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: ______________________

MAXILLARY

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

MANDIBULAR

	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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