

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 HP Enterprise Services, 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