HealthPartners

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:** _____

HealthPartners Member ID Number: _____

Clinic Name: _____

Clinic Phone number: _____

Treating Dentist Name: _____

Treating Dentist Signature: _____

Criteria for covering an adult prophy (D1110) more than once a year, not to exceed four times a year:

□ Patients who are physically disabled or reside in a facility or group home setting in which they rely on others to provide daily oral care, or are unable to adequately perform this function themselves,or
□ Patients who have a medical condition that puts them at high risk for complications, including xerostomia (such as transplants, including heart valve replacement, radiation therapy to the head or neck, history of receiving IV bisphosphonate therapy, diabetes, dialysis, cardiovascular disease, pregnant women), or
□ Patients with diagnosed cognitive impairments or brain injury that render cooperation with daily oral care challenging, or
□ Patients taking medications known to cause gingival hyperplasia or xerostomia or
□ Mental health condition that is inhibiting proper self care (explanation of how the condition is affecting self-care from clinical notes is required).

Fax to HealthPartners Dental Claims: (651) 265-1001
or email dentalclaimsattach@healthpartners.com
or Mail Stop 21103R
P.O. Box 1172
Minneapolis, MN 55440-1172