

## DENTAL PRIOR AUTHORIZATION REQUEST

### Instructions for MSA-1680-B

The Dental Prior Approval Authorization Request form (MSA-1680-B) is to be used for persons with Medicaid coverage in the Fee For Service dental benefit and persons enrolled in Children's Special Health Care Services (CSHCS). For beneficiaries enrolled in **Healthy Kids Dental**, dentists should contact Delta Dental Plan for authorization requirements.

The MSA-1680-B must be completed by private dentists or community-based dental clinics (e.g., local health departments, Federally Qualified Health Centers (FQHC)). This form is self-explanatory.

If services are approved, the provider will receive a copy of the form marked "Approved" and with a Prior Authorization number. Approved services are required to be completed within a 180-day period. To request an extension, the provider must submit a copy of the current MSA-1680-B and required documentation within 15 days prior to the end date of the current authorization. If the original prior authorization is over one year old, a new prior authorization request must be submitted.

For further information on the prior authorization of dental services, please see the Prior Authorization Section, Dental Chapter of the Medicaid Provider Manual.

Dental providers treating CSHCS beneficiaries are required to submit the beneficiary's CSHCS qualifying diagnosis. For authorization of orthodontics and/or crown & bridge services for beneficiaries enrolled in Children's Special Health Care Services, please see the CSHCS Dental Services Section, Dental Chapter of the Medicaid Provider Manual.

The completed MSA-1680-B may be mailed or faxed, depending whether x-ray films are necessary, to:

Michigan Department of Community Health  
Dental Prior Authorization  
P.O. Box 30154  
Lansing, MI 48909  
Fax: (517) 335-0075

Questions should be directed to Dental Prior Authorization at 1-800-622-0276.

Michigan Department of Community Health  
**DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST**

[www.michigan.gov/mdch](http://www.michigan.gov/mdch)

FAX: 517-335-0075

Medicaid

CSHCS

**For MDCH Consultant Use Only**

1. Prior Authorization No.

**Note: Approval refers to service only and does not authorize fees or patient eligibility, including age.**

2. Provider Name (Last, First, Middle Initial)				9. Beneficiary Name (Last, First, Middle Initial)													
3. Provider Street Address			4. Provider County		10. Birth Date / /		11. Sex <input type="checkbox"/> M <input type="checkbox"/> F										
5. City		State	ZIP Code		12. MI Health Card No.		13. Phone No. ( ) -										
6. Provider Fax Number ( ) -		7. Provider Phone No. ( ) -		14. Does Patient Live in a Nursing or AIS Home? If Yes, Facility Name <input type="checkbox"/> No <input type="checkbox"/> Yes													
8. Provider NPI No.				15. Is Patient Covered by Any Other Dental Plan? If Yes, Plan Name <input type="checkbox"/> No <input type="checkbox"/> Yes													
16. CSHCS Diagnosis – ICD.9 Diagnosis Code and Description				17. CSHCS Diagnosis - ICD.9 Diagnosis Code and Description													
18. Are X-Rays Enclosed? <input type="checkbox"/> No <input type="checkbox"/> Yes		Number of X-Rays and Date Taken / /		22. Indicate: Missing Teeth with an "X" - Teeth to Be Extracted with a "/". 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 ----- A B C D E F G H I J ----- T S R Q P O N M L K 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17													
19. Is Treatment for Orthodontics? <input type="checkbox"/> No <input type="checkbox"/> Yes		Treatment Plan Enclosed? <input type="checkbox"/> No <input type="checkbox"/> Yes															
20. Is this Initial Placement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes		Max. <input type="checkbox"/> Mand. <input type="checkbox"/>															
21. Status of Current Prosthesis:				<b>EXAMINATION AND TREATMENT RECORD</b>													
				Can Be		Used Now		L I N E	23. Tooth	24. Surface: M D O L I F	25. Area of Oral Cavity	26. Procedure Code	27. Consultant Use Only	28. Description of Service			
	Part	Full	Date Inserted	Worn Yes No	Repaired Yes No		Yes No										
Max				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		1								
Mand				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		2								
29. Address 5 Year Prognosis of Partial Dentures and/or Reason for Denture Replacement:									3								
											4						
												5					
												6					
												7					
												8					
								9									
30. Other Pertinent Dental or Medical History:																	
31. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.																	
Provider's Signature												Date:					
<b>For MDCH Consultant Use Only</b>																	
32. Consultant Remarks:								33. Review Action:									
								Approved <input type="checkbox"/>			Denied <input type="checkbox"/>						
Returned <input type="checkbox"/>			No Action <input type="checkbox"/>														
34. Consultant Signature								Date									