

DENTAL PRIOR AUTHORIZATION REQUEST FORM

Fax (602) 659-1655 or Toll Free (800) 217-9345

COMPLETE ALL MEMBER DATA BELOW:

Member Name:	Member ID Number:
Member Address:	Member Date of Birth:
Member Phone Number:	<input type="checkbox"/> MCP/AHCCCS Member <input type="checkbox"/> MCP DDD/ALTCS Member

COMPLETE ALL DENTAL PROVIDER DATA BELOW:

Requesting Dentist Name:	Provider ID Number:
Office Address:	Office Phone: Office Fax:
Office Contact:	

CHECK THE APPROPRIATE REQUEST: (Please write clearly)

- TREATMENT PLAN** – The entire proposed treatment plan exceeds \$500 and/or requires prior authorization.
- **Attach the proposed treatment plan with cost estimates.**
 - **Include additional documentation as required per the Dental Provider Manual and/or Dental Matrix.**
 - Emergency services that do not receive a prior authorization will be retro-reviewed for appropriateness.
 - The prior authorization number must be written on the dental claim for processing.

- SPECIALTY REFERRAL:** Pedodontist Oral Surgeon Endodontist Other: _____

MCP Dental Specialist Name: _____

 Reason for Referral (**Diagnosis and Tooth Number if applicable**): _____

Medical Alert/Special Needs:

- X-rays Enclosed X-rays to be returned to provider

MCP USE ONLY

Prior Authorization Number: _____ Auth Expiration Date: _____

Comments: _____

Approval Signature: _____ Date Signed: _____

VERIFY MEMBER ELIGIBILITY ON EACH DATE OF SERVICE

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