



Clinical Information for Iatrogenic Dental Trauma

| PART A: Patient/Provider Information – Please Print | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|--|-------------|--|---|----------|--|--|----------|--|---|------|--|--|------|--|--|---------------|--|---------------------------------|----------|--|---|---|--|--|--|--|---|--|--|--|---|--|---|---|---|---|--|--|
| Patient Name (Last, First, MI) | Sponsor SSN | Date of Birth (mm/dd/yyyy) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Requesting Provider | Provider Fax # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART B: Clinical Information – Please check appropriate boxes and make comments as indicated – Please Print | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>History:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;"><input type="checkbox"/> Dilantin therapy?</td> <td style="width: 20%;">Time period</td> <td style="border-bottom: 1px solid black; width: 65%;"></td> </tr> <tr> <td><input type="checkbox"/> Facial trauma?</td> <td>Location</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td><input type="checkbox"/> Cancer/tumor?</td> <td>Location</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td><input type="checkbox"/> Radiation therapy?</td> <td>Area</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td><input type="checkbox"/> Chemotherapy?</td> <td>Type</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td><input type="checkbox"/> Facial surgery?</td> <td>Type/location</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td><input type="checkbox"/> Other?</td> <td>Describe</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table> <p>Examination:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Poor oral hygiene?</td> <td style="width: 33%;"><input type="checkbox"/> Dental caries?</td> <td style="width: 33%;"><input type="checkbox"/> Moderate or severe periodontal disease?</td> </tr> <tr> <td><input type="checkbox"/> Periapical or bone pathology?</td> <td><input type="checkbox"/> Gingival hyperplasia?</td> <td></td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other? Describe: _____</td> </tr> </table> <p>Records: (ALL applicable records MUST be submitted)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> X-rays (NO PHOTOCOPIES**)</td> <td style="width: 33%;"><input type="checkbox"/> Photographs (NO PHOTOCOPIES**)</td> <td style="width: 33%;"><input type="checkbox"/> Oncology evaluation</td> </tr> <tr> <td><input type="checkbox"/> Pathology report</td> <td><input type="checkbox"/> Operative report</td> <td><input type="checkbox"/> Radiation therapy evaluation</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Prosthodontic evaluation</td> </tr> </table> <p>Additional comments: _____</p> | | | <input type="checkbox"/> Dilantin therapy? | Time period | | <input type="checkbox"/> Facial trauma? | Location | | <input type="checkbox"/> Cancer/tumor? | Location | | <input type="checkbox"/> Radiation therapy? | Area | | <input type="checkbox"/> Chemotherapy? | Type | | <input type="checkbox"/> Facial surgery? | Type/location | | <input type="checkbox"/> Other? | Describe | | <input type="checkbox"/> Poor oral hygiene? | <input type="checkbox"/> Dental caries? | <input type="checkbox"/> Moderate or severe periodontal disease? | <input type="checkbox"/> Periapical or bone pathology? | <input type="checkbox"/> Gingival hyperplasia? | | <input type="checkbox"/> Other? Describe: _____ | | | <input type="checkbox"/> X-rays (NO PHOTOCOPIES**) | <input type="checkbox"/> Photographs (NO PHOTOCOPIES**) | <input type="checkbox"/> Oncology evaluation | <input type="checkbox"/> Pathology report | <input type="checkbox"/> Operative report | <input type="checkbox"/> Radiation therapy evaluation | <input type="checkbox"/> Prosthodontic evaluation | | |
| <input type="checkbox"/> Dilantin therapy? | Time period | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Facial trauma? | Location | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cancer/tumor? | Location | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Radiation therapy? | Area | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Chemotherapy? | Type | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Facial surgery? | Type/location | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other? | Describe | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Poor oral hygiene? | <input type="checkbox"/> Dental caries? | <input type="checkbox"/> Moderate or severe periodontal disease? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Periapical or bone pathology? | <input type="checkbox"/> Gingival hyperplasia? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other? Describe: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> X-rays (NO PHOTOCOPIES**) | <input type="checkbox"/> Photographs (NO PHOTOCOPIES**) | <input type="checkbox"/> Oncology evaluation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Pathology report | <input type="checkbox"/> Operative report | <input type="checkbox"/> Radiation therapy evaluation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Prosthodontic evaluation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART C: Treatment Plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>_____</p> <p>_____</p> <p>_____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART D: Codes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>CDT, CPT, and/or HCPCS codes: _____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p style="text-align: center;">Please complete this form and fax with supporting clinical documentation to:</p> <p style="text-align: center;">TriWest Healthcare Alliance Fax: 866-269-5892</p> <p style="text-align: center;">TRICARE Prime Remote, TRICARE Reserve Select Fax: 866-312-5831</p> | <p style="text-align: center;">**Mail x-rays and photographs separately to:</p> <p style="text-align: center;">TriWest Healthcare Alliance HCS Documentation PO Box 86508 Phoenix, AZ 85080</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>This data will be used in making a final determination.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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