TOOTH REPLACEMENT (IMPLANT) REQUEST
PRIOR AUTHORIZATION ATTACHMENT

CLIENT NAME:_____CLIENT ID: _____

CLIENT DOB:_____/_____/_____CLIENT CURRENT PHONE #: (_____)_____-_____
Month Day Year

REQUESTING DENTIST: _____

REQUESTING DENTIST'S PHONE #: (_____)_____-_____NPI: _____

1. TOOTH NUMBER(S) TO BE REPLACED ___ _____ _____ _____ _____ _____ _____
2. CONDITION OF NEIGHBORING TEETH

3. WAS THE TOOTH/TEETH TO BE REPLACED LOST DUE TO:
   - ☐ CONGENITALLY MISSING
   - ☐ LOSS DUE TO TRAUMA (DATE OF ACCIDENT_____)
   - ☐ LOSS DUE TO ABNORMAL PATHOLOGY NOT RELATED TO PERIODONTAL DISEASE OR CARIOUS LESIONS

   DESCRIBE CIRCUMSTANCES: _____
4. TREATMENT BEING REQUESTED- INCLUDE CODES_____
   _____
5. DOES THIS CLIENT CURRENTLY HAVE ANY TYPE OF REPLACEMENT IN PLACE? ☐ YES ☐ NO
6. IF YES, WHAT IS CURRENTLY IN PLACE? _____
7. IS THIS CLIENT FREE OF GINGIVITIS? ☐ YES ☐ NO PERIDONTAL DISEASE ☐ YES ☐ NO
8. IS THIS CLIENT FREE OF TOBACCO USE? ☐ YES ☐ NO
9. IF NO, HAS THIS CLIENT BEEN REFERRED TO THE WYOMING QUIT LINE (1-800-754-8669)? ☐ YES ☐ NO

SIGNATURE OF PROVIDER_____ DATE_____

A COMPLETE COPY OF THE CLIENT'S CLINICAL RECORDS MUST BE INCLUDED WITH THIS REQUEST FORM. THE PROVIDER SHOULD ALSO PROVIDE ANY ADDITIONAL DOCUMENTATION TO SUBSTANTIATE THIS REQUEST INCLUDING ORAL HYGIENE REPORTS AND PROGRESS NOTES.

Please submit this form with your prior authorization request via Qualitrac. If you do not have access to the Qualitrac portal, please contact Telligen at (833) 610-1057 or wymedicaidum@telligen.com.