PEHP Health & Benefits

PREAUTHORIZATION for DENTAL SERVICES (*Excluding Single-Tooth Prosthodontic Restoration*)

For authorization, please complete this form and include patient chart notes with photographic and radiographic documentation. Submit by fax to PEHP Prior Authorization at (801) 366-7449, by mail to 560 East 200 South, Salt Lake City, UT 84102, or through the Provider Portal Message Center. For prior authorization or benefit questions, 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 #:

Section II: DENTIST INFORMATION

Rendering Dentist:	Rendering Dentist Specialty:	Rendering Dentist Address:

Dentist NPI #:	Dentist TIN #:	Contact Person:	Phone: ( )	Facsimile: ( )	Email Address:

Rendering Dental Practice/Group:	Rendering Dental Practice/Group Address:

Practice/Group NPI #:	Practice/Group TIN #:	Contact Person:	Phone: ( )	Facsimile: ( )	Email Address:

Facility/Hospital:	Facility/Hospital Address:

Facility/Hospital NPI #:	Facility/Hospital TIN #:	Contact Person:	Phone: ( )	Facsimile: ( )	Email Address:

Section III: PREAUTHORIZATION REQUEST

Nature of Request: *Please check.*

☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent

Requested Date(s) of Service:

From: To:

Place of Service: *Please check.*

☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Are services related to a motor vehicle accident? ☐ Yes ☐ No **Other accident?** ☐ Yes ☐ No

Date of Accident: __________ Accident Details: ____

Are services related to a work-related injury? ☐ Yes ☐ No

Date of Injury: ______________________________________

Is the requested service related to re-cementing, repair, or replacement?

☐ Yes ☐ No If Yes, enter most recent service date: ________________________

Is the requested service a retreatment? ☐ Yes ☐ No

If Yes, enter prior treatment date: ____

Primary Diagnosis/Condition (ICD-10 Code, if required):

Secondary Diagnosis/Condition (ICD-10 Code, if required):

Procedure Codes Requested: ***Please describe/list all requested services (CDT codes) regardless of pre-auth requirement. Unspecified codes are not covered.***

Procedure: ____ CDT Code: __________________________ Tooth Number(s) (*if applicable*): ________________________

Area of Oral Cavity (if applicable) – *Check all that apply*: ☐ Entire oral cavity (00) Arch: ☐ Maxillary (01) ☐ Mandibular (02)

Quadrant: ☐ Upper Right (10) ☐ Upper Left (20) ☐ Lower Left (30) ☐ Lower Right (40) ☐ Other (*specify below in Additional Comments*)

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Additional Comments:

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

****Please fax the completed form with records and images to 801-366-7449 or submit via the Provider Portal Message Center.***