

## Provider Notification of HealthPartners Care Adult Member Requiring more than one prophy annually

Please fax this form to notify HealthPartners when you have learned of a disability or medical condition that requires a HealthPartners Care member to have additional prophylaxis for medical necessity. The criteria for medical necessity are listed below. Please check the appropriate box to support the diagnosis. This form will need to be sent in annually when it is determined that member will require more than one cleaning due to medical necessity. (Authorizations are not required for SNBC members)

Today's Date:	
Member Name:	DOB <u>:</u>
HealthPartners Member ID Number:	
Clinic Name:	
Clinic Phone number:	
Treating Dentist Name:	
Treating Dentist Signature:	
Criteria for covering an adult prophy (D1110) more t year:	than once a year, not to exceed four times a
<ul> <li>□ Patients who are physically disabled or reside in a factority of the provide daily oral care, or are unable to adequate the patients who have a medical condition that puts them (such as transplants, including heart valve replacement, receiving IV bisphosphonate therapy, diabetes, dialysis, □ Patients with diagnosed cognitive impairments or braichallenging, or</li> <li>□ Patients taking medications known to cause gingival had mental health condition that is inhibiting proper self care</li> </ul>	nately perform this function themselves, or at high risk for complications, including xerostomic, radiation therapy to the head or neck, history of a cardiovascular disease, pregnant women), or in injury that render cooperation with daily oral care hyperplasia or xerostomia or
self-care from clinical notes is required).	are temperature of the transfer to differ in

Fax to HealthPartners Dental Claims: (651) 265-1001 or email <a href="mailto:dentalclaimsattach@healthpartners.com">dentalclaimsattach@healthpartners.com</a> or Mail Stop 21103R
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