Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

Evaluation of the Dental Implant Patient Form

NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Dental review

Dentist Name:_____ NPI:_____

Member Name:_____ CIN:_____ Age:_____

Medical History:_____

_____

_____.

Current Medications:_____

_____

_____.

Allergies to Medications:_____.

List any significant medical conditions that the member is currently being treated for: _____

_____.

Identify the physician(s) currently treating the member for any of the above-listed medical condition(s):

_____.

Detail the member's medical necessity for dental implants: _____

_____.

Detail why other covered functional alternatives for prosthetic replacement will not correct the member's dental condition:

_____

_____.

The above patient is an acceptable candidate for dental implant surgery: _____Yes _____No

_____

Dentist signature:_____**Date:**_____