D.57 THSteps Dental Mandatory Prior Authorization Request Form

Submit to:

THSteps Dental
Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917

APPROVED

DENIED

NOTE: ALL INFORMATION IS REQUIRED – PRINT CLEARLY OR TYPE

Patient's Name and Address	Sex M ( ) F ( )	Patient's Birth Date Medicaid Number

CHECK DIAGNOSTIC TOOLS SUBMITTED FOR REVIEW WITH AUTHORIZATION REQUEST:
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FOR RESTORATIVE AND ICFMR:		FOR ORTHODONTIC CASE, DIAGNOSTIC TOOLS MAILED:			
Panorex	( )	Models	( )	Cephlometric X-ray	( )
FM X-ray	( )	HLD	( )	FM X-ray	( )
Periapicals	( )	Panorex	( )	Photos	( )
Documentation	( )	Documentations	( )	Other:	

DATE OF SERVICE DIAGNOSTIC TOOLS WERE PRODUCED:

PROCEDURE CODE	TOOTH # OR LETTER	SURFACE	CHARGE
			Total

NOTE: ALL INFORMATION REQUIRED – PRINT CLEARLY OR TYPE

Signature of Dentist: Date:	TPI	Dentist Address and ZIP Telephone Number

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