

Dental Prior Authorization

Step-by-Step Portal Submission



PRIOR AUTHORIZATIONS PAs

Oklahoma HealthCare Authority

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Wednesday 08/12/2015 10:29 AM CST

User Details

Welcome G9p45Usf9

- [My Profile](#)
- [Manage Accounts](#)

Provider

Name

Provider ID

Taxonomy

SC Provider Number

Provider Services

- [Member Focused Viewing](#)
- [Search Payment History](#)

Welcome Health Care Professional!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to payment history and the ability to search for helpful information under the Resources menu.

- [Contact Us](#)
- [Secure Correspondence](#)
- [Referrals](#)
- [Update Provider Files](#)
- [Upload Behavioral Health Records](#)

Helpful Links

- [Insure Oklahoma Employer/Agent Portal](#)

CREATE AUTHORIZATION

Oklahoma HealthCare Authority

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[Create Authorization](#) | [View Authorization Status](#) | [Maintain Favorite Providers](#)

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Prior Authorizations Wednesday 08/12/2015 10:29 AM CST

Prior Authorizations

- [Create Authorization](#)
- ▶ [View Authorization Status](#)
- ▶ [Maintain Favorite Providers](#)

DENTAL

Create Authorization ?

* Indicates a required field.

Medical

Dental

[Expand All](#) | [Collapse All](#)

Requesting Provider Information

This panel contains provider information.

| Provider ID | ID Type | NPI | Name |
|---------------------|---------------|----------|--------------------|
| Zip Code 73112-2078 | Contract Code | Taxonomy | SC Provider Number |

Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID
Last Name SOONERCARE
Birth Date 07/01/2014

First Name SUSIE

Middle

Service Provider Information

Service Provider may be required depending on the type of Assignment Code selected. To use a new service provider, enter either a valid NPI or SoonerCare Provider Number. To use an existing Service Provider and have the fields auto-populate, either click the Service Provider same as Requesting Provider checkbox or select a provider previously saved to the favorites list using the Select from Favorites dropdown. To add a new provider to the favorites list, click the Add to Favorites checkbox.

Service Provider same as Requesting Provider

Select from Favorites

Provider ID ID Type Name
Zip Code Contract Code Taxonomy SC Provider Number

Add to Favorites

Other Information

Assignment Code must be selected from the dropdown. The Assignment Code can be viewed in the Prospective Authorizations results panel and in the Search Results panel when using Search Authorizations.

*Assignment Code
Fund
ORAL SURGERY
ORTHODONTIC SERVICES

Managed Care

Letter?

CODE TYPE AND ATTACHMENTS

Other Information -

Assignment Code must be selected from the dropdown. The Assignment Code can be viewed in the Prospective Authorizations results panel and in the Search Results panel when using Search Authorizations.

*Assignment Code Managed Care

Fund Letter?

Diagnosis Information +

Service Details -

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

| From Date | To Date | Code | Modifiers | Tooth Number | Units | Action |
|-----------|---------|------|-----------|--------------|-------|--------|
|-----------|---------|------|-----------|--------------|-------|--------|

Click to collapse.

*From Date *Code Type *Code

*Units Dollars Payment Method

Tooth Number

Oral Cavity Area

Remarks (optional)

Attachments +

TRANSMISSION METHOD

Service Details [-]
Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

| From Date | To Date | Code | Modifiers | Tooth Number | Units | Action |
|-----------|---------|------|-----------|--------------|-------|--------|
|-----------|---------|------|-----------|--------------|-------|--------|

Click to collapse.

*From Date To Date *Code Type *Code
*Units Dollars Payment Method

Tooth Number
Oral Cavity Area
Remarks (optional)

Attachments [-]
 Click to collapse.

| Transmission Method | File | Control # | Action |
|---------------------|------|-----------|--------|
|---------------------|------|-----------|--------|

*Transmission Method
*Upload File
*Description

ADD ATTACHMENTS

| Attachments | | | |
|-----------------------------|--------------------------------|------------------------|------------------------|
| Transmission Method | File | Control # | Action |
| Click to collapse. | | | |
| *Transmission Method | BM-By Mail | | |
| *Description | PA, R/L BW's, Pano, Tx plan | | |
| Add | Cancel | | |
| Add Service | Cancel Service | | |
| | | Submit | Cancel |

ADD ADDITIONAL ATTACHMENTS

Attachments

| | Transmission Method | File | Control # | Action |
|--------------------------|---------------------|------|----------------|------------------------|
| <input type="checkbox"/> | BM-By Mail | - | 20150812203371 | Remove |

Click to collapse.

***Transmission Method**

***Upload File**

***Description**

CONFIRM

Confirm Authorization ?

Click Confirm to submit authorization. Click Back to change data entered.

Medical

Dental

[Expand All](#) | [Collapse All](#)

Requesting Provider Information -

Provider ID _____ **ID Type** NPI _____ **Name** _____
Zip Code 73112-2078 **Contract Code** _ **Taxonomy** _ **SC Provider Number** _____

Member Information -

Member ID b23098524 **Member** SUSIE V SOONERCARE
Birth Date 07/01/2014

Service Provider Information -

Provider ID _____ **ID Type** NPI _____ **Name** _____
Zip Code 73112-2078 **Contract Code** _ **Taxonomy** _ **SC Provider Number** _____

Other Information -

Assignment Code DENTAL-GENERAL **Managed Care** _
Fund _ **Letter?** _

Diagnosis Information -

No Diagnosis Codes exist for this authorization

Service Details -

| | From Date | To Date | Code | Modifiers | Tooth Number | Units | |
|---|------------|------------|----------------------------------|-----------|-------------------------------|-------|---|
| + | 08/13/2015 | 08/13/2015 | D2710-CROWN RESIN-BASED INDIRECT | | 8-UPPER RIGHT CENTRAL INCISOR | 1 | 1 |

Back

Confirm

Cancel

AUTHORIZATION RECEIPT



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[Prior Authorizations](#) > Authorization Receipt

Wednesday 08/12/2015 12:51 PM CST

Authorization Receipt ?

Your Prior Authorization Number 5815224000 was successfully submitted.

Click **Attachment Coversheet** to view the authorization attachments coversheet.
Click **Print Preview** to view authorization details and receipt.
Click **Copy** to copy member data or authorization data.
Click **New** to create a new authorization for a different member.

[Attachment Coversheet](#)

[Print Preview](#)

[Copy](#)

[New](#)



DENTAL PA ATTACHMENT COVER SHEET



STATE OF OKLAHOMA
Oklahoma Health Care Authority
Dental Prior Authorization Attachment
Cover Sheet

| |
|---|
| <input type="checkbox"/> Attachments |
| <input type="checkbox"/> Additional Documentation |
| <input type="checkbox"/> Photos |
| <input type="checkbox"/> X-Ray |

Three fields below are required and must match the prior authorization request.

- | | |
|--|------------|
| 1. Rendering Provider SoonerCare ID Number | 123456789A |
| 2. Member ID Number | B23098524 |
| 3. Prior Authorization Number | 5815224000 |

Purpose:

This form is to be used when a prior authorization request (PAR) requiring a paper attachment is being submitted. Submission of the completed forms along with the required attachment will allow the appropriate review process to be conducted by the OHCA.

Instructions:

- Box 1; fill in the Rendering Provider SoonerCare ID Number.
- Box 2; fill in the 9-digit Member ID Number.
- Box 3; fill in the Prior Authorization Number.
 - To submit additional documentation or attachments, enter the existing PAR number in box 3 to assure your documentation will be linked with the correct existing PAR.**
- The Attachments box is to be checked when sending attachments.
- The Additional Documentation box is to be checked when submitting additional documentation to be added to an existing PAR. Enter the PAR number in box 3 above so your documentation will be linked with the correct existing PAR.
- The Photos box is to be checked when submitting photos for review.
Mail to: HP/Dental Authorization; P.O. Box 548804, Oklahoma City, OK. 73154
- The X-Ray box is to be checked when submitting X-Rays for review.
Mail to: HP/Dental Authorization; P.O. Box 548804, Oklahoma City, OK. 73154

This form is for use with Dental Prior Authorization requests requiring attachments.

Sender's Name: _____ Phone Number: _____

OHCA Revised: 05/22/2015

HCA-13D

[Print](#) [Close](#)



VIEW AUTHORIZATION STATUS



[My Home](#) [Eligibility](#) [Claims](#) [Prior Authorizations](#) [Referrals](#) [Files Exchange](#) [Financial](#) [Letters](#) [Resources](#)

[Create Authorization](#) | [View Authorization Status](#) | [Maintain Favorite Providers](#)

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Prior Authorizations

Wednesday 08/12/2015 12:59 PM CST

Prior Authorizations

▶ [Create Authorization](#)

▶ [View Authorization Status](#)

▶ [Maintain Favorite Providers](#)



PROSPECTIVE AUTHORIZATIONS TAB NOT USED FOR DENTAL

View Authorization Status ?

Prospective Authorizations | Search Authorizations | Authorization Notices

Enter at least one of the following fields to search for an authorization.

Authorization Information

DO NOT USE

Authorization Number

Assignment Code

Code Type Code

Select a Day Range or specify a Service Date. The optional date criterion provides a search option based on the Authorized Effective and Authorized End Date of the Prior Authorization.

Authorized Day Range OR Authorized Service Date

Member Information

Member ID

Provider Information

Provider NPI

This Provider is the Servicing Provider on the Authorization
 Referring Provider on the Authorization

SEARCH AUTHORIZATIONS BY PA NUMBER

View Authorization Status ?

Prospective Authorizations | **Search Authorizations** | Authorization Notices

Enter at least one of the following fields to search for an authorization.

Authorization Information

Prior Authorization Number

Assignment Code

Code Type

Code

Select a Day Range or specify a Service Date. The optional date criterion provides a search option based on the Authorized Effective and Authorized End Date of the Prior Authorization.

Authorized Day Range **OR** **Authorized Service Date**

Member Information

Member ID

Provider Information

Provider NPI

This Provider is the

Servicing Provider on the Authorization

Referring Provider on the Authorization

Search **Reset**

Search Results

The Search criteria selected in the Search Authorizations panel reflect the Search Results displayed. Total Records: 1

| Prior Authorization Number | Authorized Service Date ▼ | Member Name | Member ID | Assignment Code | Requesting Provider | Servicing Provider |
|--|---|-----------------------------|---------------------------|---------------------------------|-------------------------------------|------------------------------------|
| 5815224000 | | SOONERCARE, SUSIE | B23098524 | DENTAL-GENERAL | | |

[Export results ...](#)

SEARCH AUTHORIZATIONS BY MEMBER ID

View Authorization Status ?

Prospective Authorizations **Search Authorizations** Authorization Notices

Enter at least one of the following fields to search for an authorization.

Authorization Information

Prior Authorization Number

Assignment Code

Code Type Code

Select a Day Range or specify a Service Date. The optional date criterion provides a search option based on the Authorized Effective and Authorized End Date of the Prior Authorization.

Authorized Day Range OR Authorized Service Date

Member Information

Member ID

Provider Information

Provider NPI

This Provider is the Servicing Provider on the Authorization
 Referring Provider on the Authorization

Search Results

The Search criteria selected in the Search Authorizations panel reflect the Search Results displayed. Total Records: 1

| <u>Prior Authorization Number</u> | <u>Authorized Service Date</u> ▼ | <u>Member Name</u> | <u>Member ID</u> | <u>Assignment Code</u> | <u>Requesting Provider</u> | <u>Servicing Provider</u> |
|-----------------------------------|----------------------------------|--------------------|------------------|------------------------|----------------------------|---------------------------|
| 5815224000 | | SOONERCARE, SUSIE | B23098524 | DENTAL-GENERAL | | |

[Export results ...](#)

REQUESTED CODE AND STATUS

View Authorization Response for SUSIE V SOONERCARE [Back to View Authorization Status](#) ?

[Expand All](#) | [Collapse All](#)

Prior Authorization Number 5815224000
Submission Date 08/12/2015 **Media Type** WEB **Date Received** 08/12/2015
Decision Date _ **Update Received** _ **Date Mailed** _

Requesting Provider Information +

Member Information +

Other Information +

Diagnosis Information +

Service Provider / Service Details Information -

| Line | Authorized From Date | Authorized To Date | Requested From Date | Requested To Date | Units | Units Used | Dollars | Dollars Used | Code | Remarks | Status |
|------|----------------------|--------------------|---------------------|-------------------|-------|------------|---------|--------------|-------------------------------------|---------|------------|
| A | - | - | 08/12/2015 | 08/12/2015 | 0 | 0 | - | - | D2710-CROWN RESIN-BASED INDIRECT | - | Evaluation |

Reason
-

View Original Request
Print Preview

CLICK ON CODE TO VIEW TOOTH NUMBER

| Line | Authorized From Date | Authorized To Date | Requested From Date | Requested To Date | Units | Units Used | Dollars | Dollars Used | Code | Remarks | Status |
|-------------------------------|----------------------|--------------------|---------------------|-------------------|-------|------------|---------|--------------|----------------------------------|---------|-----------------------|
| A | - | - | 08/12/2015 | 08/12/2015 | 0 | 0 | - | - | D2710-CROWN RESIN-BASED INDIRECT | - | Evaluation |
| Reason - | | | | | | | | | | | |
| Dental Information | | | | | | | | | | | Close |
| Tooth No. | | | | | | | | | | | |
| 8-UPPER RIGHT CENTRAL INCISOR | | | | | | | | | | | |
| Oral Cavity Area | | | | | | | | | | | |
| | | | | | | | | | | | |

[View Original Request](#)

[Print Preview](#)

EXPAND ALL AND VIEW ORIGINAL REQUEST

Authorization Request [Back to View Authorization Response](#)

Prior Authorization Number 5815224000 Medical Dental [Expand All](#) [Collapse All](#)

Requesting Provider Information [-]

| | | | | |
|---------------------|---------------|----------|-----|--------------------|
| Provider ID | Contract Code | ID Type | NPI | Name |
| Zip Code 73112-2078 | _ | Taxonomy | | SC Provider Number |

Member Information [-]

| | |
|-----------------------|---------------------------|
| Member ID B23098524 | Member SUSIE V SOONERCARE |
| Birth Date 07/01/2014 | |

Service Provider Information [-]

| | | | | |
|---------------------|---------------|----------|-----|--------------------|
| Provider ID | Contract Code | ID Type | NPI | Name |
| Zip Code 73112-2078 | _ | Taxonomy | | SC Provider Number |

Other Information [-]

| | |
|--------------------------------|-----------------|
| Assignment Code DENTAL-GENERAL | Managed Care No |
| Fund _ | Letter? No |

Diagnosis Information [-]

No Diagnosis Codes exist for this authorization

Service Details [-]

| [] | From Date | To Date | Code | Modifiers | Tooth Number | Units | [] |
|-----|------------|------------|----------------------------------|-----------|-------------------------------|-------|-----|
| [] | 08/12/2015 | 08/12/2015 | D2710-CROWN RESIN-BASED INDIRECT | | 8-UPPER RIGHT CENTRAL INCISOR | 1 | 1 |

Dollars \$100.00 Payment Method _

Oral Cavity Area _

Remarks (optional) _

[Displays a list of Service Details.](#)

Attachments [-]

| [] | Transmission Method | File | Control # | Action |
|-----|---------------------|------|----------------|--------|
| [] | BM-By Mail | _ | 20150812203371 | |

Description PA, R,L BW's, Pano, Tx plan

[Print Preview](#) [Attachment Coversheet](#)

AUTHORIZATION NOTICES

Search

View Authorization Status ?

Prospective Authorizations Search Authorizations **Authorization Notices**

Enter at least one of the following fields to search for an authorization.

Provider Information

SC Provider Number
Unread Notices 109

Search Criteria -

Prior Authorization Number

Code Type **Code**

Member ID

Last Name **First Name**

Select a Day Range or Specify a Date Range

Day Range **OR** ***From** ***To**

Search **Reset**

Unread Notices Summary -

| Provider ID | Unread Notices |
|-------------|----------------|
| | 1 |
| | 18 |
| | 90 |

COLUMNS CAN BE SORTED

Search Results

The Search criteria selected in the Authorization Notices panel reflect the Search Results displayed. To access the Authorization Notice, select a "Date Sent" link. Access to an Authorization Notice will require a file viewer. If the Authorization Notice is too large to display, you will need to contact [Provider Services](#) for assistance.

Total Records: 111

| <u>Prior Authorization Number</u> | <u>Date Sent</u> ▼ | <u>Member</u> | <u>Requesting Provider</u> | <u>Servicing Provider</u> | <u>Status</u> |
|-----------------------------------|----------------------------|---------------|----------------------------|---------------------------|---------------|
| 0515209006 | 07/29/2015 | | | | Read |
| 0515209002 | 07/28/2015 | | | | Unread |
| 0515209003 | 07/28/2015 | | | | Unread |
| 5815203000 | 07/22/2015 | | | | Unread |
| 5815170003 | 07/06/2015 | | | | Unread |
| 0515163200 | 07/03/2015 | | | | Unread |
| 5815163001 | 07/03/2015 | | | | Unread |
| 5815169000 | 07/03/2015 | | | | Unread |
| 5815155000 | 06/22/2015 | | | | Unread |
| 5815170003 | 06/19/2015 | | | | Unread |
| 5815170001 | 06/19/2015 | | | | Unread |
| 0515093011 | 06/19/2015 | | | | Unread |
| 5815152002 | 06/19/2015 | | | | Unread |
| 0515163200 | 06/18/2015 | | | | Read |
| 5815163001 | 06/18/2015 | | | | Unread |
| 5815169000 | 06/18/2015 | | | | Unread |
| 0515168300 | 06/17/2015 | | | | Unread |
| 5815168001 | 06/17/2015 | | | | Unread |
| 5815168002 | 06/17/2015 | | | | Unread |
| 0515105000 | 06/17/2015 | | | | Unread |

CLICK BLUE LINKS TO VIEW TOOTH/REMARKS

View Authorization Response for SUSIE V SOONERCARE

[Back to View Authorization Status](#) 

[Expand All](#) | [Collapse All](#)

Prior Authorization Number 5815224000

Submission Date 08/12/2015

Decision Date 08/13/2015

Media Type WEB

Update Received _

Date Received 08/12/2015

Date Mailed _

Requesting Provider Information 

Member Information 

Other Information 

Diagnosis Information 

Service Provider / Service Details Information 

Provider ID
Zip Code 73112-2078

Contract Code _

ID Type NPI
Taxonomy

Name
SC Provider Number

| Line | Authorized From Date | Authorized To Date | Requested From Date | Requested To Date | Units | Units Used | Dollars | Dollars Used | Code | Remarks | Status |
|------|----------------------|--------------------|---------------------|-------------------|-------|------------|---------|--------------|--|----------------------|--------|
| A | 08/12/2015 | 08/12/2015 | 08/12/2015 | 08/12/2015 | 1 | 0 | - | - | D2710-CROWN RESIN-BASED INDIRECT | View | Denied |

Payment Method 1-Pay System Calculated Price

Reason

096-Documents for review have not been received.

[View Original Request](#)

[Print Preview](#)

REMARKS AND TOOTH NUMBER

| Line | Authorized From Date | Authorized To Date | Requested From Date | Requested To Date | Units | Units Used | Dollars | Dollars Used | Code | Remarks | Status |
|------|----------------------|--------------------|---------------------|-------------------|-------|------------|---------|--------------|----------------------------------|----------------------|--------|
| A | 08/12/2015 | 08/12/2015 | 08/12/2015 | 08/12/2015 | 1 | 0 | - | - | D2710-CROWN RESIN-BASED INDIRECT | Hide | Denied |

Payment Method 1-Pay System Calculated Price

Reason

096-Documents for review have not been received.

Remarks

1 8/13/2015 Received PA x-ray

Dental Information

[Close](#)

Tooth No.

8-UPPER RIGHT CENTRAL INCISOR

Oral Cavity Area

[View Original Request](#)

[Print Preview](#)

CLICK ON DATE TO CHANGE STATUS READ/UNREAD

| Prior Authorization Number | Date Sent ▼ | Member | Requesting Provider | Servicing Provider | Status |
|--|-----------------------------|------------------------|-------------------------------------|------------------------------------|------------------------|
| 0515209006 | 07/29/2015 | | | | Read |
| 0515209002 | 07/28/2015 | | | | Read |
| 0515209003 | 07/28/2015 | | | | Unread |
| 5815203000 | 07/22/2015 | | | | Unread |
| 5815170003 | 07/06/2015 | | | | Unread |
| 0515163200 | 07/03/2015 | | | | Unread |
| 5815163001 | 07/03/2015 | | | | Unread |
| 5815169000 | 07/03/2015 | | | | Unread |
| 5815155000 | 06/22/2015 | | | | Unread |

NOTICE THAT MEMBER RECEIVES

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER



MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

July 28, 2015

SoonerCare Prior Authorization Letter

Member Name -
Date of Birth -
Member ID -

PAU-0001-D (v.1.0)
Prior Authorization # - 0515209002

Dea

A prior authorization (PA) request was made for you to receive the services and/or products listed below.

If you have questions, call your provider, or call OHCA at 1-800-522-0310.

Approved Services:

The following service requests have been approved.

Description: MAXILLOFACIAL PROSTHESIS
This service is effective 07/01/2015 through 07/31/2015

Pending Services:

The following service requests are pending review and the reasons are listed below. Once a decision is made, you will be notified by another letter.

Description: COMPRE DENTAL TX ADOLESCENT
Reason pending: Under Review by Dental Analyst

TO THE MEMBER:

You have the right to appeal any denied or reduced services. To appeal, send in an LD-1 form to the OHCA Docket Clerk in the Legal Division. LD-1 forms are on OHCA's website at www.okhca.org or you may call 405-522-7431 to have one mailed to you.

A completed LD-1 form must be sent to the docket clerk within 20 days of receiving this notice. On the LD-1 form describe what you are appealing and why. Send this PA notice and any other information you want to use at the hearing with the form. You may represent yourself at the hearing. You may have someone else speak for you (a lawyer, a friend, family member, or other person). If you want someone else to speak for you, you must fill their name in the "Authorized Representative Information" section on the LD-1 form. The LD-1 form must be mailed to the OHCA address on the form.

TO THE PROVIDER:

Prior authorization represents a clinical decision regarding medical necessity, but is not a guarantee of member eligibility or SoonerCare payment. It is the responsibility of the provider to verify not only SoonerCare eligibility, but also to verify program eligibility and benefit plan (for example: SoonerCare Choice, SoonerCare Traditional) at the time of service. Factors that may affect payment are correct claim completion, appropriate referral (if required), provider contract, timely filing and member eligibility.

LINCOLN CENTER * 4345 N. LINCOLN BLVD. * OKLAHOMA CITY, OK 73105 * (405) 522-7300 * WWW.OKHCA.ORG
An Equal Opportunity Employer

Oklahoma
HealthCare
Authority

UNREAD NOTICE SUMMARY

View Authorization Status ?

Prospective Authorizations | Search Authorizations | **Authorization Notices**

Enter at least one of the following fields to search for an authorization.

Provider Information

SC Provider Number
Unread Notices 108

Search Criteria -

Prior Authorization Number

Code Type Code

Member ID

Last Name First Name

Select a Day Range or Specify a Date Range

Day Range OR *From *To

Unread Notices Summary -

| Provider ID | Unread Notices |
|-------------|----------------|
| | 1 |
| | 18 |
| | 89 |

MAINTAIN FAVORITE PROVIDERS



[My Home](#) [Eligibility](#) [Claims](#) [Prior Authorizations](#) [Referrals](#) [Files Exchange](#) [Financial](#) [Letters](#) [Resources](#)

[Create Authorization](#) | [View Authorization Status](#) | [Maintain Favorite Providers](#)

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Prior Authorizations

Thursday 08/13/2015 12:56 PM CST

Prior Authorizations

- ▶ [Create Authorization](#)
- ▶ [View Authorization Status](#)
- ▶ [Maintain Favorite Providers](#)



ENTER SOONERCARE PROVIDER ID



[My Home](#) [Eligibility](#) [Claims](#) [Prior Authorizations](#) [Referrals](#) [Files Exchange](#) [Financial](#) [Letters](#) [Resources](#)

[Create Authorization](#) | [View Authorization Status](#) | [Maintain Favorite Providers](#)

[Contact Us](#) | [Logout](#)

[Prior Authorizations](#) > [Maintain Favorite Providers](#)

Thursday 08/13/2015 12:57 PM CST

Favorite Providers for Authorizations



The providers on the list below will be available for selection of the servicing provider when you are creating an authorization.

You may have up to 20 providers on your favorites list.

To add a new provider enter the SC Provider Number and Location, then click Add. To delete a provider, select the Remove link in the row.

* Indicates a required field.

*SC Provider Number

| Seq | Provider Name ▲ | SC Provider Number | Address | City | State | Zip Code | Action |
|-----|-----------------|--------------------|---------|---------------|-------|------------|------------------------|
| 1 | | | | OKLAHOMA CITY | OK | 73112-2078 | Remove |



OBTAIN DENTAL HISTORY



[My Home](#) [Eligibility](#) [Claims](#) [Prior Authorizations](#) [Referrals](#) [Files Exchange](#) [Financial](#) [Letters](#) [Resources](#)

[Eligibility Verification](#) | [Treatment History](#)

[Contact Us](#) | [Logout](#)

Thursday 08/13/2015 01:12 PM CST

Eligibility

Eligibility

- ▶ [Eligibility Verification](#)
- ▶ [Treatment History](#)



SEARCH TREATMENT HISTORY

Search Treatment History ?

Medical **Dental**

* Indicates a required field.

This search feature retrieves PAID claim records for a particular member ID as of the timeframe submitted.

Enter the member ID, date of service, and procedure code or tooth number, then click **Search**. Click **Reset** to clear all fields.

Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID **b23098524** Last Name SOONERCARE First Name SUSIE Birth Date 07/01/2014

Service Information

Either Procedure Code or Tooth Number is required.

Procedure Code

*Date of Service

- Past 1 Year
- Past 2 Years
- Past 3 Years
- Past 5 Years**
- Lifetime

Tooth Number

Search

Reset

Search Results

Placeholder for Configurable Text

Member ID b23098524 Member SUSIE SOONERCARE

Total Records: 2

For Treatment Detail, click on any procedure code.

| <u>Service Date</u> ▼ | <u>Procedure Code</u> | <u>Tooth Number</u> | <u>Oral Cavity Area</u> |
|-----------------------|-----------------------|---------------------|-------------------------|
| 06/01/2015 | D0140 | | |
| 01/02/2015 | D1120 | | |

VIEW TREATMENT DETAILS

View Treatment Details For D0140

[Back to Search Results](#) 

Member Information

Member ID B23098524

Member SUSIE V SOONERCARE

Birth Date 07/01/2014

Rendering Provider Information

Rendering Provider ID 1205838026

ID Type NPI

Name JOHNNY B TOOTH

Address 4000 ROOT CANAL WAY

Phone 1-405-599-1234

City MUSTANG

State Oklahoma

Zip Code 73064

Treatment Details

| Service Date | Procedure Code | Tooth Number | Oral Cavity Area |
|--------------|----------------|--------------|------------------|
| 06/01/2015 | D0140 | | NotSpecified |

[Print Preview](#)

LIFETIME RESULTS DISCLAIMER

Search Treatment History



Medical **Dental**

* Indicates a required field.

This search feature retrieves PAID claim records for a particular member ID as of the timeframe submitted.

Enter the member ID, date of service, and procedure code or tooth number, then click **Search**. Click **Reset** to clear all fields.

Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID Last Name SOONERCARE First Name SUSIE Birth Date 07/01/2014

Service Information

Either Procedure Code or Tooth Number is required.

Procedure Code *Date of Service

Results will show services that are only compensable once per lifetime

Tooth Number

Search

Reset

No matching records found. Please expand your search criteria and search again.

REQUIRED DOCUMENTS FOR PAS

Minimum records to be submitted with every dental request include:

- HCA-13D cover sheet for dental prior authorizations; required for new submissions and reconsiderations
- Periapical films of tooth/teeth involved



REQUIRED DOCUMENTS FOR PAS, CONT.



- Right and left bitewing x-rays
- Comprehensive treatment plan
- Six-point periodontal charting, if requesting periodontal services

HCA- I 3D DENTAL PA COVER SHEET



STATE OF OKLAHOMA
Oklahoma Health Care Authority
Dental Prior Authorization Attachment
Cover Sheet

- Attachments
- Additional Documentation
- Photos
- X-Ray

Three fields below are required and must match the prior authorization request.

1. Rendering Provider
SoonerCare ID Number
2. Member ID Number
3. Prior Authorization Number

Purpose:

This form is to be used when a prior authorization request (PAR) requiring a paper attachment is being submitted. Submission of the completed forms along with the required attachments will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. Box 1; fill in the Rendering Provider SoonerCare ID Number.
2. Box 2; fill in the 9-digit Member ID Number.
3. Box 3; fill in the Prior Authorization Number.
 - a. To submit additional documentation or attachments, enter the existing PAR number in box 3 to assure your documentation will be linked with the correct existing PAR.
4. The Attachments box is to be checked when sending attachments.
5. The Additional Documentation box is to be checked when submitting additional documentation to be added to an existing PAR. Enter the PAR number in box 3 above so your documentation will be linked with the correct existing PAR.
6. The Photos box is to be checked when submitting photos for review.
Mail to: HP/Dental Authorization; P.O. Box 548804, Oklahoma City, OK. 73154
7. The X-Ray box is to be checked when submitting X-Rays for review.
Mail to: HP/Dental Authorization; P.O. Box 548804, Oklahoma City, OK. 73154

This form is for use with Dental Prior Authorization requests requiring attachments.

Sender's Name: Phone Number:

ORTHODONTIC PA REQUIRED DOCUMENTS

Minimum records to be submitted with comprehensive orthodontic request:

- Completed and scored handicapping labio-lingual deviations index (HLD-1) with diagnosis of angle's classification
- Detailed description of any oral maxillofacial anomaly
- Estimated length of treatment

ORTHODONTIC PA REQUIRED DOCUMENTS, CONT.

- Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites
- Cephalometric x-rays with tracing, and panoramic film

ORTHODONTIC PA REQUIRED DOCUMENTS, CONT.

- If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide service
- Referral from general dentist (DEN-2)

RECONSIDERATION REQUESTS

All requests for reconsideration regardless of submission method must be mailed to:

HP/Dental Authorizations

P.O. Box 548804

OKC, OK 73154

RECONSIDERATION REQUESTS CONT.

All reconsideration requests must include:

- HCA-13D cover sheet for dental PAs
- Completed ADA form
- Original assigned PA number in box 2 of ADA form
- Any additional information needed to process the reconsideration

At this time, PAs cannot be modified or voided via the Provider Portal.

ADA 2012 DENTAL CLAIM FORM FOR PA

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION
 1. Type of Transaction (Mark all applicable boxes):
 Statement of Actual Services Request for Predetermination/Prior Authorization
 Request for Review

2. Predetermination/Prior Authorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
 3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/YYYY) 14. Gender M F 15. Policyholder/Subscriber ID (SSN or ICR)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION
 18. Relationship to Policyholder/Subscriber in #12 Above
 Self Spouse Dependent Child Other

19. Reserved for Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/YYYY) 22. Gender M F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

| 24. Procedure Code (MM/DD/YYYY) | 25. Area of Oral Care | 26. Tooth Surface | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. End Point(s) | 31. City | 30. Description | 31. Fee |
|---------------------------------|-----------------------|-------------------|----------------------------------|-------------------|--------------------|------------------|----------|-----------------|---------|
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)
 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s)
 A. _____ C. _____
 B. _____ D. _____

31a. Other Fees

32. Total Fee

35. Remarks

AUTHORIZATIONS
 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
 Patient/Guardian Signature _____ Date _____

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dental or dental entity.
 Subscriber Signature _____ Date _____

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)
 48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number () - () 53. Absence Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION
 38. Place of Treatment (e.g. 11=Home; 22=Off Hospital)
 (See "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?
 No (SIP-41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/YYYY)

42. Months of Treatment No Yes (Complete 44)

43. Replacement of Prosthesis No Yes (Complete 44)

44. Date of Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from
 Occupational Illness/Injury Auto accident Other accident

46. Date of Accident (MM/DD/YYYY) 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION
 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
 Signed (Treating Dentist) _____ Date _____

54. NPI 55. License Number
 56. Address, City, State, Zip Code 56a. Procedure Specialty Code

57. Phone Number () - () 58. Absence Provider ID

©2012 American Dental Association
 43300 (Replaces ADA Dental Claim Form - 4430, 4431, 4432, 4433, 4434)

To reorder call 800.547.4746 or go online at adacatalog.org

ADA 2012 CLAIM FORM INSTRUCTIONS FOR PA

Box 1 – Required

Box 2 – Required if applicable

Box 15 – Requires member SoonerCare ID

Box 20 – Required

Box 21 – Required

Box 25 – Required if applicable

Box 27 – Required if applicable

Box 29 – Required

Box 52A – Requires group SoonerCare ID

Box 53 – Required

Box 58 – Requires rendering provider SoonerCare ID

POLICY UPDATES

- Sealant frequency – once per three years
- Utilization parameters –one permanent restorative service provided per tooth per 24 months
- Comprehensive orthodontic treatment – member must be caries free for 12 months to obtain a referral to an orthodontist

COMMON GENERAL DENTAL LINE ITEM ERRORS

Each requested service must have its own line item.

For example:

- D4341 UR
 - D4341 UL
 - D4341 LR
 - D4341 LL
- } **Correct**

Incorrect:

D4341 4 units

COMMON ORTHODONTIC PA LINE ITEM ERRORS

Each year of requested orthodontic treatment must have its own line item.

For example:

- D8080
 - D8080
- } **Correct**

Incorrect:

D8080 2 units

CONTACT US

Dental Prior Authorization

405-522-7401

Provider Services

405-522-6205

800-522-0114

DENTAL PRIOR AUTHORIZATION TEAM

- ❖ Dr. Leon Bragg – Chief Dental Officer
- ❖ Dr. Courtney Barrett – Dental Consultant
- ❖ Dr. Richard Gilman – Orthodontic Consultant
- ❖ Tracy Matthews – Dental Program Coordinator
- ❖ Dana Drew – Dental Analyst
- ❖ Sara Gillum – Dental Analyst
- ❖ Wendy Payne – Dental Analyst
- ❖ Dominique Holt – Administrative Assistant
- ❖ Tiira Dale – Administrative Assistant

