Dental Prior Authorization Level 3 (PA3) Request Form

Submission Instructions: Please complete this form when requesting dental procedures/services and send it to the World Trade Center (WTC) Health Program by posting it to the secure SFTP server and then sending an email to WTCMedCode@csgov.com indicating the secure server posting of this request. Incomplete forms will be sent back for more information.

Member Information | **Provider/Requestor Information**

Request Date:	☐ Survivor ☐ Responder	Requestor Name:	Requestor Credentials:
Member Name:	Date of Birth:	Requestor Fax:	Requestor Phone:
Member 911#:	CCE/NPN:	Requestor Email:	
Relevant Certified Condition(s) and ICD Code:		Request Urgency: Routine ☐ Urgent ☐	
		Urgency Rationale:	

Dental Request

If you need additional procedure lines, please attach a second form filling out only procedures/codes being requested.

	Area of Oral Cavity	Tooth Number	Tooth Surface	Quantity	Procedure CDT Code	Description	Estimated Fee
1							
2							
3							
4							
5							
6							
7							
8							

Dental services/procedures requiring a Level 2 Prior Authorization (PA2) are documented appropiately at CCE/NPN. Yes ☐ No ☐

Member's treatment plan less than 120 days old. Yes ☐ No ☐

Dental Provider Information (Used for Pricing)

Dental Provider Name:
Clinic/Office Address & Phone:
Provider Email:

Clinical Summary: Please provide a chronological summary narrative decribing the member's treatment course, the medical necessity for these procedures/services and how they relate to the treatment or management of the certified WTC-related condition and/or medically associated condition. Such medically necessary dental care is limited to targeted care necessary in preparation for treatment of the certified WTC-health condition or to address dental concerns resulting from treatment. Please describe the procedures/services requested above. Please describe the comprehensive dental treatment plan for the member, including ALL expected dental treatment for the next 12 months. Please also document all other relevant criteria designated in the WTC Health Program Policy and Procedures Manual and in the WTC Health Program Codebook guidelines for these procedures/services.

Digital signature accepted:

Signature:_____

FOR NIOSH WTC HEALTH PROGRAM INTERNAL USE ONLY

Decision:

Decision Comments: