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| HCA New Logo Black | **Denture/Partial Appliance Request**  **For Skilled Nursing Facility Client** | | | | |
| DATE OF REQUEST | CLIENT ID | FACILITY NAME | | CLIENT NAME | |
| ITEM/SERVICE REQUESTED | | | | | |
| **THE FOLLOWING INFORMATION IS REQUIRED FOR ALL SKILLED NURSING FACILITY CLIENTS** | | | | | |
| **Nursing Home to Complete**  Yes No  Is this the client’s first set of denture/partial?  If not, how old are previous appliances and why do they need to be replaced?    Is patient alert and oriented?  Would client be compliant with the daily use of a dental appliance?  Does your facility have staff available to ensure and/or assist with proper cleaning techniques and daily insertion and removal? (See WAC 388-97-1060(3)(j)(vii).)  Would the use of the requested appliance enhance this resident’s quality of life through improved nutritional intake?  Does the resident eat solid food?  If not, please explain:    Can the client consent to treatment? (See WAC 388-97-0260.)  If not, attach a signed release form by the designated power of attorney for the treatment bring prior   authorized.  List or attach all medical diagnosis (not ICD9 codes) to verify competency to wear denture/partial appliances. | | | | | |
| Dentist/Denturist signature below indicates that the requested service is medically necessary according to WAC 182-500-0070. | | | | | |
| DENTIST/DENTURIST’S SIGNATURE | | | PROVIDER NIP NUMBER | | DATE |
| Physician’s signature below indicates that the requested service is medically necessary according to WAC 182-500-0070. | | | | | |
| PHYSICIAN’S SIGNATURE | | | | | DATE |

**Return this form to the servicing provider.**