JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

PATIENT: _____ **DATE:** _____

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE SECTION *(TYPE OR PRINT CLEARLY)*

Checked shaded boxes (e.g. ☒ Yes) require Additional Comments below and may require submission of supporting documentation.

MAXILLARY ARCH	**MANDIBULAR ARCH**
Appliance Requested: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD	Appliance Requested: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD
☐ Member has never had a maxillary prosthetic appliance	☐ Member has never had a mandibular prosthetic appliance
Has existing appliance: ☐ FUD ☐ Cast Metal PUD ☐ Resin base PUD Age of appliance? _____ Wears appliance? ☐ Yes ☒ No	Has existing appliance: ☐ FLD ☐ Cast Metal PLD ☐ Resin base PLD Age of appliance? _____ Wears appliance? ☐ Yes ☒ No
Reason for replacement of maxillary appliance: (Check all boxes that apply) ☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other _____	Reason for replacement of mandibular appliance: (Check all boxes that apply) ☐ Worn/Broken teeth ☐ Loose ☐ Broken base / Framework ☐ Extraction of additional teeth ☐ Other _____
Replacement maxillary appliance is needed due to one of the following: Catastrophic Loss? ☒ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☒ Yes ☐ No See footnote ii. Denture no longer serviceable? ☒ Yes ☐ No See footnote iii. Significant medical condition? ☒ Yes ☐ No See footnote iv. Non-catastrophic loss? ☒ Yes ☐ No See footnote v.	Replacement mandibular appliance is needed due to one of the following: Catastrophic Loss? ☒ Yes ☐ No See footnote i. Surgical loss of oral-facial structure? ☒ Yes ☐ No See footnote ii. Denture no longer serviceable? ☒ Yes ☐ No See footnote iii. Significant medical condition? ☒ Yes ☐ No See footnote iv. Non-catastrophic loss? ☒ Yes ☐ No See footnote v.

Edentulous: ☐ Maxillary ☐ Mandibular

☒ **Block out missing teeth**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
○ **Circle teeth to be extracted**	**32**	**31**	**30**	**29**	**28**	**27**	**26**	**25**	**24**	**23**	**22**	**21**	**20**	**19**	**18**	**17**

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

MAXILLARY ARCH	**MANDIBULAR ARCH**
Teeth being replaced: _____	Teeth being replaced: _____
Teeth being clasped: _____	Teeth being clasped: _____

Does the patient want the requested services? ☒ No ☐ Yes

Does health condition of the patient limit dental adaptability? ☐ No ☒ Yes

ADDITIONAL COMMENTS PERTAINING TO APPLIANCES/TREATMENT PLAN: _____

_____

_____

_____

Provider Signature: _____

i. Circumstances beyond the control of the patient: For a patient that submits a request to replace the appliance based on circumstances beyond their control, those circumstances can be demonstrated by documentation of all of the following: (1) a demonstration of continued medical necessity; (2) an explanation of the circumstances surrounding the loss which clearly explains how the loss occurred and why the loss was beyond the control of the patient; and (3) a clear explanation of the remedial measures the patient will take to safeguard against subsequent loss. Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available.

ii. A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure.

iii. The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

iv. Dentures no longer fit due to significant medical condition. Documentation from the patient's physician supporting the medical necessity of early replacement and a letter from the dentist stating that the existing denture cannot be made functional.

v. A non-catastrophic loss or misplacement may be granted twice per lifetime. Documentation must include an explanation of preventive measures instituted to alleviate the need for further replacement. Additional requests, beyond the two lifetime exceptions shall be submitted as procedure code D5899 and will be considered on a case by case basis.