



**DENTAL TREATMENT AND  
PRIOR AUTHORIZATION**  
Nebraska Department of Health & Human Services

**I DENTAL**

Prior Authorization Number

1. Client Medicaid Case Number				2. Medicaid Provider Number	
Client Name				Provider Name	
Client Birthdate Month Day Year / /				Date Received	
<b>a.</b>	<b>CODE</b>	<b>TOOTH NO.</b>	<b>NO. OF SVS.</b>	<b>AMOUNT AUTHORIZED</b>	
a					
b					
c					
d					
e					
4.				<p>Note: This authorization is void if the client is ineligible for Nebraska Medicaid. It is the responsibility of the provider to verify client Medicaid eligibility</p> <hr/> <p>Note: Denial may be appealed in writing within 90 days of the denial date by addressing a letter to the Director of the Nebraska Department of Health &amp; Human Services requesting a hearing and stating the basis for the appeal.</p>	
<input type="checkbox"/> Treatment has been approved. <input type="checkbox"/> Treatment plan as submitted has been denied: <input type="checkbox"/> Client's Medicaid eligibility closed <input type="checkbox"/> Treatment not an allowed service by program policy. <input type="checkbox"/> Adequate occlusion by program policy. <input type="checkbox"/> Prosthetic appliance not allowed by program policy. <input type="checkbox"/> Client does not have a handicapping malocclusion as defined in program policy. <input type="checkbox"/> Crown is denied. Please restore with stainless steel crown, amalgam or composite restoration.				<input type="checkbox"/> Treatment request not reviewed: <input type="checkbox"/> Send x-rays of all remaining teeth. <input type="checkbox"/> Additional information needed regarding the treatment requested and the client dental history. <input type="checkbox"/> Needed prosthetic history when reviewing for appliances. Complete prosthetic appliance section on the ADA form. <hr/> <input type="checkbox"/> Send a postoperative x-ray of the completed root when submitting the ADA claim for payment.	
<input type="checkbox"/> Client's Medicaid eligibility is closing _____ . Medicaid can not pay for treatment after that date. <input type="checkbox"/> Client is not Medicaid eligible - Share of Cost/Excess Income obligation. If the client meets their share of cost obligation treatment can be provided as listed on this form.					
5. Treatment Deletions:					
Treatment Substitutions:					
Treatment Additions:					
6. I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Medicaid Program					
Signature of Authorized Agent				Date	



USE: Form MC-9D is completed by the Medicaid Division and used to prior authorize payment for dental services as required in 471 NAC 6-000. The authorization becomes invalid if the client is ineligible for Nebraska Medicaid or the provider is suspended or terminated from the program.

COMPLETION: Form MC-9D is completed if the client is/was Medicaid eligible, and the provider is/was enrolled in the Nebraska Medical Assistance Program for the period for which payment for services are being authorized.

NOTIFICATION OF APPEAL RIGHTS: Denial of services may be appealed in writing within 90 days of the date the authorizing agent signed the MC-9D denying the service by addressing a letter to the Director of Health & Human Services Finance & Support requesting a hearing and stating the basis for the appeal.

1. CLIENT MEDICAID CASE NUMBER: The client's 11-digit Medicaid case number is entered in this field.

CLIENT NAME: The client's name is entered.

CLIENT BIRTHDATE: The client's birthdate is entered.

NOTE: If authorizing pregnancy-related services for an ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child, the mother's name, and birthdate in these fields.

2. MEDICAID PROVIDER NUMBER: The provider's 11-digit Medicaid provider number is entered in this field. Verify that the provider number is correct.

PROVIDER NAME: The provider name is entered.

DATE RECEIVED: The date the prior authorization request was received in the Medicaid Division is entered.

3. CODE, TOOTH NO., NO. OF SERVICES, AMOUNT AUTHORIZED:

A maximum of five codes can be authorized on one form. If additional codes in the treatment plan require prior authorization an additional form is completed. Not all codes listed on the pre-treatment request will be authorized on the MC-9D, only those services that require prior authorization are listed.

CODE: The ADA procedure code of the service(s) being authorized is entered. If a procedure code listed is different than the requested treatment on the ADA form, review section 6 for consultant comments.

TOOTH NO.: If the treatment prior authorized is tooth specific, the tooth number is entered in this field.

NO. OF SVS.: (Number of Services.) The number of times the procedure code is prior authorized is entered. (Most procedures will be "1".)

AMOUNT: Complete if the procedure code prior authorized is listed as "BR" (by report.) This field is left blank if the procedure has an established fee on the Medicaid Dental Fee Schedule.

4. Treatment has been approved: The dental consultants will check this box if the treatment on the pre-treatment request has been approved.

Treatment plan as submitted has been denied: The dental consultants will check this box and may check one of the explanation boxes if treatment is being denied. Explanation boxes are:

- Client's Medicaid eligibility closed – enter the date the client's Medicaid eligibility closed
- Treatment not an allowed service by program policy.
- Adequate occlusion by program policy.
- Prosthetic appliance not allowed by program policy.
- Client does not have a handicapping malocclusion as defined in program policy.
- Crown is denied. Please restore with stainless steel crown, amalgam or composite restoration.

Treatment request not reviewed: The dental consultants will check this box and one of the explanation boxes if treatment was not reviewed and additional information is needed. Explanation boxes are:

- Send x-rays of all remaining teeth.
- Additional information needed regarding the treatment requested and the client dental history.
- Need prosthetic history when reviewing for appliances. Complete prosthetic appliance section on the ADA form.

Send a postoperative x-ray of the completed root canal when submitting the ADA claim for payment: The dental consultants may request a postoperative x-ray of the completed root canal.

Client's Medicaid eligibility is closing \_\_\_\_\_ . Medicaid can not pay for treatment after that date. Enter the date the client's Medicaid eligibility is closing.

Client is not Medicaid eligible – Share of Cost/Excess Income obligation. If the client meets their share of cost obligation treatment can be provided as listed on this form: Contact 402-471-9395 if you have any questions regarding Share of Cost/Excess Income Obligation.

5. Treatment Deletions, Substitutions, Additions:

The consultants will list the deletion of services, substitutions of services, or addition of services in this section. Providers should review this section before providing treatment.

If the Department dental consultants make treatment substitutions, the treating dentist must correct the procedure code on the ADA claim form when submitting for payment.

6. Signature of Authorized Agent, Date:

The Department dental consultant or authorizing agent signs and dates the MC-9D.