United Healthcare | Dental Benefit Providers

Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

# Evaluation of the Dental Implant Patient Form

NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Dental review

Dentist Name:_________________________________________________ NPI:____________________________

Member Name:__________________________________ CIN:_________________________ Age:___________

Medical History:_______________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________.

Current Medications:___________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________.

Allergies to Medications:_______________________________________________________________________.

List any significant medical conditions that the member is currently being treated for: ________________

__________________________________________________________________________________________.

Identify the physician(s) currently treating the member for any of the above-listed medical condition(s):

__________________________________________________________________________________________.

Detail the member's medical necessity for dental implants: _______________________________________

__________________________________________________________________________________________.

Detail why other covered functional alternatives for prosthetic replacement will not correct the member's dental condition:

__________________________________________________________________________________________

__________________________________________________________________________________________.

The above patient is an acceptable candidate for dental implant surgery: _______Yes _______No

__________________________________________________________________________________________

**Dentist signature:______________________________________Date:_______________________________**