



Clinical Information for Facility Charges for Noncovered Nonadjunctive Dental Care

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

History:

Does the patient have an underlying nondental organic condition that requires a hospital setting to safeguard his/her life from the effects of the planned dental procedures on that condition? Yes _____ No _____

Please indicate the condition:

- Hemophilia?
- Seizure disorder?
- Other? Please describe _____

Additional comments: _____

PLEASE NOTE:

1. An underlying nondental organic condition **MUST** exist, which requires a hospital setting to safeguard the life of the patient from a possible complication of this condition because of the noncovered dental work.
2. Documentation of the nondental organic condition from the physician treating the patient for that condition **MUST** be submitted.
3. The professional fees of the dentist and anesthesiologist that are related to the noncovered dental care are not covered.

PART C: Treatment Plan

Facility at which the procedures will be performed: _____

Please fax this completed form with supporting clinical documentation and/or other relevant data to:

TriWest Healthcare Alliance – Fax: 866-269-5892

TRICARE Prime Remote, TRICARE Reserve Select – Fax: 866-312-5831

This data will be used in making a final determination.

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services.

Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.” Violations of this may be punishable by fines, imprisonment, or both.