Arkansas Department of Human Services
Division of Medical Services

DATE: _____/_____/_____

BENEFICIARY NAME:_____

PROVIDER:_____ D.D.S.

MEDICAL ASSISTANCE DENTAL DISPOSITION

REASON FOR DENIAL

- □ X-rays do not substantiate need.
- □ Procedure not covered by Medicaid.
- □ Treatment plan does not qualify under Medicaid guidelines.
- □ See page(s) _____ of Dental Manual.
- □ Other_____

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REASON FOR RETURN

- □ Procedure does not require prior authorization.
- □ X-ray not diagnostic. Please retake at no expense to Medicaid.
- □ Please submit X-Ray, Mounted and Labeled Right and Left

  □ Pre-op □ Post-op □ Cephalometric □ Complete Series □ Panoramic □ Bitewings

  (All X-Rays are to be mounted, dated, doctor and patient identified, with R&L indicated.)

- □ Please submit brief narrative of problem and plan of treatment.
- □ Please submit a complete treatment plan for all teeth on the claim form.
- □ Please submit: Photos □ Study models □
- □ When requesting prior authorization, send all four (4) copies of the form to P.O. Box 1437, Slot S410, Little Rock, Arkansas 72203.
- □ X-rays not mounted and labeled.
- □ When requesting payment, send only one copy to Gainwell Technologies, P.O. Box 8034, Little Rock, AR 72203. *X-rays are not needed when submitting for payment.*
- □ See page(s) _____ of Dental Manual.
- □ Other_____

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Monday-Friday, 8:00 a.m. - 4:30 p.m.

Dental Unit Support Line:
(855) 703-2891 or (501) 320-6230