Fax completed form to: (515) 725-0938

Department of HUMAN SERVICES

Dental Request for Prior Authorization

Please complete electronically, accuracy is important.

1. Patient Name (Last)	(First)	M.I.	2. Patient Medicaid Identification No.	3. DOB-M/D/YY

4. Dispensing Provider Name	5. Provider NPI	6. Provider Taxonomy No.

7. Service Location: Street Address	8. Service Location: City, State, Zip	9. Provider Phone	10. Provider Fax

11. Dates Covered by Request						12. Prior Authorization No. (To be assigned by IME) Enter this number in the appropriate box when submitting the claim form for the services authorized.
From			To			
Month	Day	Year	Month	Day	Year	

13. Reason(s) for Request (Provide specific information and use additional sheet if necessary.)

Services to be Authorized

14. Line No.	15. Procedure or Service to be provided	16. CDT Code	17. Units of Service	18. Authorized Units (leave blank)	19. Amount Requested	20. Authorized Amount (leave blank)	21.Status (leave blank)
01							
02							
03							
04							
05							
06							

22. Important Note: In evaluating requests for prior authorization the need for treatment will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility prior to service by calling the ELVS line at 1-800-338-7752 (locally at 515-323-9639) or by accessing the Web Portal. Contact Provider Services at 800-338-7909 or (locally) 256-4609 for assistance in accessing the Web Portal.

23. Requesting Provider Signature of Authorized Representative Date

Prior Authorization Reviewer Use Only

24. Medicaid services are hereby ☐ Approved ☐ Denied for the member under Title XIX. This authorization applies only to the eligible person above for the service(s) specifically approved above.

25. Comments or Reasons for Denial of Services

Provider information, procedure, supply or drug codes authorized on this request must be the same codes entered on the claim form.

Signature Iowa Medicaid Enterprise Date