

**Combined Medical/Dental Prior Authorization Request for Dental Services
Provided in a Hospital or Surgery Center** *All Sections of this form must be completed.

REQUESTING PROVIDER INFORMATION		
Dentist Provider Name:		Practice Name:
Address:		Tax ID Number:
Phone:	Fax:	Contact Person:

SUBSCRIBER & PATIENT INFORMATION		
Subscriber Name:		Subscriber ID:
Patient Name:	Patient Date of Birth:	Patient Age:
Patient Address:		Patient Phone:

DENTAL AUTHORIZATION
Please attach an ADA claim/authorization form with dental services to be performed (include CDT codes)
Narrative: Please provide reason treatment cannot be performed in a dental office setting (include medical & dental diagnoses)
Narrative: Please describe any attempts at treatment in the dental office setting including dates of service.

MEDICAL AUTHORIZATION				
Date of Request:	Inpatient or Outpatient	Procedure Date:	No. of Treatments Requested:	Service Requested by Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis (Include ICD Code):		Procedure / Treatment Request (Include CPT Code):		
Servicing Provider Name:		Address:	Phone:	
Place of Service / Facility:		Address:	Phone:	

SUBMISSION DIRECTIONS

- Complete authorization request form and attach necessary supporting documentation including radiographs
- For non-urgent requests (retain copy for your records), mail to the following:
Nevada Dental Benefits – PA
P.O. Box 80117
Las Vegas, NV 89180
- You will receive a written response within 14 days. If you do not receive response, please contact us at: (702) 478-2014.

For urgent requests, please contact Nevada Dental Benefits Customer Service at (702) 478-2014.