TEXAS Health and Human Services

Form 6504
July 2010-E

Prior Authorization for Dental Services

The information requested is necessary to add dental services to the individual's plan of care. Case managers in the waiver program will share this information with DBMD program staff in order to obtain prior authorization of services.

Program

Deaf Blind with Multiple Disabilities (DBMD)

Identifying Data

Individual Name		Date of Birth	Medicaid No.
Dentist Name		Address	
City	State	ZIP Code	Telephone No.

To the Dentist: Examination authorization does not allow for proceeding with definitive dental care. Complete all applicable items and return to the case manager for treatment authorization.

Examination and Treatment Record

Indicate one tooth number, one procedure, and one estimated fee per line. For prosthesis (fixed or removable), indicate teeth to be replaced.

Dental Services

Tooth No.	ADA Code No.	Description of Services (including x-rays, prophylaxis materials used, etc.)	Estimated Fee	Frequency	Service Total
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
Treatment Period (No. of Months):				**Grand Total**	$

Additional Information:

Dental Sedation

Description of Services	Estimated Fee	Frequency	Service Total
	$		$

Is the major dental condition? ☐ Acute ☐ Slowly progressive ☐ Static ☐ Treatment is for cosmetic purposes.

If for prosthesis, is this initial placement? ☐ **Yes** ☐ **No**

If no, reason for replacement:

Signature – Dentist _____ License No. _____ Date _____

Signature – DBMD Program _____ Date _____

☐ Approved
☐ Denied
☐ Additional Information