NMCAA DENTAL HEALTH EXAM RECORD



If this child has Medicaid coverage and your office does not accept Medicaid

DO NOT TREAT THIS CHILD UNLESS YOU HAVE PRIOR APPROVAL

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male  Female

Program/Site Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher/CFS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| METHOD OF PAYMENTCheck one |
|  | Medicaid |
|  | Private Insurance |
|  | NMCAA |

|  |  |  |
| --- | --- | --- |
| DATE |  | FEE |
|  | EXAM |  |
|  | PROPHY |  |
|  | FLUORIDE |  |
|  | X-RAYS (only if required for diagnostic use) |  |
|  | TOTAL |  |

**Check All That Apply:**

 Dental exam complete - no further treatment necessary

 Further treatment necessary - (fillings, crowns, extractions, root canal, etc.) Must have prior

 authorization if NMCAA is responsible to pay. If Medicaid coverage, treatment can be scheduled.

 Estimated cost of treatment $ \_\_\_\_\_\_\_\_\_\_ If in excess of $150, attach treatment plan.

 Approximate number of appointments needed \_\_\_\_\_ Date Scheduled \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (uncooperative, difficulties, wait for treatment, etc.)

 NO  YES Based on the criteria below, do you have additional recommendations for this child?

Head Start programs are required to facilitate fluoride supplements, other preventative oral health measures and/or further oral health treatment for enrolled children living in communities where there is a lack of adequate fluoride in the water supply or if the child has moderate or severe tooth decay.

If yes, please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Dental Provider Signature & Date Name of Provider’s Office**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date of Exam Date of Next Exam**

 **AREA BELOW FOR NMCAA USE ONLY**

Further treatment authorized □ Yes □ No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount $\_\_\_\_\_\_\_\_\_\_\_

 **Distribution:** HS R&H/CCSC: Scan or copy the physical for DMT and the Teacher/Provider EHS R&H/FSS: Enter directly into CP and attach in CP

**AREA BELOW FOR NMCAA USE ONLY**

FURTHER TREATMENT AUTHORIZED □ Yes □ No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount $\_\_\_\_\_\_\_\_\_\_\_

**FOR NMCAA OFFICE USE ONLY: Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Time and Mileage to Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

4/23 HSPPS 1302.42 (b)(1)(i), (c)(3) EHS-HS Team\Head Start\Health\Dental Health Exam Record