# TennCare Inpatient and Outpatient Hospital Readiness Pre-Admission Form

**This form is required to be submitted with documentation as outlined in Section 15.00, Criteria for Provision of Dental Treatment in an Inpatient/Outpatient Hospital ("Hospital") Facility or in an Ambulatory Surgical Center (ASC)**

Patient Name _____

Patient ID _____

Patient Address _____

_____

Date _____

**A. I certify that I have examined this patient**
☐ Yes ☐ No Date of Exam _____

**B. There is pathology or injury requiring extensive dental treatment (restorative or surgical)**
☐ Yes ☐ No

**C. I certify that I have attempted to treat this patient in my office**
☐ Yes ☐ No Date _____

**D. If a general dentist, I have attempted to refer this patient to a dental specialist (oral surgeon or pediatric dentist)**
☐ Yes ☐ No

**If no, why was a referral not made?**

_____

_____

**E. I have attempted to manage the member with Silver Diamine Fluoride in the office (general and pediatric dentists)**
☐ Yes ☐ No

**F. I have offered Silver Diamine Fluoride treatment to the member in the office as an alternative to treatment under general anesthesia in a medical facility (general and pediatric dentists)**
☐ Yes ☐ No

**G. If answer to "E" or "F" is no, please explain why SDF has not been used (general and pediatric dentists**

_____

_____

_____

**H. Were radiographs taken to determine diagnosis?**

☐ Yes ☐ No

**I. I have submitted all the documentation required for prior authorization as described in the TennCare Office Reference Manual**

☐ Yes ☐ No

**J. If answer to "H" or "I" is no, please explain why the documentation is not being submitted:**

_____

_____

DentaQuest reserves the right to request a second opinion for any inpatient/ outpatient hospital or ambulatory surgery center request.

**I Certify That the Above Information Is Correct**

Name of Provider _____

Provider Signature _____

Date _____

**Submit to:**

DentaQuest – TennCare
Attn: Pre-authorizations
PO Box 2906
Milwaukee, WI 53201-2906
FAX: 262.834.3452