San Diego Ryan White Dental Specialty Services Authorization Request

Instructions

Prior authorizations are required for referrals to specialists participating in the Ryan White Specialty Services Program and all covered medical procedures and services. **Providers and facilities must be in network.** See the *Provider Information* publication for more information about covered and excluded services. See the *Provider Directory* for network providers.

Authorization Request Instructions

Complete this form for specialty services authorization requests and fax it to Utilization Management at **(888) 748-1290**. Authorization must be obtained *prior* to completion of services. Routine authorization requests are rendered within two (2) business days. Please call (800) 474-1434, option 2 for authorization status. *Please use the Home Health and Hospice Authorization Request form for home health and hospice referrals, and the Medical Specialty Services Authorization Request form for Medical specialty referrals.*

Date of Request:_____ ☐ Medically Expedited/Urgent*

*MEDICALLY EXPEDITED/URGENT REQUESTS: THE DEFINITION OF URGENT/EXPEDITED SERVICE REQUEST DESIGNATION IS WHEN THE TREATMENT REQUESTED IS REQUIRED TO PREVENT SERIOUS DETERIORATION IN THE PATIENT'S HEALTH OR COULD JEOPARDIZE THE PATIENT'S ABILITY TO REGAIN MAXIMUM FUNCTION. REQUESTS OUTSIDE OF THIS DEFINITION SHOULD BE SUBMITTED AS ROUTINE/ NON-URGENT. URGENT/ EXPEDITED REQUESTS THAT DO NOT MEET MEDICAL CRITERIA WILL BE DOWNGRADED TO A STANDARD REQUEST.

Patient Information

_____ _____ Gender: ☐ Male ☐ Female ☐ Transman ☐ Transwoman

Patient Name | Birth Date

_____ _____

Phone Number | Patient Address

Referring Primary Care Provider Information

_____ _____

Provider Name | Clinic Name

_____ _____

Address | Provider NPI

_____ _____ _____

Contact | Phone | Fax

I confirm that I have verified that the above named patient is eligible to receive services under the Ryan White Primary Care Program.

_____ _____

Signature of Clinic Staff Completing Form | Print Name and Title of Clinic Staff Completing Form

Indication for Referral

Reason for Referral _____

Diagnosis(es)/ICD-10 Code(s) _____

Requested CDT Code(s) and Tooth Number(s) where indicated: _____

_____

_____

Requested (Refer to) Provider Information

_____ _____ _____

Requested Provider/Facility Name | Phone | Fax

_____

Specialty

The following CDT codes are covered under the San Diego Ryan White Dental Specialty Services Program: D0330, D2740, D2751, D2950, D2951, D2952, D3310, D3320, D3330, D3410, D3421, D3425, D3426, D4341, D4342, D5213, D5214, D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7260, D7261, D7285, D7286, D7310, D7320, D7471, D7472, D7473, D7510, D9241, D9242, D9248, D9310, D9610, D0120, D0140, D0150, D0210, D0220, D0230, D0272, D0274, D1110, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2910, D2920, D4355, D5110, D5120, D5211, D5212, D5510, D5520, D6930, D7241, D7971, D9110, D9630, D9930, D9222, D9223