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 dental providers 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, refer to 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, refer to the Children's Special Health Care Services Dental Benefits Section, Dental Chapter of the Medicaid Provider Manual.

The completed MSA-1680-B may be mailed, faxed, or submitted via CHAMPS, depending on 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

All change requests to an approved prior authorization should be faxed to 517-241-7813.

Questions should be directed to Program Review Division 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.

Michigan Department of Health and Human Services

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

www.michigan.gov/mdhhs

FAX: 517-335-0075

1. Prior Authorization Number (MDHHS use only)

☐ Medicaid ☐ CSHCS

Note: The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment. MDHHS requires that the MSA-1680-B be typewritten; handwritten forms will not be accepted.

2. Provider Name (Last, First, Middle Initial)	7. Beneficiary Name (Last, First, Middle Initial)
3. Provider Street Address	8. Birth Date / / ; 9. Sex ☐ M ☐ F
4. City; State; ZIP Code	10. MI Health Card Number; 11. Phone Number ( ) -
5. Provider Fax Number ( ) - ; 6. Provider Phone Number ( ) -	12. Provider NPI Number; 13. Group NPI Number

14. CSHCS Diagnosis – ICD Diagnosis Code and Description

.

15. 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 ☐

18. Indicate missing teeth with an "X" - teeth to be extracted with a " / ".
For Orthodontics: also Indicate erupted teeth with a circle

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

16. Is treatment for orthodontics? ☐ Yes ☐ No

Is treatment plan enclosed? ☐ Yes ☐ No

17. Is this initial placement of prosthesis?

☐ Max. ☐ Yes ☐ No ☐ Mand. ☐ Yes ☐ No

If No, please document reason for replacement:

19. Indicate crowns, dental implants, impacted teeth, bridges, and teeth extracted since radiographs:

20. Status of Current Prosthesis:

	Part	Full	Date Inserted	Can Be Worn? Yes	Can Be Worn? No	Can Be Repaired? Yes	Can Be Repaired? No	Used Now? Yes	Used Now? No
Max				☐	☐	☐	☐	☐	☐
Mand				☐	☐	☐	☐	☐	☐

EXAMINATION AND TREATMENT REQUESTED

LINE	21. Tooth	22. Procedure Code	23. Consultant Use Only	24. Description of Service
1				
2				
3				
4				
5				
6				
7				
8				
9				

25. Address 5 Year Prognosis for Partial Dentures

26. Other Pertinent Dental or Medical History

27. 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:

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if payment from applicable program is sought.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.