# D.57 THSteps Dental Mandatory Prior Authorization Request Form

Submit to:

THSteps Dental
Prior Authorization Unit
PO Box 202917
Austin, TX 78720-2917

**APPROVED**

**DENIED**

**NOTE: ALL INFORMATION IS REQUIRED – PRINT CLEARLY OR TYPE**

| Patient's Name and Address | Sex<br>M ( )<br>F ( ) | Patient's Birth Date<br><br>Medicaid Number |
|---|---|---|

CHECK DIAGNOSTIC TOOLS SUBMITTED FOR REVIEW WITH AUTHORIZATION REQUEST:
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| FOR RESTORATIVE AND ICFMR: | | FOR ORTHODONTIC CASE, DIAGNOSTIC TOOLS MAILED: | | | |
|---|---|---|---|---|---|
| Panorex | ( ) | Models | ( ) | Cephlometric X-ray | ( ) |
| FM X-ray | ( ) | HLD | ( ) | FM X-ray | ( ) |
| Periapicals | ( ) | Panorex | ( ) | Photos | ( ) |
| Documentation | ( ) | Documentations | ( ) | Other: | |

**DATE OF SERVICE DIAGNOSTIC TOOLS WERE PRODUCED:**

| PROCEDURE CODE | TOOTH # OR LETTER | SURFACE | CHARGE |
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| | | | *Total* |

**NOTE: ALL INFORMATION REQUIRED – PRINT CLEARLY OR TYPE**

| Signature of Dentist:<br><br>Date: | TPI | Dentist Address and ZIP<br><br>Telephone Number |
|---|---|---|

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