SC/RP Preauthorization form: Denti-Cal University Project

Provider Name and ID #: _____ Date: _____

Patient Name: _____Chart ID#:_____

- **Scaling/Root planing D4341** FULL quad (circle quad/s):
  UR UL LR LL

- **Scaling/Root planing D4342** PARTIAL 1-3 teeth/quad (circle quad/s):
  UR UL LR LL

Criteria (Please check):

□ Date and Type of Radiograph: _____ (Requires PAs of all involved teeth for the quadrant in question & BWX **last 14 months**; No BWX needed if patient is pregnant)

□ Requires current and complete periodontal evaluation chart
- Current: within 12 months
- Complete
  - At least four pocket readings per tooth, two buccal two lingual
  - Mobility for each tooth
  - Missing teeth and teeth to be extracted annotated

□ A benefit once per quadrant every 24 months

□ **EACH QUALIFYING TOOTH** must have:
- At least one pocket depth of 4 mm or greater
- Connective tissue attachment loss
- Radiographic evidence of minimal bone loss and/or subgingival calculus on the root surface

□ *Excluding tooth that is:*
- non-restorable, extraction indicated, or having a poor 5-year longevity prognosis

Patient meets criteria for SRP and consult noted in EHR:_____ (faculty signature)

Admin Check List:

□ Transaction notes: COE completed
□ Diagnosis & **Prognosis codes in Treatment History Tab**
□ Insert the form request # if more than one is pending
□ History for previous treatment paid by Denti-Cal
□ Radiographs within the last 14 months
□ Perio Charting: mobility scores for all teeth (0-3, no blanks)

□ EVC #: _____ (Enter in EHR)

□ ACC Name: _____

AFTER CLINIC DIRECTOR DECISION, SUBMIT ALL FORMS TO FINANCIAL ASSISTANT