



PINAL COUNTY  
Wide open opportunity

PINAL/GILA LONG TERM CARE  
REQUEST FOR REFERRAL  
**DENTAL SERVICES FOR MEMBERS 21 AND OLDER**  
PLEASE FAX ALL REQUESTS TO (520) 866-6717

MEMBER NAME: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_

DOB: \_\_\_\_\_ OTHER INSURANCE: \_\_\_\_\_ MEDICARE A  B

REQUESTED PROVIDER: \_\_\_\_\_ ID: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**URGENCY STATUS (see \* for definitions of status):**

- Standard (Based on members' condition – Not to exceed 14 days)  
 Expedited – Urgent (within 3 days)

Date of Service: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

**Services Requested:**

Tooth Number	Requested CPT Code	Estimated Cost	Tooth Number	Requested CPT Code	Estimated Cost	Other Codes Requested	Estimated Cost

**Please answer the following questions:**

- Is member in severe pain? Yes  No
- Does member have an acute infection? Yes  No  If yes, describe location of pain/infection and if pain is intermittent or constant, and duration of pain. \_\_\_\_\_
- What treatment for pain relief/infection has been used? \_\_\_\_\_
- Has member had a traumatic injury to teeth, bone, or soft tissue? Yes  No  If yes, please describe extent of injury. \_\_\_\_\_
- If requesting dentures, answer the following questions:  
Has member ever worn dentures? Yes  No  Successfully? Yes  No   
If repair is being requested, is the repair essential to the serviceability of the appliance? Yes  No
- Does member have TMJ? Yes  No   
Describe the medical reasons such as low body mass index, malnutrition or other medical findings that support the need for dentures: \_\_\_\_\_  
If partials are recommended, describe how they are essential function? \_\_\_\_\_

Absence of teeth/dentures does not, per se, create a nutritional criterion for medical necessity. Adjustment of texture or use of supplements will generally meet nutritional needs. The inability for proper mastication alone does not constitute justification for the provision of dentures.

**Please attach the following: (Mandatory)**

- PCP order
- Physician progress notes, which describe dental condition.
- Any other relevant documentation

**Referring Provider Information:**

Provider Name: \_\_\_\_\_ ID Number: \_\_\_\_\_ Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_

PCP/PCP Designee Signature: \_\_\_\_\_

**PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records.**

**\*Standard Authorization Request:** This is a request that P/GLTC provides a decision as promptly as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to reach a decision.

**\*Expedited Authorization Request:** A request for which P/GLTC provides a decision to the member as expeditiously as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request with a possible extension of up to 14 days if the member or provider requests and extension or if P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.

**Referral authorization is not guarantee of payment.**