NYS MEDICAL ASSISTANCE TITLE XIX PROGRAM
ORDER/PRIOR APPROVAL REQUEST DENTAL SERVICES

DO NOT STAPLE IN BARCODE AREA

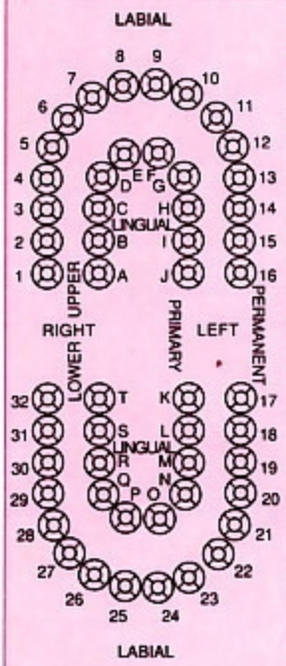
ORDER DATE	CLIENT ID

CLIENT NAME	CLIENT ADDRESS	CLIENT TELEPHONE NUMBER	SEX	DATE OF BIRTH
			M F	M M D D C C Y Y

REFERRING PROVIDER NAME	REFERRING PROVIDER NUMBER	PROF CD	REFERRING PROVIDER ADDRESS/TELEPHONE

REQUESTING PROVIDER NAME	REQUESTING NUMBER	LOC CD	REQUESTING PROVIDER ADDRESS/TELEPHONE

SERVICING PROVIDER NAME	SERVICING PROVIDER NUMBER	PROF CD	SERVICING PROVIDER ADDRESS/TELEPHONE



Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. See charting system shown.

	PROCEDURE CODE	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION	TIMES REQ	AMT REQ
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

ARE X-RAYS INCLUDED? ☐ YES ☐ NO ☐ F.M.S. ☐ PANOREX

BITEWINGS How many? _____

PERIAPICALS How many? _____

If Prosthesis is this initial placement? ☐ YES ☐ NO

If no, enter date of prior placement M M / D D / C C Y Y

REMARKS FOR UNUSUAL SERVICES

	PROCEDURE CODE	MOD	DENT SITE	TIME REQ	TOTAL AMOUNT REQUESTED		PROCEDURE CODE	MOD	DENT SITE	TIME REQ	TOTAL AMOUNT REQUESTED		PROCEDURE CODE	MOD	DENT SITE	TIME REQ	TOTAL AMOUNT REQUESTED
1						13						25					
2						14						26					
3						15						27					
4						16						28					
5						17						29					
6						18						30					
7						19						31					
8						20						32					
9						21						33					
10						22						34					
11						23						35					
12						24						36					

Sample - Not For Submission

PA REVIEW OFFICE CODE

↑
← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER