CONNECTICUT DENTAL HEALTH PARTNERSHIP
the dental plan for
HUSKY Health

Anesthesia Prior Authorization Request Form

[Must be completed by the performing provider and submitted with Prior Authorization documentation for dental procedures for which anesthesia is requested]

Date of Request: _____ Routine ___ Urgent ___ Expedited ___

Section I: Client Information

_____	_____	_____
Last Name	First Name	Client Identification Number
_____	_____	_____
Date of Birth	Client's PCP	PCP's Phone Number

Section II: Clinical Documentation

Dental Diagnosis: _____

_____

Medical Conditions Warranting
Medical Necessity for Dental Anesthesia: _____

_____

Proposed Dental Procedures/Services: _____

_____

Proposed Anesthesia: Include Pharmacological Agents to Be Used and Anticipated Units of Anesthesia Needed

_____

_____

Section III: Provider Information

_____	_____
Requesting Provider Name (Print)	NPI (Print)
_____	_____
Provider Signature	Date

CTDHP Review: Approved ____ Denied ____ Modified ____

Units Approved: _____ Prior Authorization Approval Number: _____

Prior approval is not a guarantee of payment of claims. Payment of claims is subject to member eligibility, frequency limitations, and coverage guidelines.

Return completed form to:

BeneCare Dental Plans, PO Box 40109, Philadelphia, PA 19106-0109