



## PRIOR AUTHORIZATION for ANESTHESIA SERVICES FOR DENTAL

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

### Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:
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### Section II: PROVIDER(S) INFORMATION

Ordering Provider:	Ordering Provider Address:
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Ordering Provider NPI #:	Ordering Provider TIN #:	Contact Person:	Phone: (     )	Facsimile: (     )	Email Address:
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Rendering Provider:	Rendering Provider Address:
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Provider NPI #:	Provider TIN #:	Contact Person:	Phone: (     )	Facsimile: (     )	Email Address:
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Facility/Hospital:	Facility/Hospital Address:
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Facility NPI #:	Facility TIN #:	Contact Person:	Phone: (     )	Facsimile: (     )	Email Address:
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### Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: <b>Please check.</b> <input type="checkbox"/> Auth Extension <input type="checkbox"/> Pre-Auth <input type="checkbox"/> Retro Auth	B. Requested Date(s) of Service: From:                      To:	C. Place of Service: <b>Please check.</b> <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Inpatient <input type="checkbox"/> Office <input type="checkbox"/> Outpatient
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D. Primary Diagnosis/ICD-10 Code:	E. Secondary Diagnosis/ICD-10 Code:
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F. Are services related to a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident: _____	G. Are services related to a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Injury: _____
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H. Type of Anesthesia being requested: <b>Please check all that apply.</b> 1. <input type="checkbox"/> General Anesthesia (CPT code range 00100-01999; CPT code 41899 for dental services under medical) 2. <input type="checkbox"/> Intravenous Sedation 3. <input type="checkbox"/> Monitored Anesthesia Care (CPT code range 00100-01999; CPT code 41899 for dental services under medical) 4. <input type="checkbox"/> Nitrous Oxide	I. Requested Anesthesia CPT Code(s):
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J. Service (s) Requested: <b>Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.</b>	
Service/Description: _____	CPT/HCPCS code: _____ <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right
Service/Description: _____	CPT/HCPCS code: _____ <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right
Service/Description: _____	CPT/HCPCS code: _____ <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right
Service/Description: _____	CPT/HCPCS code: _____ <input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right

QUESTION	YES	NO	COMMENTS/NOTES
1. Is the patient 6 years old or younger and has a dental condition (e.g., baby bottle syndrome) that requires repairs of significant complexity (e.g., multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions, or any combination of these noted or other dental procedures)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the patient exhibit physical, intellectual, or medically compromising conditions, (i.e., cerebral palsy, epilepsy, cardiac problems, and hyperactivity) for which dental treatment under local anesthesia or sedation in a dental office has failed to provide a successful result & which, under anesthesia, can be expected to produce a superior result?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the patient require an extensive dental procedure and is classified by the American Society of Anesthesiologists (ASA) as class 3 or class 4?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the patient require an extensive dental procedure and classified with a Mallampati score of 3 (soft palate, base of uvula visible) or 4 (soft palate not visible at all)?	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Comments:
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By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

*\*Please fax completed form and medical records to 801-366-7449.*