

**NF PETI Medical Necessity Certification Form
Dental Services Criteria**

Client name _____

Medicaid State ID Number _____

Medical Necessity (Shall be completed by the attending physician)

Circle all appropriate items.

Dentures full or partial

1. Edentulous, loss of teeth or planned removal of teeth.
2. Denture wearer previously and currently not wearing due to:
 - A. Client did not have dentures when admitted.
 - B. Client's dentures are broken/ lost. Nursing facility shall provide information regarding breakage/loss.
 - C. Dentures fit poorly.
 - D. Fit is poor and existing dentures cannot be adapted.
3. Client desires and has the physical and cognitive ability to wear dentures.
4. There is no history of or current contraindication to the client's wearing dentures, (e.g. poor healing, history of chronic mouth or gum infections, history of poor tolerance to dentures).

Dental and Preventative Care

1. Treatment is requested for:
 - A. Caries
 - B. Abscesses
 - C. Need for repair of teeth
 - D. Periodontal (gum) concerns
 - E. Other, be specific _____
2. Input received from primary care physician noting contraindications and/or the need for prophylactic antibiotics.

Surgical procedures, crowns, fixed bridges or other dental procedures besides routine dental hygiene.

1. Surgery necessary to prepare mouth for dentures. Client shall meet criteria in Sections 3 and 4 above.
2. Extractions.
3. Other dental procedures requested through NF PETI shall contain adequate documentation of medical necessity. Tooth numbers shall be provided with each request.

Facility Instructions

1. Prescriptions for dentures (partial or full, fixed or removable) or dental care shall be provided by a licensed dentist (Doctor of Dental Surgery, Doctor of Medical Dentistry).
2. Purchase of new dentures, full or partial, to replace existing dentures shall include documentation of the reason the existing dentures require replacement.
3. For any procedure listed as a potential Adult Dental Medicaid benefit, a claim shall be submitted to Medicaid and denied before that procedure can be submitted to NF PETI.

Revised August 2005

Dental Criteria for NF PETI

Side 2

4. The nursing facility shall complete the following section regarding prophylaxis (e.g. scaling, planing, debridement, routine cleaning and polishing, and related services), routine dental evaluations and x-rays when submitting a NF PETI request for coverage of service(s).
 - A. Has resident had any form of dental prophylaxis in the last 12 months? If yes, give date. _____
 - B. Were any of the prophylactic services previously performed, or is the service currently being requested to be performed by an independent dental hygienist? ____Yes ____ No
 - C. Has resident had any clinical oral evaluations or radiographs (x-rays) billed as NF PETI during the calendar year that were paid from the client's first \$400 of NF PETI funds? ____ Yes ____ No
If yes, provide procedure code, date of service, provider name and amount paid.
5. Attach a copy of the itemized provider bill or treatment plan which includes diagnostic codes, ADA-CDT procedure codes, tooth numbers included in each procedure and the cost of each procedure.

Requested NF PETI amount:_____

I certify that I consider the supplies and/or services included in this request to be medically necessary and that there are no medical or cognitive contraindications to providing these supplies and/or services.

Signature of Attending Physician _____ Date _____ License# _____

Signature of Dental Provider _____ Date _____ License# _____

I agree to the purchase of the supplies and/or equipment covered by this request. I understand that NF PETI may not cover the entire cost.

Signature of Client or Responsible Party _____ Relationship _____

Incomplete forms shall be returned for completion.