

**WVCHIP/UMC**  
**ENDODONTIC PRECERTIFICATION REQUEST FORM**  
**FOR USE WITH CDT Codes D3410, D3421, or D3999**  
**(UP TO AGE 19 YEARS)**

Date \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ID# \_\_\_\_\_

Address \_\_\_\_\_

**Treating Dentist**

Name \_\_\_\_\_ Medicaid ID# \_\_\_\_\_ NPI \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Service Requested \_\_\_\_\_ Diagnosis/CDT code(s) \_\_\_\_\_

Date Care to be Started \_\_\_\_\_ Request Period From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_

Frequency/Duration of Services/Tooth number(s) \_\_\_\_\_

**Referring Practitioner**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

**Must Meet ALL**

- Radiographs showing clearing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated: bitewings, periapicals or Panorex.
- Tooth is filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- Filling material is approved by FDA.

**Must Meet ALL**

- Absence of gross periapical or periodontal pathosis is demonstrated radiographically deeming the tooth restorable.
- Root canal therapy is not for 3<sup>rd</sup> molars, unless they are an abutment for a partial denture.
- The general oral condition does not demonstrate loss of arch integrity.
- Tooth demonstrates 50%> bone support.
- Root canal therapy is not in anticipation of placement of an over denture.

**FOR UMP USE ONLY:**

Date approved \_\_\_\_\_ Precertification number \_\_\_\_\_ Date of Notification \_\_\_\_\_

Date denied by Reviewer \_\_\_\_\_ Date of Notification \_\_\_\_\_

Date Reconsideration Received \_\_\_\_\_ Date approved \_\_\_\_\_ Date denied \_\_\_\_\_

Date of Notification \_\_\_\_\_