BAKERSFIELD PACE
BY INNOVATIVE INTEGRATED HEALTH

PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

Providers may submit prior authorization (PA) requests by fax to Fresno PACE (855) 629-6635

SECTION I - PATIENT INFORMATION

Patient Identification Number	Date of Birth - Patient	Address - Patient (Street, City, State, ZIP+ Code)
Name - Patient(Last, First, Middle Initial)	Gender - Patient ❑ Male ❑ Female	

SECTION II - PROVIDER INFORMATION

Name and Address - Billing Provider (Street, City, State ZIP Code + 4)	Telephone Number - Billing Provider
	Fax Number

SECTION III - DIAGNOSIS / TREATMENT INFORMATION

Place of Service

❑ Dental Office (POS "11") ❑ Outpatient Hospital (POS "22") ❑ Ambulatory Surgical Center (POS "24")

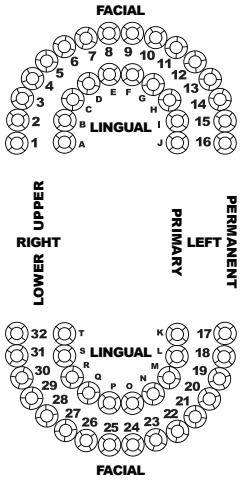
❑ Skilled Nursing Facility (POS "31") ❑ Other (specify): _____

Area of Oral Cavity	Tooth	Procedure Code	Modifier	Description of Service	Quantity Requested	Charge
					Total Charges	

An approval authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Pace payment methodology and policy.

Dental Diagram

- Check periodontal case type if applicable.
  - ❑ I
  - ❑ II
  - ❑ III
  - ❑ IV
  - ❑ V
- Cross out missing teeth
- Circle teeth to be extracted



Staple X-Rays Envelope Here

Number of X-rays _____

Type of X-rays _____

SIGNATURE - Rendering Provider	Date Signed

Comments