Anesthesia Prior Authorization Request Form

[Must be completed by the performing provider and submitted with Prior Authorization documentation for dental procedures for which anesthesia is requested]

Date of Request: ____________________ Routine ___ Urgent ___ Expedited ___

Section I: Client Information

____________________	____________________	____________________
Last Name	First Name	Client Identification Number
____________________	____________________	____________________
Date of Birth	Client's PCP	PCP's Phone Number

Section II: Clinical Documentation

Dental Diagnosis: ____

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Medical Conditions Warranting
Medical Necessity for Dental Anesthesia: ____

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Proposed Dental Procedures/Services: ____

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Proposed Anesthesia: Include Pharmacological Agents to Be Used and Anticipated Units of Anesthesia Needed

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Section III: Provider Information

______________________________	______________________________
Requesting Provider Name (Print)	NPI (Print)
______________________________	______________________________
Provider Signature	Date

CTDHP Review: Approved ____ Denied ____ Modified ____

Units Approved: ________________ Prior Authorization Approval Number: ______________________

Prior approval is not a guarantee of payment of claims. Payment of claims is subject to member eligibility, frequency limitations, and coverage guidelines.

Return completed form to:

BeneCare Dental Plans, 555 E. City Ave Ste. 600 Bala Cynwyd, PA 1 9 0 0 4