PREAUTHORIZATION for SINGLE-TOOTH PROSTHODONTIC RESTORATION

(*Only required for Peg Laterals, Restorative Labial Veneers, and Tooth Surface Loss Restorations*)

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:

Dental Practice/Group:	Dental Practice/Group Address:

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

Section III: PREAUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Date of Service:	Place of Service: *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	From: To:	☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

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

Procedure: _____ CDT Code: _____ Tooth Number(s): _____

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

Date of Accident: _____ Accident Details: _____

B. Are services related to a work-related injury?

☐ Yes ☐ No Date of Injury: _____

C. Type of Single-Tooth Restoration Being Requested: ***Please check.***

☐ Custom Crown ☐ Interim Restoration ☐ Onlay ☐ Prefabricated Crown ☐ Provisional Restoration ☐ Restorative Labial Veneer ☐ Temporary Restoration

D. Primary Diagnosis/Condition (ICD-10 Code, if required):	E. Secondary Diagnosis/Condition (ICD-10 Code, if required):
F. Date of Initial Restoration if Replacement:	**G. Date of Most Recent Re-Cement/Re-Bond or Repair:**

QUESTION	YES	NO	COMMENTS/NOTES
H. ☐ Crowning of Peg Lateral Incisors (Tooth #7 and #10):			
1. Is the requested service for peg laterals related to genetic conditions (e.g., Down Syndrome, Ectodermal Dysplasia, Orofacial Digital Syndrome, Rieger Syndrome, or Witkop Syndrome) or developmental disruptions during tooth formation?	☐	☐	
2. Does the patient require restoration of proper incisal edge form to enable effective biting of food and provide appropriate occlusal guidance, thereby correcting functional limitations caused by peg lateral morphology?	☐	☐	
3. Does the patient require treatment to strengthen teeth with insufficient enamel or dentin that would otherwise be prone to fracture, ensuring durability and resistance to normal oral function?	☐	☐	

PEHP Health & Benefits

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:

QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
4. Does the patient require treatment to provide a stable foundation for prosthetic applications, such as using crowns on peg laterals as abutments for fixed bridges or as supportive structures for implant restorations?	☐	☐	
5. Does the patient have pre-treatment bitewing or periapical radiographs that show a developmental anomaly?	☐	☐	*Please submit radiograph images*
6. Does the patient have intraoral photographs (close-up images taken inside the mouth to show tooth surfaces) and clinical photographs (extraoral images of the teeth and smile) that support the diagnosis and demonstrate the treatment need?	☐	☐	*Please submit intraoral and clinical photographic images*
7. Is the requested service intended primarily for cosmetic purposes (e.g., esthetic enhancement only)?	☐	☐	
I. ☐ Crowns and Onlays for Tooth Surface Loss (TSL):			
1. Does the patient have extensive tooth surface loss (TSL) due to any of the following causes? *Please check all that apply.* ☐ Abfraction ☐ Abrasion ☐ Attrition ☐ Erosion ☐ Other	☐	☐	***Note:** Pre-auth is required only for cases of abrasion or attrition*
2. Does the patient experience difficulty chewing or incising food due to loss of tooth structure that impairs normal oral function?	☐	☐	
3. Does the patient experience generalized or localized sensitivity resulting from exposed dentin or pulp due to surface loss?	☐	☐	
4. Does the patient show continued loss of tooth structure caused by occlusal forces, indicating active deterioration?	☐	☐	
5. Does the patient present with pulpal symptoms, such as reversible pulpitis or pulp exposure, directly attributable to surface loss?	☐	☐	
6. Does the patient have increased susceptibility to structural failure or breakage due to weakened tooth integrity from surface loss?	☐	☐	
7. Does the patient have pre-treatment bitewing or periapical radiographs that that demonstrate structural compromise such as loss of enamel, dentin, or supporting tooth structure due to tooth surface loss (TSL)?	☐	☐	*Please submit radiograph images*
8. Does the patient have intraoral photographs and clinical photographs, which are extraoral images of the teeth and smile, that together support the diagnosis of tooth surface loss (TSL) and demonstrate the medical necessity of treatment?	☐	☐	*Please submit intraoral and clinical photographic images*
9. Is the requested crown or onlay intended primarily for cosmetic purposes (e.g., esthetic enhancement only)?	☐	☐	
J. ☐ Restorative Labial Veneers (Tooth #6 through #11):			
1. Does the patient have extensive tooth surface loss (TSL) due to any of the following causes? *Please check all that apply.* ☐ Abfraction ☐ Abrasion ☐ Attrition ☐ Erosion ☐ Other	☐	☐	***Note:** Pre-auth is required for all labial veneer requests.*
2. Does the patient present with enamel-only fractures that are too extensive or irregular to be adequately repaired with a direct restoration (e.g., composite resin placed directly into the tooth in a single appointment)?	☐	☐	
3. Does the patient have enamel defects (such as hypocalcification, hypoplasia, or severe decalcification) where such defects are too extensive or irregular to be adequately repaired with a direct restoration (e.g., composite resin placed directly into the tooth in a single appointment)?	☐	☐	
4. Does the patient experience difficulty chewing or incising food due to loss of tooth structure that impairs normal oral function?	☐	☐	
5. Does the patient experience generalized or localized sensitivity resulting from exposed dentin or pulp due to surface loss?	☐	☐	
6. Does the patient show continued loss of tooth structure caused by occlusal forces, indicating active deterioration?	☐	☐	
7. Does the patient have pre-treatment bitewing or periapical radiographs (X-rays) confirming no pathology and supporting the medical necessity of the veneer treatment?	☐	☐	*Please submit radiograph images*
8. Does the patient have intraoral photographs and clinical photographs, which are extraoral images of the teeth and smile, that together support the diagnosis of tooth surface loss (TSL) and demonstrate the medical necessity of treatment?	☐	☐	*Please submit intraoral and clinical photographic images*
9. Is the requested labial veneer intended primarily for cosmetic purposes (e.g., esthetic enhancement only)?	☐	☐	

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.***