

Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

Evaluation of the Dental Implant Patient Form

NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Dental review

Dentist Name: _____ NPI: _____

Member Name: _____ CIN: _____ Age: _____

Medical History: _____

Current Medications: _____

Allergies to Medications: _____

List any significant medical conditions that the member is currently being treated for: _____

Identify the physician(s) currently treating the member for any of the above-listed medical condition(s):

Detail the member's medical necessity for dental implants: _____

Detail why other covered functional alternatives for prosthetic replacement will not correct the member's dental condition:

The above patient is an acceptable candidate for dental implant surgery: _____ Yes _____ No

Dentist signature: _____ Date: _____