TennCare Inpatient and Outpatient Hospital Readiness Pre-Admission Form

This form is required to be submitted with documentation as outlined in Section 15.00, Criteria for Provision of Dental Treatment in an Inpatient/Outpatient Hospital ("Hospital") Facility or in an Ambulatory Surgical Center (ASC)

Patient Name _____

Patient ID _____

Patient Address _____

_____

Date _____

A. I certify that I have examined this patient
☐ Yes ☐ No Date of Exam _____

B. There is pathology or injury requiring extensive dental treatment (restorative or surgical)
☐ Yes ☐ No

C. I certify that I have attempted to treat this patient in my office
☐ Yes ☐ No Date _____

D. If a general dentist, I have attempted to refer this patient to a dental specialist (oral surgeon or pediatric dentist)
☐ Yes ☐ No

If no, why was a referral not made?

_____

_____

E. I have attempted to manage the member with Silver Diamine Fluoride in the office (general and pediatric dentists)
☐ Yes ☐ No

F. I have offered Silver Diamine Fluoride treatment to the member in the office as an alternative to treatment under general anesthesia in a medical facility (general and pediatric dentists)
☐ Yes ☐ No

G. If answer to "E" or "F" is no, please explain why SDF has not been used (general and pediatric dentists

_____

_____

_____

H. Were radiographs taken to determine diagnosis?

☐ Yes ☐ No

I. I have submitted all the documentation required for prior authorization as described in the TennCare Office Reference Manual

☐ Yes ☐ No

J. If answer to "H" or "I" is no, please explain why the documentation is not being submitted:

_____

_____

DentaQuest reserves the right to request a second opinion for any inpatient/ outpatient hospital or ambulatory surgery center request.

I Certify That the Above Information Is Correct

Name of Provider _____

Provider Signature _____

Date _____

Submit to:

DentaQuest – TennCare
Attn: Pre-authorizations
PO Box 2906
Milwaukee, WI 53201-2906
FAX: 262.834.3452