

UnitedHealthcare Community Plan of Nebraska Medicaid Dental Quick Reference Guide

Effective: January 1, 2025



UHCdental.com/medicaid

The Dental Hub may be used to check eligibility, submit prior authorization, claims, and access useful information regarding plan coverage.

To register for the Dental Hub, you will need a W-9 and a recently paid claim, or the verification code included in your Welcome Letter. For additional assistance with the Dental Hub, call Provider Services.



Provider services

Phone: **1-866-519-5961**

8 a.m. – 6 p.m. EST Monday–Friday (IVR: 24/7)

Member eligibility, benefits, claims, authorizations, network participation and contract questions



Prior authorization

UnitedHealthcare NE Authorizations
P.O. Box 2053
Milwaukee, WI 53201

Appeals for service denials

UnitedHealthcare NE Appeals
Attn: Appeals Department
P.O. Box 361
Milwaukee, WI 53201

Toll-free: **1-866-519-5961**



Claims

UnitedHealthcare NE Claims

P.O. Box 2176
Milwaukee, WI 53201

EDI Payer ID

GP133

Claim disputes or adjustments

UnitedHealthcare NE Appeals
P.O. Box 361
Milwaukee, WI 53201

Corrected claims

UnitedHealthcare NE
Claims Reprocessing and
Overpayments
P.O. Box 481
Milwaukee, WI 53201

Claims may be submitted electronically via your clearinghouse, online via the provider portal or via the mailing addresses here.

Important notes

This guide is intended to be used for quick reference and may not contain all of the necessary information; it is subject to change without notice. For current detailed benefit information, please visit the Dental Hub or contact our Provider Services toll free number.



**Dental Benefit
Providers®**

Sample member ID card

Please note: The address for submitting dental claims is UHC NE Claims P.O. Box 2176 Milwaukee, WI 53201.

		Health Plan/Plan de salud (80840) 911-87726-04	
Member ID/ID del Miembro: 000611157		Group/grupo: NESHAD	
Member/Miembro: REISSUE ENGLISH		Payer ID/ID del Pagador: 87726	
Medicaid Number: 99999111557			
Rx Bin: 610494 Rx Grp: ACUNE Rx PCN: 4444		0501 Administered by UnitedHealthcare of the Midlands, Inc.	

In an emergency go to nearest emergency room or call 911.		Printed: 02/13/25
En caso de emergencia, acuda a la sala de emergencia mas cercana o llame el 911. This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website uhcommunityplan.com or call.		
For fraud and grievances, call 800-641-1902, TTY 711		
Dental Benefit Providers/Proveedores de Beneficios Dentales: 800-641-1902		
For Members/Para Miembros:		800-641-1902 TTY 711
NurseLine/Linea de enfermeras:		877-543-4293
Enrollment Broker/Agent de ventas:		888-255-2605
For Providers:		UHCprovider.com 866-331-2243
Claims:		PO Box 31365, Salt Lake City, UT 84131
For Pharmacist: 1-877-231-0131		
Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334		

Benefit coverage, limitations, and requirements

Member benefits are listed in the following Benefit Grid, which contains all covered dental procedures and is intended to align to all State and Federal regulatory requirements; therefore, this Grid is subject to change. For the most updated member benefits, exclusions, and limitations please visit our website at UHCdental.com/medicaid.

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D0120	PERIODIC ORAL EXAMINATION	0 - 999	1 per 180 days	N	
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	0 - 999	2 per 365 days	N	
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	0 - 3	2 per 365 days	N	
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	0 - 999	1 per 1095 days	N	
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	0 - 999	1 per 1095 days	N	
D0170	RE-EVALUATION- LIMITED, PROBLEM FOCUSED (ESTAB. PATIENT; NOT POST-OP. VISIT)	0 - 999	1 per 365 days	N	
D0171	RE-EVALUATION - POST OPERATIVE OFFICE VISIT	0-999	1 per 365 days	N	
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	0 - 999	1 per 1095 days	N	
D0190	SCREENING OF A PATIENT	0 - 999	2 per 365 days	N	PHDH can submit a claim for this code when performed in a public health setting

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D0191	ASSESSMENT OF A PATIENT	0 - 999	2 per 365 days	N	PHDH can submit a claim for this code when performed in a public health setting
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	0 - 999	1 per code every 1095 days	N	A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record. Maximum coverage per date of service is equal to full mouth series
D0220	INTRAORAL - PERIAPICAL-FIRST FILM	0 - 999	1 per 1 day	N	
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL FILM	0 - 999	no limit but must recode to full mouth as needed per 1 day	N	
D0240	INTRAORAL-OCCLUSAL FILM	0 - 999	2 per 180 days	N	
D0270	BITEWING-EACH FILM	0 - 999	4 per 365 days	N	A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record
D0272	BITEWING-TWO FILMS	0 - 999	4 per 365 days	N	A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record
D0273	BITEWINGS - THREE FILMS	0 - 999	4 per 365 days	N	A maximum of four bitewing radiographs is covered every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger and medical necessity must be documented in the client's dental record
D0274	BITEWING-FOUR FILMS	0 - 999	4 per 365 days	N	
D0330	PANORAMIC FILM	0 - 999	1 per 1095 days	N	
D0340	CEPHALOMETRIC FILM	0 - 20	1 per 1 lifetime	N	Covered for Medicaid approved orthodontic treatment plan
D0470	DIAGNOSTIC CASTS	1 - 20	1 per 1 lifetime	N	Covered for Medicaid approved orthodontic treatment plan
D1110	PROPHYLAXIS-ADULT	14 - 20	2 per 365 days	N	PHDH can submit a claim for this code when performed in a public health setting
D1110	PROPHYLAXIS-ADULT	21 - 999	2 per 180 days	N	PHDH can submit a claim for this code when performed in a public health setting
D1120	PROPHYLAXIS-CHILD	0 - 13	2 per 365 days	N	PHDH can submit a claim for this code when performed in a public health setting
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS	0 - 999	2 per 365 days	N	PHDH can submit a claim for this code when performed in a public health setting
D1208	TOPICAL APPLICATION OF FLUORIDE- EXCLUDING VARNISH	0 - 999	2 per 365 days	N	PHDH can submit a claim for this code when performed in a public health setting
D1351	SEALANT - PER TOOTH	0 - 20	1 per 730 days; N per tooth	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION PER TOOTH	0 - 999	3 per 365 days; per tooth	Y	A permanent restoration is not payable on the same tooth for 90 days following D1354 by the same provider, practice or group. Providers are not permitted to bill both CDT codes D1354 and D1355 for the same tooth on the same date of service.
D1355	CARIES PREVENTITIVE MEDICAMENT APPLICATION PER TOOTH	0 - 999	3 per 365 days; per tooth	Y	A permanent restoration is not payable on the same tooth for 90 days following D1355 by the same provider, practice or group. Providers are not permitted to bill both CDT codes D1354 and D1355 for the same tooth on the same date of service.
D1510	SPACE MAINTAINER - FIXED UNILATERAL	0 - 20	1 per 365 days; per quadrant	N	
D1516	SPACE MAINTAINER FIXED BILATERAL MAXILLARY	0 - 20	1 per 365 days	N	
D1517	SPACE MAINTAINER FIXED BILATERAL MANDIBULAR	0 - 20	1 per 365 days	N	
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MAXILLARY	0 - 20	1 per 365 days	N	
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MANDIBULAR	0 - 20	1 per 365 days	N	
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER-PER QUADRANT	0 - 20	1 per 365 days	N	
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER-PER QUADRANT	0 - 20	1 per 365 days	N	
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXILLARY	0 - 20	1 per 365 days	N	
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIBULAR	0 - 20	1 per 365 days	N	
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED - UNILATERAL	0 - 20	1 per 365 days	N	
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and I-32

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and 1-32
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and 1-32
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A-T and 1-32
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth C-H, M-R, 6-11, 22-27
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	0 - 999	1 per 365 days	N	All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not. Only one D2140-D2394 every 365 days per surface per tooth is covered for teeth A,B,I,J,K,L,S,T,1-5,12-16,17-21,28-32
D2710	CROWN - RESIN BASED COMPOSITE (INDIRECT)	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2722	CROWN-RESIN WITH NOBLE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D2740	CROWN-PORCELAIN/ CERAMIC SUBSTRATE	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2790	CROWN-FULL CAST HIGH NOBLE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2792	CROWN-FULL CAST NOBLE METAL	0 - 999	1 per 1825 days	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	0 - 999	1 code per tooth every 365 days	N	Not payable within the first 180 days of initial placement
D2920	RE-CEMENT OR RE-BOND CROWN	0 - 999	1 code per tooth every 365 days	N	Not payable within the first 180 days of initial placement
D2929	PRE FABRICATED PORCELAIN/CERAMIC CROWN PRIMARY TOOTH	0 - 999	1 per code per tooth every 730 days	N	Covered for teeth C-H and M-R
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0 - 999	1 per code per tooth every 730 days	N	
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	0 - 999	1 per code per tooth every 730 days	N	
D2932	PREFABRICATED RESIN CROWN	0 - 999	1 per code per tooth every 730 days	N	Covered for teeth C-H and M-R
D2933	PREF. STAINLESS STEEL CROWN WITH RESIN WINDOW.	0 - 999	1 per code per tooth every 730 days	N	Covered for teeth C-H and M-R
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0 - 999	1 per code per tooth every 730 days	N	Covered for teeth C-H and M-R

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D2940	PROTECTIVE RESTORATION	0 - 999	1 per lifetime; per tooth	N	
D2950	CORE BUILDUP, INCLUDING ANY PINS	0 - 999	1 per code per tooth per 1825 days	N	Covered for teeth 2-15, 18-31
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	0 - 999	1 per code per tooth per 365 days	N	
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	0 - 999	1 per code per tooth per 1825 days	N	Covered for teeth 2-15, 18-31
D2980	CROWN REPAIR- BY REPORT	0 - 999	1 per 1 lifetime	N	
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	0-999		N	The code must not be used to claim an item or service that is not covered by Medicaid. A description of the treatment provided and medical necessity must be submitted with the claim. This service is retrospectively reviewed for approval of payment
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)(PRIMARY TEETH ONLY)	0 - 999	1 per 1 lifetime	N	
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	Not covered for third molars
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR	0 - 999	1 per code per tooth per 1 lifetime	N	Minimum 365 days post D3310
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID	0 - 999	1 per code per tooth per 1 lifetime	N	Minimum 365 days post D3320
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	0 - 999	1 per code per tooth per 1 lifetime	N	Minimum 365 days post D3330

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D3351	APEXIFICATION/ RECALCIFICATION- INITIAL VISIT (APICAL CLOSURE/ CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)	0 - 999	1 per 1 lifetime	N	Not covered for third molars
D3410	APICTOMY/ PERIRADICULAR SURGERY-ANTERIOR	0 - 999	1 per 1 lifetime	N	Covered for teeth 6-11 and 22-27
D4210	GINGIVECTOMY OR GINGIVOPLASTY, 4 OR MORE CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT	0 - 999	1 per code per quadrant per 730 years	N	
D4211	GINGIVECTOMY OR GINGIVOPLASTY, 1 TO 3 CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT	0 - 999	1 per code per quadrant per 730 years	N	
D4323	SPLINT EXTRA- CORONAL NATURAL TEETH OT PROSTHETIC CROWNS	0 - 999	1 per code per arch per day	N	A description of the treatment provided and medical necessity must be submitted with the claim.
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	0 - 999	1 per code per quadrant every 365 days; max 2 quadrants per day unless reported in hospital	Y	A minimum of four (4) affected teeth in the quadrant. Periapical x-rays must show subgingival calculus and loss of crestal bone. When requiring local anesthesia only one (1) half of the mouth per day is a benefit unless completed as a hospital case. D4341 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-authorization with x-rays, periodontal charting including current probing, rationale, a treatment plan that demonstrates that curettage, scaling, or root planing is required in addition to a routine prophylaxis and indication of quadrant (10,20,30,40)
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	0 - 999	1 per code per quadrant every 365 days; max 2 quadrants per day unless reported in hospital	Y	Periapical x-rays must show subgingival calculus and loss of crestal bone. When requiring local anesthesia only one (1) half of the mouth per day is a benefit unless completed as a hospital case. D4342 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-authorization with x-rays, periodontal charting including current probing, rationale, a treatment plan that demonstrates that curettage, scaling, or root planing is required in addition to a routine prophylaxis and indication of quadrant (10,20,30,40)

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	0 - 999	1 per 365 days	N	Not covered on the same day of periodontic treatment or exam
D4910	PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING SCALING & ROOT PLANING)	0 - 999	4 per 365 days	Y	Include date of previous periodontal surgical or SRP Perio charting for authorization. Prior authorization must be submitted annually
D5110	COMPLETE DENTURE - MAXILLARY	0 - 999	1 per 1825 days	Y	<p>The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. <p>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>
D5120	COMPLETE DENTURE - MANDIBLE	0 - 999	1 per 1825 days	Y	<p>The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. <p>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5130	IMMEDIATE DENTURE - MAXILLARY	0 - 999	1 per 1825 days	Y	<p>The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture.</p> <p>A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.</p> <p>Prosthetic appliances are covered once every five (5) years when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. <p>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>
D5140	IMMEDIATE DENTURE - MANDIBULAR	0 - 999	1 per 1825 days	Y	<p>The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. <p>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5211	UPPER PARTIAL DENTURE-RESIN BASE (INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	0 - 999	1 per 1825 days	Y	<p>The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:</p> <ul style="list-style-type: none"> • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. <p>Replacement prosthetic appliances are covered when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable <p>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5212	LOWER PARTIAL DENTURE-RESIN BASE(INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	0 - 999	1 per 1825 days	Y	<p>The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:</p> <ul style="list-style-type: none"> • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. <p>Replacement prosthetic appliances are covered when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable <p>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	0 - 999	1 per 1825 days	Y	<p>The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:</p> <ul style="list-style-type: none"> • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. <p>Replacement prosthetic appliances are covered when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable <p>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5214	MANDIBULAR PARTIAL DENTURE-CASE METAL FRAMEWORK WITH RESIN DENTUR BASES (INCLUDING ANY CONVENTIONAL CLASPS, REST & TEETH)	0 - 999	1 per 1825 days	Y	<p>The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:</p> <ul style="list-style-type: none"> • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. <p>Replacement prosthetic appliances are covered when:</p> <ul style="list-style-type: none"> • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable <p>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</p>
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	0 - 999	1 per 1 day	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	0 - 999	1 per 1 day	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	0 - 999	1 per 1 day	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	0 - 999	1 per 1 day	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	0 - 999	2 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	0 - 999	2 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	0 - 999	2 per 365 days; per tooth	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	0 - 999	2 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	0 - 999	2 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	0 - 999	2 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	0 - 999	2 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5630	REPAIR OR REPLACE BROKEN CLASP - PARTIAL PER TOOTH	0 - 999	2 per 365 days; per tooth	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5640	REPLACE BROKEN TEETH - PER TOOTH	0 - 999	2 per 365 days; per tooth	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	0 - 999	2 per 365 days; per tooth	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	0 - 999	2 per 365 days; per tooth	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5710	REBASE COMPLETE MAXILLARY DENTURE	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5711	REBASE COMPLETE MANDIBULAR DENTURE	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5720	REBASE MAXILLARY PARTIAL DENTURE	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5721	REBASE MANDIBULAR PARTIAL DENTURE	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5765	SOFT LINER FOR COMPLETE OR REMOVABLE DENTURE	0 - 999	1 per 365 days	N	Adjustments are inclusive for the first 180 days following placement of the prosthesis
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	0 - 999	1 per 1825 days	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	0 - 999	1 per 1825 days	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5820	FLIPPER PARTIAL DENTURE (MAXILLARY)	0 - 999	1 per 1825 days	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5821	FLIPPER PARTIAL DENTURE (MANDIBULAR)	0 - 999	1 per 1825 days	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5850	TISSUE CONDITIONING, MAXILLARY	0 - 999	2 per 365 days	N	Covered once within the first 180 days following placement of the initial prosthesis. Covered twice per 365-day period after the initial 180-day window. Documentation Requirement: <ul style="list-style-type: none"> Medical necessity must be documented in the client's dental record

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D5851	TISSUE CONDITIONING, MANDIBULAR	0 - 999	2 per 365 days	N	Covered once within the first 180 days following placement of the initial prosthesis. Covered twice per 365-day period after the initial 180-day window. Documentation Requirement: <ul style="list-style-type: none"> Medical necessity must be documented in the client's dental record
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	0 - 999	1 per 1825 days	Y	Requires pre-authorization, narrative, and operative notes. Documentation must clearly indicate that denture treatment was interrupted and unable to be completed. the stage(s) of treatment completed must be identified. Coverage is allowed under the following circumstances: <ul style="list-style-type: none"> Treatment was interrupted after final impressions were taken but before initial jaw relation Treatment was interrupted after initial jaw relation but before processing.
D7111				N	
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	0 - 999	1 per code per tooth per 1 lifetime	N	
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH	0 - 999	1 per code per tooth per 1 lifetime	N	
D7220	REMOVAL OF IMPACTED TOOTH--SOFT TISSUE	0 - 999	1 per code per tooth per 1 lifetime	N	
D7230	REMOVAL OF IMPACTED TOOTH - PARTICALLY BONY	0 - 999	1 per code per tooth per 1 lifetime	N	
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	0 - 999	1 per code per tooth per 1 lifetime	N	
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	0 - 999	1 per code per tooth per 1 lifetime	N	
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	0 - 999	1 per code per tooth per 1 lifetime	N	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. requires x-rays and rationale for all teeth: 1-32, A-T, 51-82, and AS-TS. Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member's treatment record does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, all records may be reviewed and recoupment of payment for services will be initiated.

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTLY EVULSED OR DISPLACED TOOTH AND/OR ALVEOLUS	0 - 999	1 per code per tooth per 1 lifetime	N	
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	0 - 999	1 per code per tooth per 1 lifetime	N	
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	0 - 999	1 per code per tooth per 1 lifetime	N	
D7285	INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	0 - 999	1 per day per patient	N	
D7286	INCISIONAL BIOPSY OF ORAL TISSUE - SOFT	0 - 999	1 per day per patient	N	
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	Covered when performed to prepare a quadrant for a prosthetic appliance. Removal of tori is considered inclusive to this procedure
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	Covered when performed to prepare a quadrant for a prosthetic appliance. Removal of tori is considered inclusive to this procedure
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	Covered when performed to prepare a quadrant for a prosthetic appliance. Removal of tori is considered inclusive to this procedure
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	Covered when performed to prepare a quadrant for a prosthetic appliance. Removal of tori is considered inclusive to this procedure
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM (1-3-03)	0-999	1 per 1 day	N	
D7411	Excision of benign lesion greater than 1.25 cm	0-999	1 per 1 day	N	
D7412	Excision of benign lesion, complicated	0-999	1 per 1 day	N	
D7413	Excision of malignant lesion up to 1.25 cm	0-999	1 per 1 day	N	
D7414	Excision of malignant lesion greater than 1.25 cm	0-999	1 per 1 day	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D7415	Excision of malignant lesion, complicated	0-999	1 per 1 day	N	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	0-999	1 per 1 day	N	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	0-999	1 per 1 day	N	
D7450	Removal of benign or odontogenic cyst or tumor-lesion diameter up to 1.25 cm (1-3-03)	0-999	1 per 1 day	N	
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03)	0-999	1 per 1 day	N	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm (1-3-03)	0-999	1 per 1 day	N	
D7461	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03)	0-999	1 per 1 day	N	
D7465	Destruction of lesion(s) by physical or chemical method, by report	0-999	1 per 1 day	N	
D7471	Removal of lateral exostosis (maxilla or mandible)	0-999	1 per 1 day	N	
D7510	INCISION & DRAINAGE OF ABSCESS, INTRAORAL SOFT TISSUE	0 - 999	1 per 1 day	N	Not allowed on the same date of service as an extraction in the same area of the mouth
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	0 - 999	1 per code every 1095 days	N	Covered for the treatment of TMJ
D7961	BUCCAL LABIAL FRENECTOMY (FRENULECTOMY)	0 - 999	1 per 1 lifetime	N	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	0 - 999	1 per 1 lifetime	N	
D8020	LIMITED ORTHODONTIC TREATMENT/TRANS. DENTITION	0 - 20	1 per 1 lifetime	Y	Requires pre-authorization and will be limited to 12 months. Must include panoramic radiographs of the teeth being moved or the space that is being maintained. Complete HDL form and rationale/treatment plan. Requires Color photos

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	0-20	1 per lifetime	Y	Requires pre-authorization, rationale/treatment plan, a completed HDL form, complete set of diagnostic color photos (or OrthoCad equivalent), and panoramic x-ray. Cephalometric radiograph is required. Periapical radiographs are optional. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee. Most cases will be limited to twenty-four months of adjustments. Procedures covered under code D8090: Constructing and placing fixed maxillary appliance, active treatment \$422.68 Constructing and placing fixed mandibular appliance, active treatment \$422.68 Each one- month period of active treatment - maxillary arch \$41.67 Each one-month period of active treatment - maxillary arch, unusual service (surgical correction case) \$60.72 Each one-month period of active treatment - mandibular arch \$41.67 Each one month period of active treatment - mandibular arch, unusual service (surgical correction case) \$60.72 Retainer or retention appliance \$113.12 Each one-month period of retention appliance adjustments, maxillary arch. Not to exceed four (4). \$22.61 Each one-month period of retention appliance adjustments, mandibular arch. Not to exceed four (4). \$22.61 Rapid palatal expander (RPE) or crossbite correcting (fixed) appliance \$214.31 Herbst appliance \$321.48 Protraction facemask \$192.88 Slow expansion appliance \$210.75 Headgear \$192.88 Inclined plane (Hawley) appliance, bite plane, with clasps \$185.76 Orthodontic appliance not listed Manually Priced Orthodontic procedure not listed Manually Priced Space maintainer - fixed - unilateral, part of comprehensive orthodontic treatment plan \$130.96 Space maintainer - fixed - bilateral, part of comprehensive \$226.22
D8210	REMOVABLE APPLIANCE THERAPY (THUMB-SUCKING & TONGUE THRUST)	0 - 20	1 per 1 lifetime	N	
D8220	FIXED APPLIANCE THERAPY (THUMB-SUCKING AND TONGUE THRUST)	0 - 20	1 per 1 lifetime	N	
D8696	REPAIR OF ORTHODONTIC APPLIANCE MAXILLARY	0 - 20	5 per 1 lifetime	N	
D8697	REPAIR OF ORTHODONTIC APPLIANCE- MANDIBULAR	0 - 20	5 per 1 lifetime	N	
D8698	RE-CEMENT OF RE-BOND FIXED RETAINER- MAXILLARY	0 - 20	5 per 1 lifetime	N	
D8699	RE-CEMENT OR RE-BOND FIXED RETAINER- MANDIBULAR	0 - 20	5 per 1 lifetime	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D8703	REPLACEMENT OF OF LOST OR BROKEN RETAINER-MAXILLARY	0 - 20	1 per 1 lifetime	N	
D8704	REPLACEMENT OF LOST OR BROKEN RETAINER-MANDIBULAR	0 - 20	1 per 1 lifetime	N	
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT.	0 - 20		Y	Used for transfer cases; additional surgical fees when surgery has been completed; additional requests for appliances for noncompliant patients; and other unspecified orthodontic procedures, by report. Requires pre authorization and narrative of medical necessity
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURE (1-3-03)	0 - 999	1 per code per 1 day	N	Not covered if definitive treatment the same day of same tooth.
D9219	EVALUATION FOR MODERATE SEDATION, DEEP SEDATION, OR GENERAL ANESTHESIA	0-999	1 per code per 1 day	N	
D9222	DEEP SEDATION/ GENERAL ANESTHESIA - FIRST 15 MIN	0 - 999	1 per code per 1 day	N	Covered for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day
D9223	DEEP SEDATION/ GENERAL ANESTHESIA -EACH 15 MIN. INCREMENT	0 - 999	7 per code per 1 day	N	Covered for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day
D9230	INHALATION OF NITROUS OXIDE/ ANXIOLYSIS, ANALGESIA	0 - 999	1 per code per 1 day	N	Covered for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA-FIRST 15 MIN	0 - 999	1 per code per 1 day	N	Covered for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ ANALGESIA - EACH 15 MIN INCREMENT	0 - 999	3 per code per 1 day	N	Covered for dental procedures that are covered Medicaid benefits and when medically necessary. One type of anesthesia is covered per day
D9248	NON-INTRAVENOUS MODERATE (CONSCIOUS) SEDATION	0 - 999	1 per code per 1 day	N	
D9310	DIAGNOSTIC CONSULTATION	0 - 999	1 per 365 days	N	Not payable if another exam procedure is billed by the same dental practice on the same day
D9410	HOUSE/EXTENDED CARE FACILITY CALL	0 - 999	1 per day per facility	N	Covered one time per day per facility
D9420	HOSPITAL CALL	0 - 999	1 per day per facility	N	Covered one time per day per facility
D9944	OCCLUSAL GUARD HARD APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE	0 - 999	1 per code every 1095 days	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D9945	OCCLUSAL GUARD SOFT APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE	0 - 999	1 per code every 1095 days	N	
D9946	OCCLUSAL GUARD HARD APPLIANCE PARTIAL ARCH REMOVABLE DENTAL APPLIANCE	0 - 999	1 per code every 1095 days	N	
D9997	DENTAL CASE MANAGEMENT	0-999		N	No reimbursement for this code. Used to identify a member with special healthcare need(s) and/or high caries risk. A narrative indicating the member's special healthcare need(s) and/or high caries risk should be included when this code is submitted on a claim.
T1013	SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES	0-999	8 per code per day (15 mins per code)	N	

B.1.b Benefit grid - special healthcare need(s)

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D0120	PERIODIC ORAL EXAMINATION	0-999	1 per 90 days	N	A narrative indicating the member's special healthcare need(s) as it relates to their dental care and/or high caries risk diagnosis should be included when submitting code D9997 on a claim. This code must be billed alongside applicable procedure codes (e.g., D0120, D1110, D1120, D1206, D1208). Please note: services will not be reimbursed without D9997 included on the claim.
D1110	PROPHYLAXIS - ADULT	14-999	1 per 90 days	N	A narrative indicating the member's special healthcare need(s) as it relates to their dental care and/or high caries risk diagnosis should be included when submitting code D9997 on a claim. This code must be billed alongside applicable procedure codes (e.g., D0120, D1110, D1120, D1206, D1208). Please note: services will not be reimbursed without D9997 included on the claim.
D1120	PROPHYLAXIS - CHILD	0-13	1 per 90 days	N	A narrative indicating the member's special healthcare need(s) as it relates to their dental care and/or high caries risk diagnosis should be included when submitting code D9997 on a claim. This code must be billed alongside applicable procedure codes (e.g., D0120, D1110, D1120, D1206, D1208). Please note: services will not be reimbursed without D9997 included on the claim.
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS	0 - 999	1 per 90 days	N	A narrative indicating the member's special healthcare need(s) as it relates to their dental care and/or high caries risk diagnosis should be included when submitting code D9997 on a claim. This code must be billed alongside applicable procedure codes (e.g., D0120, D1110, D1120, D1206, D1208). Please note: services will not be reimbursed without D9997 included on the claim.
D1208	TOPICAL APPLICATION OF FLUORIDE- EXCLUDING VARNISH	0 - 999	1 per 90 days	N	A narrative indicating the member's special healthcare need(s) as it relates to their dental care and/or high caries risk diagnosis should be included when submitting code D9997 on a claim. This code must be billed alongside applicable procedure codes (e.g., D0120, D1110, D1120, D1206, D1208). Please note: services will not be reimbursed without D9997 included on the claim.

Code	Description	Age limit	Limits	Prior auth required	Required documentation / Additional information
D9997	DENTAL CASE MANAGEMENT				No reimbursement for this code. Used to identify a member with special healthcare need(s). A narrative indicating the member's special healthcare need(s) should be included when this code is submitted on a claim.

Orthodontic forms

Handicapping Labiolingual Deviation (HLD) Index - NE (Mod):

The submitting dentist shall complete and submit the Handicapping Labiolingual Deviation (HLD) Index score sheet when submitting an orthodontic pre-treatment request. The attached score sheet may be photocopied by the dental office for completion and submission.

If the diagnosed condition does not qualify in 1 through 6 listed on the Handicapping Labiolingual Deviation (HLD) Index the dental provider must complete items 7 through 14. The total score on 7 through 14 of the Handicapping Labiolingual Deviation (HLD) Index must be 28 or greater to qualify for Medicaid coverage of orthodontic treatment.

Nebraska Orthodontic Pre-Treatment Request Form(s):

Orthodontic (interceptive and comprehensive) pre-treatment request details must be submitted using the description of the treatment to be completed. The pretreatment request can be submitted on the Nebraska Interceptive Orthodontic Pre-Treatment Request form, the Comprehensive Orthodontic Pre-Treatment Request form, or listed on an American Dental Association (ADA) claim.

Orthodontic Case Tool:

The submitting dentist should complete and submit the orthodontic case tool when submitting an orthodontic pre-treatment request. The tool can be found on UHCdental.com/medicaid under State specific alerts and resources.

NEBRASKA MEDICAID HANDICAPPING LABIO-LINGUAL DEVIATIONS FORM (HLD INDEX)

THIS FORM IS A QUANTITATIVE, OBJECTIVE METHOD FOR MEASURING MALOCCLUSION. THE HLD PROVIDES A SINGLE SCORE, BASED ON A SERIES OF MEASUREMENTS THAT REPRESENT THE DEGREE TO WHICH A CASE DEVIATES FROM NORMAL ALIGNMENT AND OCCLUSION.

PATIENT INFO

CLIENT NAME: _____ CLIENT MEDICAID NUMBER _____
 CLIENT ADDRESS: _____ CLIENT DATE OF BIRTH ___/___/___

PROVIDER INFO

(must be 20 years old or under)

PROVIDER NAME: _____ PROVIDER ID NUMBER: _____

CONDITIONS OBSERVED

PROCEDURE: SCORING STEPS 1 THROUGH 6. IF ONE OF THESE CONDITIONS EXIST, INDICATE WITH AN "X" AND SCORE NO FURTHER.

- 1. DEEP IMPINGING OVERBITE. SCORE "X" _____
- 2. CROSSBITE OF THREE OR MORE PERMANENT AND/OR DECIDUOUS POSTERIOR TEETH OR ANTERIOR CROSSBITE OF ONE TO TWO TEETH. SCORE "X" _____
- 3. CONGENITAL BIRTH DEFECT THAT AFFECTS SKELETAL RELATIONSHIP AND/OR DENTITION. SCORE "X" _____
- 4. IMPACTED CUSPIDS WITH MOST OF THE PERMANENT DENTITION PRESENT. SCORE "X" _____
- 5. OVERJET GREATER THAN 9 MM OR ANTERIOR CROSSBITE. SCORE "X" _____
- 6. MALOCCLUSION WITH OPEN BITE FROM CANINE TO CANINE. SCORE "X" _____

IF YOU HAVE MARKED AN "X" IN ANY OF THE ABOVE; **STOP**; AND PROCEED TO PRIOR AUTHORIZATION STEP 16.

PROCEDURE: COMPLETE 7 through 14 IF CASE DOES NOT QUALIFY IN 1 through 6 ABOVE. THE TOTAL SCORE WILL DETERMINE IF THE CASE QUALIFIES FOR ORTHODONTIC TREATMENT. COMPLETE INSTRUCTIONS ARE ON THE SECOND PAGE; "SCORING INSTRUCTIONS FOR HANIDAPPING MALOCCLUSION."

- POSITION THE PATIENT'S TEETH IN CENTRIC OCCLUSION. RECORD MEASUREMENTS N THE ORDER GIVEN AND ROUND TO THE NEAREST MILLIMETER (MM).
- ENTER SCORE "0" IF CONDITION IS ABSENT.
- NOTE: WHEN COMPLETEING 11 AND 12, IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVER CONDITION. DO NOT SCORE BOTH CONDITIONS.

- 7. OVERJET IN MM. (1 - 8 MM) _____
- 8. OVERBITE IN MM. (ANTERIOR CROSSBITE) _____
- 9. MANDIBULAR IN PROTRUSION, IN MM. X5 _____
- 10. OPEN BITE, IN MM. X4 _____
- 11. ECTOPIC ERUPTION: COUNT EACH TOOTH EXCLUDING 3RD MOLARS.
 LIST TEETH _____ # OF TEETH X3 _____
- 12. ANTERIOR CROWDING OR SPACING: SCORE ONE POINT FOR MAXILLA, AND/OR ONE POINT FOR MANDIBLE; TWO POINT MAXIMUM.
 SCORE THE ONE OR TWO X5. # X5 _____
- 13. LABIOLINGUAL SPREAD IN MM. _____
- 14. POSTERIOR UNILATERAL CROSSBITE. (MUST INVOLVE TWO OR MORE ADJACENT TEETH, ONE OF WHICH MUST BE A MOLAR)
 IF PRESENT SCORE 4 _____

A TOTAL SCORE OF 28 OR GREATER CONSTITUTES A HANDICAPPING MALOCCLUSION: TOTAL OF 7 through 14 _____

IF 7 – 14 ABOVE SCORED 28 OR GREATER, PROCEED TO PRIOR AUTHORIZATION STEP 16.

- 15. IF TOTAL SCORE IS 27 OR UNDER, **STOP**, DO NOT PROCEED TO PRIOR AUTHORIZATION STEP 16. A SCORE OF 27 OR UNDER WILL NOT BE REVIEWED, CONSIDER THIS SCORE SHEET AS PROOF OF DENIAL FOR CONSIDERATION. DO NOT PROCEED TO COMPLETE AND BILL FOR CEPH FILM AND DIAGNOSTIC CASTS, THEY MAY NOT BE PAID WITHOUT AN ORTHODONTIC TREATMENT APPROVAL.
- 16. IF THE ABOVE CONDITIONS QUALIFY FOR A REVIEW (YOU MUST HAVE AN "X" AND/OR A SCORE OF 28 OR ABOVE) YOU MAY PROCEED TO SUBMIT FOR PRIOR AUTHORIZATION WITH REQUIRED DOCUMENTATION CHECKED OFF BELOW. IN ORDER FOR MEDICAID PATIENTS TO RECEIVE TIMELY TREATMENT, PLEASE CONSIDER YOUR REQUEST FOR APPROVAL AS YOUR ACCEPTANCE OF THE MEDICAID FEE AND A COMMITMENT TO COMPLETE CARE. ADA FORM _____ CEPH FILM _____ X-RAYS _____ PHOTOS _____ NARRATIVE _____

Handicapping Labiolingual Index (HLD) - (NE-Mod)
Scoring Instructions for Severe Malocclusions

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the index, and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or disposable ruler) scaled in millimeters. Absence of any condition must be recorded by entering "0" on 7 - 14. Measurements are rounded to the nearest millimeter.

- 1 – 6. Indicate an "X" on the score-sheet. These conditions are automatically considered a handicapping malocclusion and no further scoring is necessary.
7. **Overjet in Millimeters:** This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Enter the number of millimeters as the HLD score.
8. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Anterior crossbite may exist in certain conditions and should be measured and recorded. Enter the number of millimeters as the HLD score. (Vertical measurement.)
9. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. A anterior crossbite, if present, should be shown under "overbite". The measurement in millimeters is entered on the score-sheet and multiplied by five (5). Enter the multiplied total as the HLD score. (Horizontal measurement.)
10. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. In cases of pronounced protrusion associated with open bite, measurement of the open bite should be estimated. The measurement is entered on the score-sheet and multiplied by four (4). Enter the multiplied total as the HLD score.
11. **Ectopic Eruption:** Count each tooth. Teeth deemed to be ectopic must be more than 50% blocked out and clearly out of the dental arch. Mutually blocked teeth are counted one time and third molars are excluded. If condition #12, anterior crowding is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. **DO NOT SCORE BOTH CONDITIONS.** Enter the number of teeth on the score-sheet and multiply by three (3). Enter the multiplied total as the HLD score.
12. **Anterior Crowding or spacing:** Arch length insufficiency or excess must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. If condition #11, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. **DO NOT SCORE BOTH CONDITIONS.** Two point maximum multiplied by five (5) for a maximum score of 10. Enter the multiplied total as the HLD score.
13. **Labiolingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is present only the most severe individual millimeter measurement should be entered on the index. Enter the number of millimeters as the HLD score.
14. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. If posterior unilateral crossbite is present enter four (4) as the HLD score.

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name:	Patient's Medicaid #:
Birthdate:	Date of Request:
Provider Name:	Provider Medicaid #:
Provider Address: (Street, City, State, Zip)	Phone Number:

<u>Treatment Request:</u>	<u>Maxillary Arch</u>	<u>Mandibular Arch</u>	<u>Fee</u>	<u>Administrative Use Only</u>
Inclined plane (Hawley) appliance, bite plane, with clasps	_____	_____	_____	_____
Cross-bite appliance, anterior, acrylic	_____	_____	_____	_____
Cross-bite appliance, posterior, two bands plus attachments	_____	_____	_____	_____
Adjustments of appliance (# each arch)	_____	_____	_____	_____
Space maintainer – fixed – unilateral	_____	_____	_____	_____
Space maintainer – fixed – bilateral	_____	_____	_____	_____
Description appliance not listed:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
	<u>Number Requested</u>			
Chrome steel wire clasps – each .036 or minimum .030	_____	_____	_____	_____
Attachment springs for appliance, each	_____	_____	_____	_____

Diagnostic Narrative:

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name: Enter the full name (first, middle initial, and last name) of the client.

Patient's Medicaid #: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- Appliances: Under the Maxillary Arch and Mandibular Arch column check the type of appliances being requested.
- Adjustments of pedodontic and interceptive appliances: Enter the number of adjustments for the Maxillary arch and Mandibular Arch in the appropriate column.
- Chrome steel wire clasps - enter the number of clasps requested.
- Attachment springs for appliance - enter the number of springs requested.
- Enter the dentist usual and customary fee for each treatment being requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Client Name: Enter the full name (first, middle initial, and last name) of the client.

Client's Medicaid: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the date the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- In the Maxillary Arch and Mandibular Arch column check the column for the treatment or type of appliance being requested for each arch.
- Number of months of arch adjustments – Enter the number of months of monthly adjustments being requested for each arch.
- Number of months of retention appliance treatment – Enter the number of months of retention visits.
- Fee Column: Enter the dentist usual and customary fee for the treatment requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.



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