Dental Prior Authorization Level 3 (PA3)

Controlled Unclassified Information

Submission Instructions: Please refer to the World Trade Center (WTC) Health Program Administrative Manual when completing this form. Please apply the following naming convention for labeling the PDF: **PA3_Dental_[respective CCE/NPN]**. Send the completed form to the WTC Health Program by posting it to the CARE portal, or the SFTP server and then sending a Personally Identifiable Information (PII)-free e-mail to WTCMedCode@csra.com indicating the secure server posting of this request. Incomplete forms will be returned for more information. **Reference the WTCHP codebook to determine if additional information is required prior to submission.**

Request Information

Request Date_____ Request Type_____

Date of Last Provider Visit_____ Date of Last Authorization_____

Episode Type_____ Date of Service_____

Case Exception ☐ Yes ☐ No If yes, explain in Clinical Summary section at the end of the form

Member and Provider/Requester Information

Member Information

Last_____ First_____ MI_____

Date of Birth_____ Member #_____ Member Type_____

Provider Information

CCE/NPN_____ Requesting Provider Name_____

Requesting Provider Credentials_____

Requesting Provider Email_____

Requesting Provider Phone_____ Requesting Provider Fax_____

Dental Provider Name_____ Dental Provider Phone_____

WTC-Related Treatment

Relevant WTC-Related and/or Medically Associated Certified Condition(s) and ICD Code(s)

_____ _____ _____

_____ _____ _____

_____ _____ _____

WTC-Related or MAC Treatment Type_____

WTC-Related or MAC Treatment Completion Date_____

Dental Request

Use the space provided in the addendum for additional procedure lines

Dental Services _____ Dental Care Type _____

	Tooth Number	Quantity	Procedure CDT Code	Description
1				
2				
3				
4				
5				
6				

Pre-Cancer Treatment and Pre-Transplant Dental Services Rationale

The CCE/NPN Clinical Director may request authorization of pre-cancer treatment or pre-transplant dental services if ALL the criteria below are met and clearly documented in the member's medical record.

Criteria	Clinical Director's Initials
The member has a certified WTC-related certified cancer or will undergo an organ or HSC transplant secondary to a certified WTC-related health condition, or health condition medically associated with a certified WTC-related health condition.	
The services are provided while the member is under the care of a WTC Health Program-affiliated provider.	
Dental services are determined to be medically necessary because all the following criteria are established: • The member will undergo chemotherapy and/or radiation for treatment of a certified cancer OR will undergo organ or HSC transplant. • There is documentation of CCE/NPN Clinical Director PA2 authorization of a pre-treatment or pre-transplant dental examination. • A clinical note from dental examination and relevant radiographs is submitted with the PA3 request. • The member has not previously used the one-time benefit. • Clinical notes including a dental treatment plan demonstrating medically necessary required treatment prior to chemotherapy/radiation treatment or transplantation are submitted with the PA3 request.	

Head and/or Neck Cancer Medically Necessary Dental Services Rationale

The CCE/NPN Clinical Director may request authorization of pre-cancer treatment or pre-transplant dental services if ALL the criteria below are met and clearly documented in the member's medical record

Criteria	Clinical Director's Initials
Documentation of a certified WTC-related head and/or neck cancer.	
The services are provided while the member is under the care of a WTC Health Program-affiliated provider.	
Documentation of medical necessity describing how the requested dental service(s) relates to the management of the relevant, certified WTC-related head and/or neck cancer and whether the dental care is adjunctive or corrective.	
A finalized and up-to-date (<120 days old) dental treatment plan.	

Clinical Narrative

Please provide a clinical summary describing the medical necessity for the dental procedures/services requested and how they relate to the treatment or management of the certified WTC-related condition and/or MAC. Such medically necessary dental care is limited to targeted care necessary in preparation for treatment of the WTC-related health condition or to address dental concerns resulting from that treatment.

Medical Director Concurrence: I certify that for the services requested and cited above, a Level 2 prior authorization has been granted by me based upon the corresponding requirements in the WTC Health Program Administrative Manual and that this member's dental treatment plan is less than 120 days old. This approval and all associated required documentation of policy requirements and medical necessity is being maintained in the member's medical record or other CCE/NPN tracking system.

CCE/NPN Clinical Director Signature_____ **Date**_____

FOR NIOSH WTC HEALTH PROGRAM INTERNAL USE ONLY

Decision

Decision Comments

NIOSH Staff Signature_____ **Date**_____

Dental Prior Authorization Level 3 (PA3) Addendum Dental Request

Use the space below to document any additional Dental PA3 information.

Member Name_____ Member 911#_____

	Tooth Number	Quantity	Procedure CDT Code	Description
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

Clinical Narrative (cont.)