Dental
Prior Authorization Level 3 (PA-3) Request Form

Submission Instructions: Please complete this form when requesting Dental and send it to the World Trade Center Health Program by posting it to the secure SFTP server and then sending an email to WTCMedCode@csc.com indicating the secure server posting of this request. Incomplete forms will be sent back for more information. Please note each dental procedure per tooth, separately. DO NOT FILL OUT NIOSH DECISION OR NIOSH DECISION RATIONALE.

General and Member Information

Request Date

Member Type

◯ Responder ◯ Survivor

Member Name

Choose a CCE/NPN

Member Date of Birth

Member 911#

Relevant Certified Condition

ICD Code

Relevant Certified Condition

ICD Code

Relevant Certified Condition

ICD Code

CCE/NPN Requester Information

Requester Name

Requester Credentials

Requester E-mail

Requester Phone

Clinical Director Name (if not requester)

Clinical Director Concurrence Signature

Pre-Dental workup/testing is documented properly (PA2) in members record.

◯ YES ◯ NO

Dental Request

Procedure/Service | Tooth/Area | CDT Code | Estimated Charge

NIOSH Decision | NIOSH Decision Rationale | Approved Charge

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NIOSH Decision | NIOSH Decision Rationale | Approved Charge

Clinical Summary: Please describe the type of procedure(s)/service(s) requested. Provide medical necessity rationale for requested procedures, in particular noting how it relates to the treatment or management of the certified WTC-related condition or medically associated condition. Treatment must be non-experimental and non-investigational . Document or attach other required criteria noted in the WTCHP Codebook guidelines, WTCHP Policy and Procedures Manual or other relevant supporting information.

Dental Provider Information (Used for Pricing)

Provider Name

Credentials and Specialty

Clinic/Office Address

Clinic/Office Phone

Provider E-mail

TO BE FILLED OUT BY NIOSH

Name

Credentials

NIOSH Decision

Signature

NIOSH Decision Comments