COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
MEDICAL ASSISTANCE PROGRAMS

DENTAL PRIOR AUTHORIZATION REQUEST
MA 98

The MA 98 form is to be used by dentists when they wish to request services requiring prior authorization.

Instructions for proper completion of the form are found on the inside of this cover sheet.

**PLEASE SUBMIT COMPLETED MA 98
WITH X-RAYS ENCLOSED IN APPROPRIATE
ENVELOPE (ENV 98) TO:**

**Department of Public Welfare
Office of Medical Assistance
P.O. Box 8187
Harrisburg, Pennsylvania 17105**

PLEASE TURN TO INSTRUCTIONS ON REVERSE

GUIDELINES FOR COMPLETING THE DENTAL PRIOR AUTHORIZATION REQUEST (MA 98)

PATIENT INFORMATION

Items 1 through 5 are to be completed using information obtained from the Eligibility Verification System (EVS)

Item 1 — Recipient Number (MUST)

Enter the 10-digit recipient identification number obtained from the recipient's Pennsylvania ACCESS Card.

Item 2 — Patient's Name (MUST)

Enter the recipient's last name, first name, and middle initial (if any) exactly as they appear on the recipient's Pennsylvania ACCESS Card.

Item 3 — Birthdate (MUST)

Enter the recipient's date of birth in an 8-digit format (mmddccyy).

Item 4 — Sex (OPTIONAL)

Check the appropriate box, "M" (male) or "F" (female).

Item 5 — Resource Code (LEAVE BLANK)

PROVIDER INFORMATION

Items 6 through 14 are to be completed using the information found on the provider's Medical Assistance "Provider Notice Information Form.".

Item 6 — Provider's Name (MUST)

Enter the provider's last name, first name, and middle initial.

Item 7 — Provider Type (PREPRINTED)

Item 8 — M.A. I.D. Number (MUST)

Enter the provider's 9-digit PROMISe™ Provider ID Number.

Item 9 — Address Code (MUST)

Enter the 4-digit Service Location.

Item 10 — Provider's Own Reference No. (OPTIONAL)

Enter your own reference number or recipient's name to comply with the provider's filing system.

Items 11 through 14 will only be completed if the payment for services will be sent to someone other than the dentist providing the services.

Item 11 — Payee Name (MUST, IF APPLICABLE)

Enter the name of the person, group, or organization designated to receive payment.

Item 12 — Payee Type (LEAVE BLANK)

Item 13 — Payee M.A. I.D. NUMBER (MUST, IF APPLICABLE)

Enter the payee's 9-digit PROMISe™ Provider ID Number.

Item 14 — Payee Address Code (MUST, IF APPLICABLE)

Enter the payee's 4-digit Service Location.

REQUESTED PRIOR AUTHORIZED SERVICES

When requesting a single service, complete Items 15A through 15G as follows:

Item 15A — Procedure Name (MUST)

Enter the procedure terminology found in the Medical Assistance Program Fee Schedule.

Item 15B — Tooth No./Letter (MUST, IF APPLICABLE)

Enter the tooth number or tooth letter that identifies the permanent or primary tooth involved. Only one tooth number or letter may be entered on each line.

When requesting prior authorization for multiple extractions, indicate the appropriate teeth to be extracted in 15B through 21B. Up to seven (7) separate teeth and procedures can be identified on each MA 98. Extractions require separate lines for each tooth to be extracted.

This item must be completed when requesting authorization for periodontal procedures **D4210** (gingivectomy or gingivoplasty - per quadrant) and **D4341** (periodontal scaling and root planing - per quadrant). Enter the appropriate code to identify the quadrant on which the service will be provided;

10 - Upper right quadrant 30 - Lower left quadrant

20 - Upper left quadrant 40 - Lower right quadrant

For reimbursement purposes, a quadrant is defined as 5-8 teeth. For individuals with less than 5 teeth present in their mouth, procedure code **D4341** <u>will not</u> be approved.

Item 15C — Type Service (LEAVE BLANK)

Item 15D — Procedure Code (MUST)

Enter the 5-character CDT-4 procedure code for the service requested. The procedure code can be found on the Medical Assistance Program Fee Schedule.

Item 15E & F — Modifier (MUST, IF APPLICABLE)

Enter any applicable modifiers.

Item 15G — Visit Code (LEAVE BLANK)

Items 16A through 21G are available for additional requested services and must be completed as described in Items 15A through 15G above.

Item 22 — Treatment Plan (MUST)

This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½ x 11.

Prior authorization of dental services must be performed as part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

1. pertinent dental history;
2. pertinent medical history, if applicable;
3. the strategic importance of the tooth;
4. the condition of the remaining teeth;
5. the existence of all pathological conditions;
6. preparatory services performed and completion date(s);
7. documentation of all missing teeth in the mouth;
8. the oral hygiene of the mouth;
9. all proposed dental work;
10. identification of existing crowns, periodontal services, etc.
11. identification of the existence of full and/or partial denture(s), with the date of initial insertion;
12. the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality and prognosis;
13. identification of abutment teeth by number;
14. for periodontal services, include a comprehensive periodontal evaluation.

NOTE: *FOR THOSE SERVICE PROGRAMS WHERE DENTAL SERVICES ARE LIMITED TO SERVICES PROVIDED IN AN INPATIENT HOSPITAL, HOSPITAL SHORT PROCEDURE UNIT OR AMBULATORY SURGICAL CENTER, PLEASE INCLUDE A STATEMENT IDENTIFYING WHERE THE SERVICE WILL BE PROVIDED.*

Item 23 — Tooth Chart (MUST)

Indicate all missing teeth by marking an "X" on the chart.

Use a slash (/) to indicate any teeth requiring extraction.

Check Appropriate Block Below (MUST)

Place an "X" in the appropriate block to indicate if this is an initial prior authorization request for the service or if it is a resubmission of a previously denied request. If the resubmission block is checked, please include the denied Prior Authorization Reference Number from the original submission.

Item 24 — Number of Attachments Other Than X-rays (MUST, IF APPLICABLE)

Indicate the number of attachments, excluding X-rays, that are being submitted with the MA 98. For example, if you attached two additional pages to include additional treatment plan information, you would enter a "2". Identify each individual attachment in the "Remarks" section of the MA 98.

Item 25 — X-ray Envelope Number (MUST, IF APPLICABLE)

Place the 7-digit number appearing on the left side of the X-ray envelope (ENV 98) in this item.

Use the following procedure to submit X-rays with the MA 98:

1. Place your return address on the ENV 98 so the X-rays can be returned to you.
2. Place the X-rays in the ENV 98. The radiographs must be:
   a. properly mounted;
   b. clearly readable;
   c. free from defects;
   d. the clarity must be such that interpretation can be made without difficulty by using a conventional view box;
   e. taken in a manner that all clinical crowns and roots are observable; and
   f. labeled with the recipient's name, the recipient number, the provider's name, and the date the radiograph was taken.
3. Use one ENV 98 for each recipient.
4. Be sure that your return address is placed on the ENV 98 in the white block labeled "Provider Return Address." This envelope will be used by the Department when returning X-rays to you. DO NOT USE TAPE OR STAPLES TO SEAL THE ENV 98.
5. Place the ENV 98 with the completed MA 98 in an MA 320 envelope and mail to the Department.

Item 26 — Provider's Signature (MUST)

The dentist requesting the prior authorized service must sign the MA 98. His/her signature indicates that the prior authorized service will be performed in accordance with Medical Assistance regulations.

A signature stamp is acceptable if the provider authorizes its use and assumes responsibility for the request.

NOTE: *ALL UNSIGNED PRIOR AUTHORIZATION REQUESTS WILL BE RETURNED TO THE PROVIDER WITHOUT BEING PROCESSED.*

Item 27 — Date (MUST)

Enter the month, day and year the MA 98 was completed. Use an 8-digit format for the date (mmddccyy).

DENTAL PRIOR AUTHORIZATION REQUEST
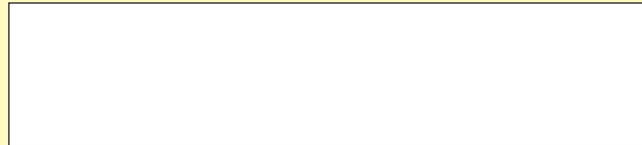
LEAVE THIS FIELD BLANK

PATIENT INFORMATION

1	RECIPIENT NUMBER					
2	PATIENT'S LAST NAME	FIRST NAME	M.I.	3 BIRTHDATE	4 SEX	5 RESOURCE CODE

PROVIDER INFORMATION

6	PROVIDER NAME	7 PROV. TYPE	8 MA ID NUMBER	9 ADD. CODE	10 PROVIDER'S OWN REFERENCE NO.
11	PAYEE NAME	12 PROV. TYPE	13 MA ID NUMBER	14 ADD. CODE	

REQUESTED PRIOR AUTHORIZED SERVICES

PROCEDURE NAME		TOOTH NO/LTR		TYPE SERVICE		PROCEDURE CODE		MODI-FIER		MODI-FIER		VISIT CODE
15A		B		C		D		E		F		G
16A		B		C		D		E		F		G
17A		B		C		D		E		F		G
18A		B		C		D		E		F		G
19A		B		C		D		E		F		G
20A		B		C		D		E		F		G
21A		B		C		D		E		F		G

22 TREATMENT PLAN / MEDICAL JUSTIFICATION (REFER TO HANDBOOK FOR EXPLICIT GUIDELINES)

23

LABIAL
UPPER
LINGUAL
RIGHT
PRIMARY
LEFT
PERMANENT
LOWER
LINGUAL
LABIAL
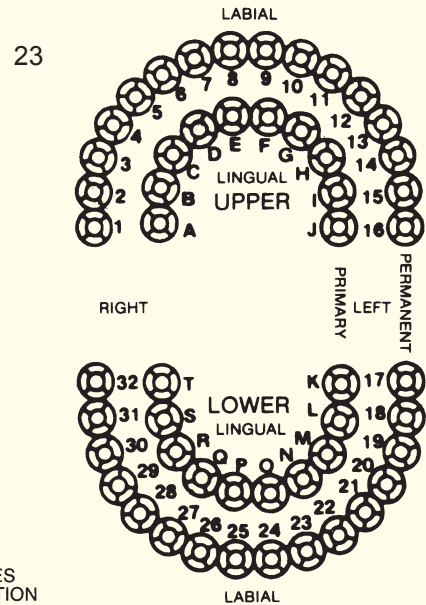
⊗ MISSING

⊘ REQUIRES EXTRACTION

CHECK APPROPRIATE BLOCK BELOW:

☐ INITIAL REQUEST	☐ SUBMISSION OF A PREVIOUSLY DENIED REQUEST	ENTER THE DENIED P.A. REFERENCE NUMBER ►

24 NUMBER OF ATTACHMENTS OTHER THAN X-RAYS ►	25 X-RAY ENVELOPE NUMBER	I Hereby Certify that the Conditions Expressed in the Treatment Plan are an Accurate Reflection of the Requested Dental Service(s).

REMARKS

26	27
PROVIDER SIGNATURE	DATE

DPW COPY

MA 98   1/05