NMCAA DENTAL HEALTH EXAM RECORD

Text

Description automatically generated with low confidence

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 PAYMENT  Check 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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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