DENTAL PRIOR APPROVAL 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, Healthy Michigan Plan Health Plans, Integrated Care Organizations and pregnant women enrolled in a Medicaid Health Plan, providers should contact the assigned 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)). MDHHS requires that the MSA-1680-B be typewritten, handwritten forms will not be accepted.

The status of a prior authorization request may be reviewed in CHAMPS. Additionally, providers will receive a Prior Authorization determination letter. Approved services are required to be completed before the end of the Prior Authorization. To request an extension, the provider must submit a copy of the determination letter 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 related to the services being requested. For authorization of orthodontics and/or crown and bridge services for beneficiaries enrolled in CSHCS, please see the Children’s Special Health Care Services Dental Services Section, Dental Chapter of the Medicaid Provider Manual.

The completed MSA-1680-B may be mailed, faxed, or submitted via CHAMPS, depending whether Radiograph films are necessary, to:

Michigan Department of Health and Human Services
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.

If submitting electronically, the completed MSA-1680-B and all radiographs must be attached, as required by policy.

Radiographs will only be returned upon request, as indicated in box 17.
2. Provider Name (Last, First, Middle Initial)  
9. Beneficiary Name (Last, First, Middle Initial)

3. Provider Street Address  
10. Birth Date
   / / 
11. Sex  
   M F

4. City  
   State  
   ZIP Code

5. Provider Fax Number  
   Provider Phone Number
   ( ) -

7. Provider NPI No.  
   Group NPI No.

14. Does patient live in a nursing home?  
   Yes  No
If Yes, Facility Name

15. Is Patient Covered by Any Other Dental Plan?  
   Yes  No
If Yes, Plan Name

16. CSHCS Diagnosis – ICD Diagnosis Code and Description

20. 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

17. Are Radiographs Attached?  
   Yes  No
If yes, Number of Radiographs and Date Taken
   / / 
Radiographs will only be returned upon request.
Check here for return of Radiographs

19. Is this Initial Placement of Prosthesis?  
   Max.  Yes  No  Mand.  Yes  No
If "No", please document Reason for Replacement:

22. Status of Current Prosthesis:

23. Tooth

24. Procedure Code

25. Consultant Use Only

26. Description of Service

EXAMINATION AND TREATMENT REQUESTED

Can Be  
Worn? Used Now
Yes No Yes No

Examination

27. Address 5 Year Prognosis for Partial Dentures

28. Other Pertinent Dental or Medical History

29. 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 Name (printed/typed):  
Provider Signature:  
Date:

For MDHHS Consultant Use Only

30. Consultant Remarks

31. Review Action  
   Approved  Denied  No Action
   Returned  Approved as amended

32. Consultant Signature  
   Date