Nevada Dental Benefits, Ltd. ®
a PRIMECARE™ company

Culinary Health Fund™

Combined Medical/Dental Prior Authorization Request for Dental Services Provided in a Hospital or Surgery Center

*All Sections of this form must be completed.

REQUESTING PROVIDER INFORMATION

Dentist Provider Name:		Practice Name:
Address:		Tax ID Number:
Phone:	Fax:	Contact Person:

SUBSCRIBER & PATIENT INFORMATION

Subscriber Name:	Subscriber ID:	
Patient Name:	Patient Date of Birth:	Patient Age:
Patient Address:	Patient Phone:	

DENTAL AUTHORIZATION

Please attach an ADA claim/authorization form with dental services to be performed (include CDT codes)

Narrative: Please provide reason treatment cannot be performed in a dental office setting (include medical & dental diagnoses)

Narrative: Please describe any attempts at treatment in the dental office setting including dates of service.

MEDICAL AUTHORIZATION

Date of Request:	Inpatient or Outpatient	Procedure Date:	No. of Treatments Requested:	Service Requested by Patient? ☐ Yes ☐ No
Diagnosis (Include ICD Code):		Procedure / Treatment Request (Include CPT Code):		
Servicing Provider Name:		Address:		Phone:
Place of Service / Facility:		Address:		Phone:

SUBMISSION DIRECTIONS

1. Complete authorization request form and attach necessary supporting documentation including radiographs
2. For non-urgent requests (retain copy for your records), mail to the following:

   Nevada Dental Benefits – PA
   P.O. Box 80117
   Las Vegas, NV 89180

3. You will receive a written response within 14 days. If you do not receive response, please contact us at: (702) 478-2014.

For urgent requests, please contact Nevada Dental Benefits Customer Service at (702) 478-2014.