DELTA DENTAL

Removable Prosthodontics Assessment Form

Patient Name _____ **Enrollee ID** _____

Enrollee Date of Birth _____ **Evaluation Date** _____

Maxillary Arch

Type of appliance being requested:

- ☐ Complete Denture Procedure Code _____
- ☐ Partial Denture Procedure Code _____

Currently has maxillary appliance:

- ☐ Complete Denture ☐ Partial Denture
- ☐ Patient has never had Maxillary appliance

Age of existing denture/partial denture _____

Has existing denture/partial denture been repaired, relined. If yes, please explain _____

☐ **Does patient wear denture/partial denture**

If no, please explain _____

Reason for replacement:

- ☐ The appliance has degraded to the point of prosthesis instability, loss of retention, loss of support, inability to eat.
  Please describe _____
- ☐ Chronic irritation beneath the denture bases.
- ☐ Additional teeth require extraction or have been lost.
- ☐ Denture adhesives are routinely required for the patient to eat, or to retain the dentures.
- ☐ Patient will not, or cannot, wear the removable prostheses.
- ☐ Prosthetic teeth are discolored, cracked, broken, or missing.
- ☐ The removable prostheses have been lost
- ☐ Other. Please describe _____

Mandibular Arch

Type of appliance being requested:

- ☐ Complete Denture Procedure Code _____
- ☐ Partial Denture Procedure Code _____

Currently has mandibular appliance:

- ☐ Complete Denture ☐ Partial Denture
- ☐ Patient has never had Mandibular appliance

Age of existing denture/partial denture _____

Has existing denture/partial denture been repaired, relined. If yes, please explain _____

☐ **Does patient wear denture/partial denture**

If no, please explain _____

Reason for replacement:

- ☐ The appliance has degraded to the point of prosthesis instability, loss of retention, loss of support, inability to eat.
  Please describe _____
- ☐ Chronic irritation beneath the denture bases.
- ☐ Additional teeth require extraction or have been lost.
- ☐ Denture adhesives are routinely required for the patient to eat, or to retain the dentures.
- ☐ Patient will not, or cannot, wear the removable prostheses.
- ☐ Prosthetic teeth are discolored, cracked, broken, or missing.
- ☐ The removable prostheses have been lost
- ☐ Other. Please describe _____

Centric Occlusion Adequate ☐ Inadequate ☐

Vertical Dimension Adequate ☐ Inadequate ☐

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32

X Cross out missing teeth **O Circle teeth to be extracted**

Additional Comments _____

Dentist Signature _____ **Date** _____

How to Complete the Justification of Need for Prosthesis Form

- Patient name: Enter the enrollee's name.
- Evaluation date: Enter the date the enrollee was evaluated.
- Type of appliance being requested: Enter the type of prosthetic appliance that is being requested. Enter appropriate CDT code.
- Age of existing appliance: Enter the age of the existing prosthetic appliance.
- Reason for replacement: Document the reason the existing appliance needs to be replaced. Check the boxes that apply. If needed, use the space in the lower part of the form for documenting details.
- Missing teeth: Use an "X" to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers.
- Additional comments: Use this section for additional comments/documentation specific to the requested treatment and the enrollee's clinical condition.
- Signature: The dentist completing the evaluation should complete the form.

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