Remit to:
P.O. BOX 7090, TALLAHASSEE, FL 32314-7090

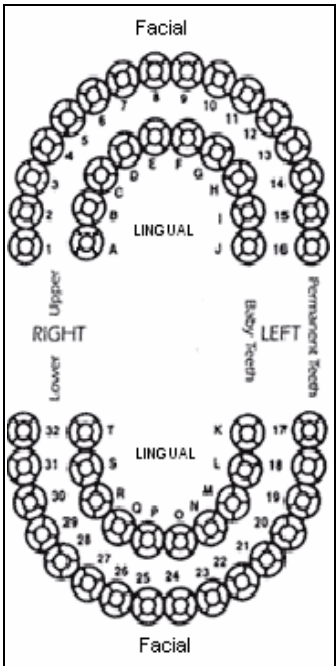
STATE OF FLORIDA
PRIOR AUTHORIZATION
REQUEST FOR TREATMENT AUTHORIZATION
DENTAL SERVICES
FLORIDA MEDICAID PROGRAM

0501

Dental Treatment plans indicated for eligible patients that will exceed the minimum amounts as described in the provider's handbook must be submitted for approval before beginning treatment. Radiographs, when required, should be submitted in suitable mounts. Complete the following form using the standardized American Dental Associate tooth notation system and procedure code, listing your usual and customary fees.

Last Name | First Name | Date of Birth

Medicaid ID Number | Examination Date | Amount Applied for Since July 1



Please indicate on chart which teeth are being replaced by a partial denture.

UNITS OF SERVICE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIAL USED, ETC.)	PROCEDURE CODE	FEE	OFFICE USE ONLY	
Services required, but not included in the provider handbook procedure list, may be described in a similar manner, using another sheet if needed.		**TOTAL**			

Payment can only be made for services rendered to Florida Medicaid recipients during the period of their eligibility and in accordance with the established fee schedule. Authorization for the above procedures is given subject to the patient being eligible as specified in the Florida Administrative Rules (10C-7.47). Eligibility status is updated monthly. To ensure payment, eligibility should be re-checked each month.

Dentist Name | Dentist Signature

Address | Provider Number | Date

FOR AGENCY USE ONLY

- ☐ Approved as Prescribed
- ☐ Approved with the following exception(s): _____

Authorizing Signature: _____ Date

DPA 1041 07/08