (please attach a code and tooth specific ADA Dental authorization form or copy of the treatment plan)

Give a detailed explanation why General Anesthesia is being requested. In the explanation state whether other treatment options were attempted, and the results. Also, list other important information contributing to the need for hospitalization, such as the condition of the teeth/mouth, physical or mental disability, behavior issues, etc.

For use by Dental Plan Staff

Date services approved	Approval #
Dates services valid	Approved by
Comments	

(Rev 05/20)