JUSTIFICATION OF NEED FOR PROSTHODONTICS (removable)

Complete each item on the form and ATTACH TO YOUR ENCOUNTER DOCUMENTATION. If applicable, please attach x-rays of remaining teeth and chart missing teeth.

PATIENT: _____ MEMBER#: _____
DATE: _____ DATE OF BIRTH: _____

COMPLETE EACH APPROPRIATE ITEM ***PLEASE TYPE OR PRINT CLEARLY***

MAXILLARY

Appliance Requested: ❑ FUD ❑ PUD ❑ Int. Partial
Existing Appliance: ❑ FUD ❑ PUD ❑ Int. Partial ❑ Never Had
Wears Appliance? ❑ Yes ❑ No Age of Appliance:_____
If no, explain: ❑ Lost _____
❑ Stolen _____
❑ Discarded _____

Comments: _____

MANDIBULAR

Appliance Requested: ❑ FLD ❑ PLD ❑ Int. Partial
Existing Appliance: ❑ FLD ❑ PLD ❑ Int. Partial ❑ Never Had
Wears Appliance? ❑ Yes ❑ No Age of Appliance:_____
If no, explain: ❑ Lost _____
❑ Stolen _____
❑ Discarded _____

Comments: _____

	Adequate	Inadequate	If inadequate, explain:
Denture Base	❑	❑	_____
Framework	❑	❑	_____
Denture Teeth	❑	❑	_____
Retention	❑	❑	_____
Soft Tissue	❑	❑	_____
Hard Tissue	❑	❑	_____
Opposing Dentition	❑	❑	_____

	Adequate	Inadequate	If inadequate, explain:
Denture Base	❑	❑	_____
Framework	❑	❑	_____
Denture Teeth	❑	❑	_____
Retention	❑	❑	_____
Soft Tissue	❑	❑	_____
Hard Tissue	❑	❑	_____
Opposing Dentition	❑	❑	_____

	Adequate	Inadequate
Centric Occlusion	❑	❑
Vertical Relation	❑	❑ Open ___ mm. ❑ Closed ___mm.

Edentulous: ❑ Maxillary ❑ Mandibular

1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

✖ Block out missing teeth ❍ Circle teeth to be extracted

FOR PARTIAL DENTURE OR INTERIM PARTIAL

MAXILLARY

Teeth Being Replaced _____
Teeth Being Clasped _____

MANDIBULAR

Teeth Being Replaced _____
Teeth Being Clasped _____

If arch contains remaining teeth, indicate projected longevity and arch integrity (e.g. bone loss, tooth mobility, etc.): _____

If prosthesis has been lost, explain all circumstances: _____

Does the patient want requested services? ❑ No ❑ Yes

Does health condition of the patient limit dental adaptability? ❑ No ❑ Yes Explain: _____

ADDITIONAL COMMENTS _____

Provider Signature _____ License # _____

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