Harvard Pilgrim Health Care

Dental/Oral Surgery Procedures

Prior Authorization Request Form

Member:	Member ID#:
Member DOB:	Member Age:
Requesting physician:	Requesting physician HPHC ID #:
	NPI number:
Contact name:	Contact phone #:
	Contact FAX #:
Facility (if not done in MD office):	Facility ID #:
☐ Surgical day care ☐ Inpatient	☐ Office
Scheduled date of surgery (if known):	
Diagnosis(s):	CPT code(s):
Procedure(s):	CPT code(s):
Procedure(s):	CPT code(s):
Procedure(s):	CPT code(s):
Procedure(s):	CPT code(s):

Dental/Oral Surgery Procedures	Clinical Documentation Required
Orthognathic surgery* for correction of disabling functional malocclusion. *Note: Authorization of an approval for orthognathic surgery will be valid for 6 months. Procedures to be performed after 6 months will require resubmission and review of contemporary records in order to confirm the procedures required.	*Please submit **all** of the following:* • Narrative description of the functional impairment • Proposed treatment plan, including: - photographs - panorex radiographs - tracings to support the analysis and treatment plan
Periodontal surgery for the treatment of drug-induced gingival hyperplasia.	*Please submit **all** of the following:* • Clinical notes and photographs documenting drug induced gingival hyperplasia • Peridontal charting
Tooth extraction for a member: • Pre or post head/neck or mantle radiation • Pre chemotherapy or bone marrow or organ transplant • Severely immunodeficient due to chemotherapy or post transplant • With osteonecrosis of the jaw secondary to: IV bisphosphonate therapy, chemotherapy, bone marrow or organ transplantation, or immunodeficiency due to HIV • With osteoradinecrosis of the jaw due to head/neck or mantle radiation	*Please submit **all** of the following:* • Clinical notes and narrative documenting the medical and dental history, dental exam, and treatment plan • Radiographs and/or CT scan and photos demonstrating bone involvement where applicable
Medical/Surgical care for: • Osteonecrosis of the jaw secondary to: IV bisphosphonate therapy, chemotherapy, bone marrow or organ transplant, or immunodeficiency due to HIV • Osteoradionecrosis of the jaw due to head and neck or mantle radiation	*Please submit **all** of the following:* • Clinical notes and narrative documenting the medical and dental history, dental exam, and treatment plan • Radiographs and/or CT scan and photos demonstrating bone involvement where applicable

Fax completed form with supportive documentation to 800-232-0816
Please mail photos, diagnostic studies to:
Harvard Pilgrim Health Care—Attn: Oral Surgical Review 3rd Floor
1600 Crown Colony Drive, Quincy, MA 02169

To be completed by Harvard Pilgrim:

Harvard Pilgrim Transaction Number: _____ From: _____ To: _____