DC054
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 ADA or Medi-Cal Dental form for prior authorization. Please submit form to:

Patient First Name : _____ Last Name: _____

Date: _____

COMPLETE ALL SECTIONS *(PLEASE TYPE). PLEASE SEND ADDITIONAL FORM IF REQUESTING FOR MORE THAN ONE APPLIANCE.*

☐ MAXILLARY ARCH and/or ☐ MANDIBULAR ARCH

Appliance Requested: ☐ FUD ☐ FLD ☐ Cast Metal PUD ☐ PLD ☐ Resin base PUD ☐ PLD

☐ Never had a maxillary/mandibular prosthetic appliance

☐ Has an existing maxillary/mandibular prosthetic appliance

Existing Appliance: ☐ FUD ☐ FLD ☐ Cast Metal PUD ☐ PLD ☐ Resin base PUD ☐ PLD

Age of Appliance: _____

Wears appliance? ☐ Yes ☐ No

If "No", please explain: _____

Catastrophic Loss? ☐ Yes ☐ No

Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of official public service agency report.

If lost in facility or hospital, explain circumstances:

_____

Reason for replacement of existing maxillary/mandibular appliance (Check all boxes that apply)

☐ Worn/Broken teeth ☐ Loose ☐ Broken base/Framework

☐ Extraction of additional teeth Other_____

Missing teeth number(s): _____

Teeth number(s) to be extracted: _____

REQUIRED FIELD FOR PARTIAL DENTURES (All Types)

☐ MAXILLARY ARCH/ ☐ MANDIBULAR ARCH

Teeth being replaced: _____

Teeth being clasped: _____

ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:

_____

Date of Request _____

Provider Name _____

Provider Phone Number _____