mdco
MANAGED DENTAL CARE OF OREGON

Mail Prior Authorizations to:

Managed Dental Care of Oregon

Attn: Pre-Authorizations

3000 Market St. NE, Ste. 228
Salem OR 97301

Sending Prior Authorizations to any other address will only delay the process up to 7-21 days.

E-mail Prior Authorizations to:

See attached contact list

- Please include support documentation.
- For all requests for current radiographs or periodontal charting, please make sure this documentation is less than 6 months old

If documentation is not complete, the prior authorization will be sent back to your office for resubmission with full correct documentation

****PA does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service.****

Crowns: D2390, D2710, D2712, D2751, D2752

ADA Form: _____
Current pre-op X-ray: _____
Current Perio Chart: _____
Diagnosis and Chart Notes: _____

- Crowns must be pre-authorized and will only be considered for patients 21 years and under or pregnant.
- Stainless Steel Crowns for patients 21 years and under or pregnant do not require a preauthorization.

Sedation: General, Oral, and IV

ADA Form: _____
Diagnosis and Chart Notes: _____

- Chart notes must include documentation of behavior, medical condition, or other circumstance which makes sedation appropriate
- Care planned must be of scope and amount appropriate for sedation recommended

Molar Root Canal: D3330

ADA Form: _____
Current pre-op X-ray: _____
Diagnosis and Chart Notes: _____

- D3330: considered for patients under 21 years of age, pregnant or extraordinary circumstances.

Full/Immediate Denture: D5110-D5140

ADA Form: _____
Current pre-op X-ray: _____
Diagnosis and Chart Notes: _____

Extractions: D7220-D7241, D7250, D7251

ADA Form: _____
Current pre-op X-ray: _____
Diagnosis and Chart Notes: _____
Tooth Number: _____

- Please include diagnosis and symptom of ***each*** tooth.
- Coverage limited to symptoms of severe pain, swelling and/or infection, non-restorable decay.
- **D7140 & D 7210**: NO longer require pre-authorization, however the patient does need to be experiencing one or more of the following symptoms: **swelling, infection, severe pain, or gross decay**

Partial Dentures: D5211 & D5212, D5820 & D5821

ADA Form: _____
Current pre-op X-ray: _____
Current Perio Chart: _____
Diagnosis and Chart Notes: _____

Replacing teeth #: _____

MANAGED DENTAL CARE OF OREGON

Endodontic Referrals

1. A restorative plan must be included for endodontically-treated teeth. The tooth must be restorable.
2. Please submit a good quality radiograph including the apex of the tooth.
3. Please submit your progress notes, including your clinical findings and the pulpal diagnosis for the tooth.
4. The tooth should have a good to fair prognosis. Teeth with poor prognoses will not be approved for root canal therapy.

Oral Surgery

1. Please submit a good quality radiograph with your preauthorization.
2. Please submit your progress notes which clearly describe the clinical findings from your examination.
3. Please document why this service you are requesting is indicated, with a diagnosis.

Full Dentures

1. Please provide diagnostic radiographs, progress notes, and age of last denture.

Partial Dentures

1. Please provide diagnostic radiographs, progress notes, and age of last denture.
2. Please provide recent periodontal probing and documentation that periodontal condition has been stable over time.
3. Please document that all decay has been treated prior to preauthorizing denture.
4. Home care should be good to fair. Patient with poor home care will not be approved for partial dentures.
5. The abutment teeth should have a good to fair prognosis. Abutment teeth with poor prognoses will not be approved for partial dentures.

Crowns

1. Please provide preoperative radiograph and progress notes.
2. Please provide recent periodontal probing and documentation that periodontal condition has been stable over time.
3. Home care should be good to fair. Patients with poor home care will not be approved for crowns.

Increased frequency

1. For more frequent recalls or periodontal maintenance, please indicate why this is being recommended. Reasons might include medical need or physical limitations. Poor home care is not sufficient indication.
2. Pre-authorizations for more frequent recalls are good for 3 years. After this period, they must be reauthorized.

Hospital/ General Anesthesia and IV/Oral Sedation

1. Please include a description of why sedation is indicated: include description of behavior, medical condition, or other circumstances that influenced your care recommendation.
2. Treatment plan and progress notes must be submitted with preauthorization.
3. Care planned should be of scope and amount appropriate for type of anesthesia being requested.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) -
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code
57. Phone Number ( ) -
58. Additional Provider ID

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental prodedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"