

NJ FamilyCare/Medicaid UnitedHealthcare Community Plan of New Jersey

Quick reference guide – Effective Jan. 1, 2021

This reference guide provides you with quick access to a variety of helpful resources about the UnitedHealthcare Community Plan of New Jersey NJ FamilyCare/Medicaid plan.



Provider Services

Main provider contact

Phone: Call **888-362-3368**.

Inquire about provider-related items, such as:

- Behavioral health
- Pharmacy
- Hearing services
- Vision services
- Durable medical equipment (DME)
- Hospital billing

Representatives are available weekdays, 6 a.m. – 6 p.m. (except major holidays).

For general inquiries (excluding grievances and appeals), email newjersey_pr_team@uhc.com.



UHCprovider.com/NJcommunityplan

UnitedHealthcare's provider portal for Community Plan of New Jersey. You can find:

- Policies and clinical guidelines
- Provider forms and references
- Training and education
- Bulletins and newsletters
- Care Provider Manual



UHCCommunityPlan.com/NJ

UnitedHealthcare Community Plan of New Jersey's webpage for members.



Link and Electronic Data Interchange (EDI)

Link is your secure gateway to UnitedHealthcare's online tools. Here you can:

- Confirm member eligibility and benefits
- Submit claims and check status
- Submit a reconsideration request
- Request prior authorization
- Update facility/practice data

EDI is an automated way to exchange information with UnitedHealthcare and other payers. To learn more about using Link and EDI, please visit [UHCprovider.com/link](https://uhcprovider.com/link) and [UHCprovider.com/edi](https://uhcprovider.com/edi).



Eligibility and Benefits

Use the eligibilityLink tool at UHCprovider.com/eligibility, EDI 270/271 transactions or call **888-362-3368**.



Prior Authorization Requests

Online: Go to UHCprovider.com/priorauth.

Phone: Call **888-362-3368**.

Claims Submission

Submit within 180 days of service or the time frame outlined in your Participation Agreement.

Payer ID: **86047**

Electronic Claims:

Claims can be filed as an EDI 837 transaction or by using the Claims Submission tool in UHCprovider.com/claims. Use Link to track receipt.

Mail paper claims to:

UnitedHealthcare Community Plan of New Jersey
P.O. Box 5250, Kingston, NY 12402-5250

For FedEx (use for large packages/more than 500 pages):

UnitedHealthcare Community Plan of New Jersey
1355 S. 4700 West, Suite 100, Salt Lake City, UT 84104

You will receive a provider remittance advice (PRA) with details of your claims reimbursement after receipt.



Claims Reconsideration

You can submit any one-time case reviews of an administrative denial within 90 days from the determination date.

Mail reconsiderations to:

UnitedHealthcare Community Plan of New Jersey
Attention: Reconsideration
P.O. Box 31364, Salt Lake City, UT 84131-0364

Submit electronic reconsiderations on UHCprovider.com/claims. Use Link to track the receipt.



Claims Management and Reconsideration Use Claims Tool available at UHCprovider.com/claims or call **888-362-3368**.



Appeals Submission

Mail formal appeals to:
UnitedHealthcare Community Plan of New Jersey
Attention: Appeals
P.O. Box 31364, Salt Lake City, UT 84131-0364



Coordination of Benefits

If Coordination of Benefits (COB) is involved where UnitedHealthcare is considered a secondary payer, COB of claims should be submitted within 60 days from the date of the primary insurer's explanation of benefits (EOB) or 180 days from the dates of service, whichever is later.



Prescription Drugs

For a Formulary List and links to Prior Authorization requests, visit [UHCprovider.com/NJcommunityplan](https://uhcprovider.com/NJcommunityplan) > Pharmacy Resources and Physician-Administered Drugs. Call **800-310-6826** for assistance.



PreCheck MyScript®

Integrated directly within your EMR and allows you to easily run a pharmacy trial claim and get real-time prescription coverage detail for your UnitedHealthcare patients. Visit [UHCprovider.com/precheckmyscript](https://uhcprovider.com/precheckmyscript).



Cardiology Prior Authorization

For prior authorization or a current list of CPT® codes that require prior authorization, visit [UHCprovider.com/cardiology](https://uhcprovider.com/cardiology). Click Menu on the top left, select Prior Authorization and Notification, then Cardiology.



Radiology Prior Authorization

Visit [UHCprovider.com](https://uhcprovider.com) > Prior Authorization and Notification > Radiology. Call **866-889-8054**.



Healthy First Steps

Program to assist pregnant women for prenatal and perinatal care. Refer pregnant and high-risk OB members. Call **877-813-3417**, TTY 711, weekdays from 8 a.m. – 7 p.m. (except major holidays).



Care Coordination and Management

Refer members with complex conditions who frequently use health care services or special needs. **NJ FamilyCare/Medicaid:** Call **888-362-3368**. **MLTSS NJ FamilyCare/Medicaid:** Call **888-702-2168**.



Care Provider Manual

UnitedHealthcare Community Plan of New Jersey's provider administrative reference guide. Visit [UHCprovider.com/NJcommunityplan](https://uhcprovider.com/NJcommunityplan) > Care Provider Manuals > New Jersey > [View the UnitedHealthcare Community Plan of New Jersey Care Provider Manual](#).



Provider Orientation Training

Visit [UHCprovider.com/training](https://uhcprovider.com/training) for access to self-guided training. Learn about how to work with UnitedHealthcare and other continuing education modules to keep you informed and up-to-date.



Provider Enrollment

Contact the National Credentialing Center (NCC) by calling **877-842-3210**, and choosing telephone prompts Other Professional Services > Credentialing > Join the Network. Contact NCC for questions about the application process and status. The application review and notification of application status takes 30 days. We will not hold an application open for greater than 30 days waiting for missing required documentation from the initial submission. Email newjersey_pr_team@uhc.com to inquire whether new provider applications are being accepted.



Assisted Living/Nursing Facility Questions

Phone: Call **888-702-2168**



UnitedHealthcare Community Plan NJ FamilyCare

 UnitedHealthcare Community Plan Health Plan (80840) 911-86047-08 Member ID: 000300076 Group Number: NJFAMCAR Member: REISSUE ENGLISH PCP Name: DOUGLAS GETWELL PCP Phone: (201)792-3022 See reverse for dental/vision benefits DOI -0501	Payer ID: 86047  Rx Bin: 610494 Rx Grp: AMNJ Rx PCN: 4343 NJ FamilyCare A Underwritten by AmeriChoice of New Jersey, Inc.	Printed: 10/02/18 If you are not sure if your problem is an emergency, call your PCP first. No prior authorization is required for emergencies. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan or call. Member Services/ Dental/Vision: 1-800-941-4647 TDD/TTY 711 In an emergency go to nearest emergency room or call 911. For Providers: UHCprovider.com 1-888-362-3368 Medical Claims: PO Box 5250, Kingston, NY, 12402-5250 Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903 For Pharmacists: 1-877-305-8952
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Sample member ID cards for illustration only. Actual information varies depending on payer, plan and other requirements.

NJ FamilyCare/Medicaid member services: 800-941-4647, TTY 711

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DMAHS Approved February 2021

PCA-1-20-02920-C&S-QRG_09232020

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UnitedHealthcare Dual Complete® ONE (FIDE SNP)

UnitedHealthcare Community Plan of New Jersey

Quick reference guide – Effective Jan. 1, 2021

This reference guide provides you with quick access to a variety of helpful resources about the UnitedHealthcare Community Plan of New Jersey Dual Complete® ONE (FIDE SNP) plan.



Provider Services

This is the main provider customer service contact.

Phone: Call **888-362-3368** to inquire about provider-related items, such as:

- Behavioral Health
- Pharmacy
- Hearing Services
- Vision Services
- Durable Medical Equipment (DME)
- Hospital Billing

Representatives are available weekdays, 8 a.m. – 6 p.m. (except major holidays).

For general inquiries (excluding grievances and appeals), email newjersey_pr_team@uhc.com.



UHCprovider.com/NJcommunityplan

UnitedHealthcare's provider portal for Community Plan of New Jersey. You can find:

- Policies and Clinical Guidelines
- Provider Forms and References
- Training and Education
- Bulletins and Newsletters
- Care Provider Manual



UHCCommunityPlan.com/NJ

UnitedHealthcare Community Plan of New Jersey's webpage for members.



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- Confirm member eligibility and benefits
- Submit claims and check status
- Submit a reconsideration requests
- Request prior authorization
- Update facility/practice data

EDI is an automated way to exchange information with UnitedHealthcare and other payers. To learn more about using Link and EDI, please visit UHCprovider.com/link and UHCprovider.com/edi.



Eligibility and Benefits

Use the eligibilityLink tool at UHCprovider.com/eligibility, EDI 270/271 transactions or call **888-362-3368**.



Prior Authorization Requests

Online: Go to UHCprovider.com/priorauth.

Phone: Call **888-362-3368**.

Claims Submission

Submit within 180 days of service, or the time frame outlined in your Participation Agreement.

Payer ID: **86047**

Electronic Claims:

Claims can be filed as an EDI 837 transaction or by using the Claims Submission tool at UHCprovider.com/claims. Use Link to track receipt.

Mail paper claims to:

UnitedHealthcare Community Plan of New Jersey
P.O. Box 5250, Kingston, NY 12402-5250

For FedEx (use for large packages/more than 500 pages):

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You will receive a provider remittance advice (PRA) with details of your claims reimbursement after receipt.



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Attention: Reconsideration
P.O. Box 31364, Salt Lake City, UT 84131-0364

Submit electronic reconsiderations on UHCprovider.com/claims. Use Link to track receipt.



Claims Management and Reconsideration

Use the Link tool available on UHCprovider.com or call 888-362-3368.



Appeals Submission

Mail formal appeals to:

UnitedHealthcare Community Plan of New Jersey
Attention: Appeals
P.O. Box 31364, Salt Lake City, UT 84131-0364



Coordination of Benefits

UnitedHealthcare Community Plan is managing both the member's Medicaid and Medicare services under the UnitedHealthcare Dual Complete ONE (FIDE SNP) plan, you won't have to submit the claim twice as a participating provider. Our internal process will settle the secondary Medicaid claim once the Medicare claim is processed. UnitedHealthcare Community Plan of New Jersey will always be the Medicaid payer.



Prescription Drugs

For a Formulary List and links to Prior Authorization requests, visit

UHCprovider.com/NJcommunityplan > Pharmacy Resources and Physician-Administered Drugs.
Call **800-310-6826** for assistance.



PreCheck MyScript®

Integrated directly within your EMR, this tool allows you to easily run a pharmacy trial claim and get real-time prescription coverage detail for your UnitedHealthcare patients. Visit UHCprovider.com/precheckmyscript.



Cardiology Prior Authorization

For prior authorization or a current list of CPT® codes that require prior authorization, visit UHCprovider.com/cardiology. Click Menu on top left, select Prior Authorization and Notification, then Cardiology.



Radiology Prior Authorization

Visit UHCprovider.com > Prior Authorization and Notification > Radiology. Or call **866-889-8054**.



Healthy First Steps

Program that assists pregnant women for prenatal and perinatal care. Refer pregnant and high-risk OB members. Call **877-813-3417**, TTY **711**, weekdays from 8 a.m. to 7 p.m. (except major holidays).



Care Coordination and Management

Refer members with complex conditions who frequently use health care services or special needs. Dual Complete ONE/FIDE SNP: Call **888-362-3368**.
MLTSS Dual Complete ONE/FIDE SNP: Call **888-702-2168**.



Network Referrals

Online: Go to UHCprovider.com > Find Dr. > Search for a Provider > Medical Directory > Medicare Plans > UnitedHealthcare Dual Complete.

Phone: Call **888-362-3368**.

To submit a behavioral health service referral, please call **888-362-3368**.



Care Provider Manual

UnitedHealthcare Community Plan of New Jersey's provider administrative reference guide. Visit UHCprovider.com/NJcommunityplan > Care Provider Manuals > New Jersey > View the UnitedHealthcare Community Plan of New Jersey Care Provider Manual.



Provider Orientation Training

Visit UHCprovider.com/training for access to self-guided training. Learn about how to work with UnitedHealthcare and other continuing education modules to keep you informed and up-to-date.



Model of Care Training

Please complete the required Model of Care training at UHCprovider.com > Menu > Resource Library > Training > Special Needs Model of Care Training for Providers.



Provider Enrollment

Contact the National Credentialing Center (NCC) by calling **877-842-3210** and choosing the following telephone prompts: Other Professional Services > Credentialing > Join the Network. Contact NCC for questions about the application process and status. The application review and notification of application status takes 30 days. We will not hold an application open for greater than 30 days waiting for missing required documentation from the initial submission. Email newjersey_pr_team@uhc.com to inquire whether new provider applications are being accepted.



Assisted Living/Nursing Facility Questions

Phone: Call **888-702-2168**.



OptumHealth NurseLine

Phone: Call 877-440-9407, 7 days a week, 24 hours a day.



Personal Emergency Response System (Tunstall)

Phone: Call 800-514-4911, Monday – Friday, 8 a.m. – 8 p.m.



UnitedHealthcare Dual Complete ONE

For more information about Dual Complete ONE (FIDE SNP) for New Jersey, visit UHCprovider.com/NJcommunityplan > New Jersey UnitedHealthcare Dual Complete® Special Needs Plans



UnitedHealthcare Community Plan Dual Complete ONE, Sample Cards

 <p>UnitedHealthcare Dual Complete ONE</p> <p>Health Plan (80840): 999-99999-99 Member ID: 999999999 Group Number: NJDUALCM</p> <p>Member: SUBSCRIBER BROWN UHC Medicaid ID: 999999999999 Payer ID: 86047</p> <p>PCP Name: DR. PROVIDER BROWN PCP Phone: (999)999-9999 Provider Network Name Copay: No Copays</p> <p>Dental Benefits Included</p>  <p>Rx Bin: 999999 Rx Grp: XXXXXXXX Rx PCN: 9999</p> <p><small>H3113 PBP# 005 Preauthorization not required for emergency care UnitedHealthcare Dual Complete® ONE (HMO D-SNP)</small></p>	<p>Customer Service Hours: 8 a.m. to 8 p.m. local time, 7 days a week</p> <p>For Members Website: www.UHCCommunityPlan.com Customer Service: SEE YOUR CARD TTY 711 Mental Health: SEE YOUR CARD TTY 711</p> <hr/> <p>For Providers UHCprovider.com 999-999-9999 Medical Claim Address: PO Box 12345, Anywhere, USA</p> <p>Pharmacy Claims PO Box 12345, Anywhere, USA For Pharmacists 999-999-9999</p>
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Sample member ID cards for illustration only. Actual information varies depending on payer, plan and other requirements.

Dual Complete ONE/FIDE SNP Member Services

Phone: 800-514-4911, TTY: 711

UnitedHealthcare Community Plan of New Jersey

Home- and Community-Based Services quick reference guide

This reference guide provides you with quick access to a variety of helpful resources about UnitedHealthcare Community Plan of New Jersey Home- and Community-Based Services (HCBS).



Prior Authorization Requests

Phone: 866-604-3267

Fax: 888-840-9284

All Home and Community Based Services (HCBS) or Managed Long Term Services and Supports (MLTSS) require prior authorization.

All members requiring HCBS/MLTSS receive a comprehensive assessment by a case manager. Case managers work with members to develop a person-centered care plan that includes:

- Coordination and monitoring of needed services
- Communication of necessary information about changes in the members' health or the ability to help care providers in planning, delivering and monitoring services
- Coordination of resources across all facets of care to help coordinate care
- Identification of needed HCBS/MLTSS services by the case manager and member, based on the care plan. After agreement on the services, the case manager authorizes the HCBS/MLTSS services.

If you need assistance identifying a member's Care Coordinator, please call 866-604-3267, 8 a.m. – 5 p.m. Eastern Time, Monday – Friday.



Claims Submission

Electronic Claims:

Claim Submission Tool

You can submit claims electronically using our Claim Submission tool at UHCprovider.com/claims > **Submit a Claim**. Here you can also find more information and training for filing claims.

Office Ally

Office Ally is a free, web-based service where you can enter professional (CMS-1500) and institutional (UB-04) claims manually or upload them through your existing software.

To learn more, contact Office Ally at 360-975-7000, option 3 and refer to code **UHCCP** or go to UHCprovider.com/edi > EDI Clearinghouse Options.

Electronic Data Interchange (EDI) Clearinghouse

You can select any clearinghouse with a connection to UnitedHealthcare to exchange EDI transactions. To learn more, go to UHCprovider.com/edi > Electronic Transactions.

Please submit claims within 365 days of service.

Payer ID: 86047

Paper Claims:

Please mail claims to the address listed on the back of the member's ID card.



Other Resources for HCBS and MLTSS Care Providers

Your Provider Advocate

For more information about the UnitedHealthcare Community Plan of New Jersey HCBS services, please contact our HCBS Provider Advocate team at hcbs_northeast_pr@uhc.com.

Community Plan Website

On the date your program starts, you can access UnitedHealthcare Community Plan network participation information, including your provider manual, resources for claims and member information, training and education information and network news.

Go to UHCprovider.com/NJcommunityplan.

Electronic Tools and Resources

Visit UHCprovider.com/NJcommunityplan > Claims and Payments > Electronic Data Interchange (EDI).

Link

Link is your gateway to UnitedHealthcare's online tools. Use Link online tools to quickly find the comprehensive information you need. To sign in to Link, go to UHCprovider.com and click on the Link button in the top right corner.

To learn more about using Link, please visit UHCprovider.com/link. If you need technical help to access Link, please email ProviderTechSupport@uhc.com or call our Help Desk at 866-842-3278, option 1, 8 a.m. – 10 p.m. Eastern Time, Monday – Friday.

Provider Services

Call Provider Services to:

- Confirm member eligibility and benefits
- Provide care coordination notification
- Check claims status
- Request prior authorization
- Update facility/practice data
- Submit an appeal request

Phone: 888-362-3368

You may be prompted to enter the member's date of birth, the date of service, the member's ID number and the group number listed on the member's ID card.

Representatives are available weekdays, 8 a.m. – 6 p.m. Eastern Time (except major holidays).

Provider Enrollment

If you are interested in becoming a participating MLTSS provider, please email NJ_MLTSS_CRED@UHC.com for more information or to request a credentialing application. Please include the name of the facility and the words "Credentialing Application" on the subject line.

MLTSS Care Management

Phone: 800-645-9409

Contact for questions about Personal Preference Program (PPP).



Behavioral Health Quick Reference Guide

New Jersey FamilyCare & FIDE SNP

Call Center for UnitedHealthcare	1-888-362-3368 <ul style="list-style-type: none">• Appeals and Grievances• Claims• Coordination of Benefits• Dual eligible members with Medicare• Medicaid members with commercial coverage• Billing concerns• Office Base Addictions Treatment Services• Behavioral Health Care Management• Care Coordination
Websites & What's Available	<p>providerexpress.com</p> <ul style="list-style-type: none">• New Provider Orientation "Navigating Optum" viewable on demand• Network Manual• Demographic Updates• Guidelines / Policies & Manuals• Clinical Resources• Level of Care Guidelines• Administrative Resources• Recovery & Resiliency Toolkit• Video Channel• Best Practices Guidelines• Webinars/Training Resources <p>uhcprovider.com</p> <ul style="list-style-type: none">• State-specific health plan information• Check member eligibility• Check claim status & payments• Claims Reconsideration• Electronic Data Interchange (EDI) information• Tools & Resources• Tutorials

Claims Submission	<p>Paper Claim submission: Optum Behavioral Health P.O. Box 30760 Salt Lake City, UT 84130-0760</p> <p>Claims must be submitted within 180 days from the date of service</p>
EDI	<p>Claims Payer ID: 87726 Electronic Remittance Advice (ERA) Payer ID: 86047 EDI Support: 1-800-210-8315 or email ac_edi_ops@uhc.com</p>
Electronic Payments & Statements (EPS)	<p>It's quick and easy, go to uhcprovider.com > Claims & Payments > Electronic Payments & Statements Questions – 1-866-842-3278, option 5</p>
Clinical Appeals	<p>NJ FamilyCare: Optum Appeals & Grievances P.O. Box 30512 Salt Lake City, UT 84130-0512</p> <p>Fide SNP: UnitedHealthcare Appeals Department P.O. Box 31364 Salt Lake City, UT 84131-0364</p>
Best Practice Guidelines	<p>We have adopted Best Practice Guidelines, which were developed by nationally recognized organizations. Provider Express > Guidelines/Policies & Manuals > Best Practice Guidelines</p>
Utilization Management Guidelines	<ul style="list-style-type: none"> • Emergent admissions require notification within 24 hours of admission. • Prior Authorization is required for all non-emergent inpatient Admissions. • Comorbidity Diagnosis with a Medical and Behavioral Admission require both a Medical <i>AND</i> <i>subsequent</i> Behavioral Health Authorization or separate notification. • To obtain Prior Authorization call 1-888-362-3368 - Enter TIN #, select option 3 (intake), enter member ID/DOB, select option for “Mental Health” • We do not accept faxes. A call is required.
Level of Care Guidelines	<ul style="list-style-type: none"> • Optum Level Of Care Guidelines for Mental Health Level Of Care and can be found at: providerexpress.com > Clinical Resources > Level of Care Guideline • UnitedHealthcare Community Plan uses ASAM level of Care Guidelines for Alcohol and Drug Treatment and Substance Use Disorder (SUD) • Reference: American Society of Addiction Medicine (ASAM) asam.org/resources/the-asam-criteria

Network Management Contacts	<p>Barbara Pinkston-Martinez, Network Manager for Facilities and Clinics</p> <p>njnetworkmanagement@optum.com Provider Escalated Issues: 1-877-614-0484 Fax: 1-866-483-6254</p>
Pharmacy	<p>UnitedHealthcare Community Plan Pharmacy Services Department Fax: 1-866-940-7328 Phone: 1-800-310-6826</p> <p>Link to Preferred Drug List: uhcprovider.com/content/dam/provider/docs/public/commplan/nj/pharmacy/NJ-Preferred-Drug-List-Provider.pdf</p>
Provider Enrollment	<p>To request to join the network, visit: https://www.providerexpress.com/content/ope-provexpr/us/en/our-network.html</p> <p>The review and notification timeline of a clean application takes between 45-60 days. Email njnetworkmanagement@optum.com to inquire whether new provider applications are being accepted.</p>

UnitedHealthcare 2021 Dental Quick Reference Guide (QRG)

UnitedHealthcare Community Plan of New Jersey Medicaid



www.UHCproviders.com

The Provider Web Portal may be used to check eligibility, submit claims, and to access useful information regarding plan coverage.

www.njfamilycare.org

NJ FamilyCare website



Provider Services

Phone: 1-800-508-4881

9:00 a.m. – 6:00 p.m. ET Monday – Friday (IVR: 24/7)
Member eligibility, benefits, claims, authorizations, network participation and contract questions



Member Pre-Service Appeals and Grievances

UHC Medicaid Claim Disputes
PO Box 31364
Salt Lake City, UT 84131



Prior Authorizations

UHC Medicaid Authorizations
PO Box 2073
Milwaukee, WI 53201



Claims

UHC Medicaid Claims
PO Box 2180
Milwaukee, WI 53201

EDI Payer ID

GP133

Claim Appeals or Adjustments

UHC Medicaid Claim Disputes
PO Box 1266
Milwaukee, WI 53201

Important Notes

This guide is intended to be used for quick reference and may not contain all of the necessary information and is subject to change without notice. For current detailed benefit information, please visit the provider web portal or contact our provider services toll free number.

Coordination of Benefits – If Coordination of Benefits (COB) is involved where UnitedHealthcare is considered a secondary payer, COB claims should be submitted within 60 days from the date of the primary insurer's Explanation of Benefits (EOB) or 180 days from the date of service, whichever is later.

Dental Provider Manual – A comprehensive UnitedHealthcare Dental Provider Manual is available on our Provider Web Portal at www.UHCproviders.com.

Provider Enrollment – Dental providers interested in joining the UnitedHealthcare network should visit UHCdental.com and click Join Our Network to complete the Provider Packet Request Form. A Network Contractor will contact the provider to review dental fees and the application process.

Out-of-State and Out-of-Network Providers – Questions related to procedures regarding approvals and claims payment for Out-of-State and Out-of-Network providers should be directed to Provider Services at 1-800-508-4881.

Sample Member ID Card

The diagram shows a sample Member ID Card with the following information and callouts:

- Health Plan (80840) 911-86047-08**: Your plan ID number
- Member ID: 999999999**: Your member ID number
- Group Number: NJFAMCAR**: Member Services phone number
- Member: SUBSCRIBER BROWN**: Name of your Primary Care Provider
- PCP Name: DR. PROVIDER BROWN**: Name of your Primary Care Provider
- PCP Phone: (999)999-9999**: Name of your Primary Care Provider
- Payer ID: 86047**: Information for your pharmacist
- OPTUMRx™**: Information for your pharmacist
- Rx Bin: 610494**: Information for your pharmacist
- Rx Grp: AMNJ**: Information for your pharmacist
- Rx PCN: 4343**: Information for your pharmacist
- Member Services/Dental/Vision: 1-800-941-4647**: Member Services phone number
- TTY 711**: Member Services phone number
- In an emergency, go to nearest emergency room or call 911.**
- For Providers: UHCprovider.com 1-888-362-3368**
- Medical Claims: PO Box 5250, Kingston, NY, 12402-5250**
- Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903**
- For Pharmacists: 1-877-305-8952**

Benefit Coverage, Limitations, and Requirements

The list below contains the covered procedures for this plan, along with applicable frequency limits and prior-authorization requirements.

Benefits for members in FamilyCare Plans B, C, and D terminate at age 19.

* See next section for Additional Coverage for members with Special Health Needs

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D0120 *	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	0-999	2 PER 12 MONTH	NO	
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	0-999	2 PER 12 MONTH	NO	
D0145	ORAL EVALUATION, PATIENT UNDER THREE	0-2	2 PER 12 MONTH	NO	
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	3-999	1 PER 36 MONTH	NO	
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	0-999	2 PER 12 MONTH	NO	
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED	0-999	2 PER 12 MONTH	NO	
D0171	RE-EVALUATION - POST OPERATIVE OFFICE VISIT	0-999	2 PER 12 MONTH	NO	
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	0-999	1 PER 36 MONTH	NO	

UnitedHealthcare Community Plan of New Jersey

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D0190	SCREENING OF A PATIENT	0-18	1 PER 12 MONTH	NO	
D0210	INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES	0-999	1 PER 36 MONTH	NO	
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	0-999		NO	
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL IMAGE	0-999		NO	
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	0-999	2 PER 12 MONTH	NO	
D0250	EXTRAORAL - 2D PROJECTION RADIOGRAPHIC IMAGE	0-999	2 PER 12 MONTH	NO	
D0251	EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE	0-999		NO	
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	0-999		NO	
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	0-999		NO	
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	0-999		NO	
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	0-999		NO	
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	21-999		NO	
D0310	SIALOGRAPHY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D0322	TOMOGRAPHIC SURVEY	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D0330	PANORAMIC RADIOGRAPHIC IMAGE	0-999	1 PER 36 MONTH	NO	
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE	0-999	1 PER 12 MONTH	NO	
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	0-999	4 PER 12 MONTH	NO	
D0351	ORAL/FACIAL PHOTOGRAPHIC IMAGES	0-999	1 PER 1 DAYS	NO	
D0364	CONE BEAM - LESS THAN ONE WHOLE JAW	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0365	CONE BEAM - ONE FULL DENTAL ARCH - MANDIBLE	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0366	CONE BEAM - ONE FULL DENTAL ARCH - MAXILLA	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0367	CONE BEAM - BOTH JAWS	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0368	CONE BEAM O TMJ SERIES	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0380	CONE BEAM - LESS THAN ONE WHOLE JAW	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0381	CONE BEAM - ONE FULL DENTAL ARCH - MANDIBLE	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0382	CONE BEAM - ONE FULL DENTAL ARCH - MAXILLA	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0383	CONE BEAM - BOTH JAWS	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D0384	CONE BEAM O TMJ SERIES	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0393	TREATMENT SIMULATION USING 3D IMAGE VOLUME	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0394	DIGITAL SUBTRACTION OF TWO OR MORE IMAGES	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0395	FUSION OF TWO OR MORE 3D IMAGE VOLUMES	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D0411	TEST FOR DIABETES	0-999	1 PER 12 MONTH	NO	
D0416	VIRAL CULTURE	0-999	2 PER 1 DAYS	YES	COPY OF DIAGNOSTIC TEST RESULTS WITH CLAIM
D0417	VIRAL CULTURE	0-999	1 PER 1 DAYS	NO	
D0470	DIAGNOSTIC CASTS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D0472	ACCESSION OF TISSUE, GROSS EXAMINATION	0-999	8 PER 1 DAYS	YES	COPY OF PATHOLOGY REPORT WITH CLAIM
D0473	ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION	0-999	8 PER 1 DAYS	YES	COPY OF PATHOLOGY REPORT WITH CLAIM
D0474	ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION	0-999	8 PER 1 DAYS	YES	COPY OF PATHOLOGY REPORT WITH CLAIM
D0480	ACCESSION OF EXFOLIATIVE CYTOLOGIC SMEARS, MICROSCOPIC EXAMINATION	0-999	4 PER 1 DAYS	NO	
D0502	OTHER PATHOLOGY PROCEDURES, BY REPORT	0-999		YES	COPY OF PATHOLOGY REPORT WITH CLAIM
D0601	CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF LOW RISK	0-20	1 PER 12 MONTH	NO	
D0602	CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF MODERATE RISK	0-20	1 PER 12 MONTH	NO	
D0603	CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF HIGH RISK	0-20	1 PER 12 MONTH	NO	
D1110 *	PROPHYLAXIS - ADULT	16-999	2 PER 12 MONTH	NO	
D1120 *	PROPHYLAXIS - CHILD	0-15	2 PER 12 MONTH	NO	
D1206 *	TOPICAL APPLICATION OF FLUORIDE VARNISH	0-20	2 PER 12 MONTH	NO	
D1208 *	TOPICAL APPLICATION OF FLUORIDE	0-999	2 PER 12 MONTH	NO	
D1351	SEALANT - PER TOOTH	0-16	1 PER 36 MONTH	NO	
D1352	PREVENTIVE RESIN RESTORATION	0-999	1 PER TOOTH WITHOUT PA	NO	
D1353	SEALANT REPAIR - PER TOOTH	0-16	1 PER 36 MONTH	NO	
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION - PER TOOTH	0-999	2 PER 12 MONTH	NO	
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	0-14	1 PER QUADRANT WITHOUT PA	NO	
D1516	SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY	0-14	1 PER ARCH WITHOUT PA	NO	
D1517	SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR	0-14	1 PER ARCH WITHOUT PA	NO	
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	0-14	1 PER ARCH WITHOUT PA	NO	

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CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR	0-14	1 PER ARCH WITHOUT PA	NO	
D1551	RE-CEMENT OR RE-BOND SPACE MAINTAINER - MAXILLARY	0-14	1 PER ARCH WITHOUT PA	NO	
D1552	RE-CEMENT OR RE-BOND SPACE MAINTAINER - MANDIBULAR	0-14	1 PER ARCH WITHOUT PA	NO	
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT	0-14	1 PER QUADRANT WITHOUT PA	NO	
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT	0-999	1 PER QUADRANT WITHOUT PA	NO	
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MAXILLARY	0-999	1 PER ARCH WITHOUT PA	NO	
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MANDIBULAR	0-999	1 PER ARCH WITHOUT PA	NO	
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED	0-10	1 PER QUADRANT WITHOUT PA	NO	
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	0-999	1 PER 12 MONTH	NO	
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	0-999	1 PER 12 MONTH	NO	
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	0-999	1 PER 12 MONTH	NO	
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	0-999	1 PER 12 MONTH	NO	
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	0-999	1 PER 12 MONTH	NO	
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	0-999	1 PER 12 MONTH	NO	
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	0-999	1 PER 12 MONTH	NO	
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE	0-999	1 PER 12 MONTH	NO	
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	0-999	1 PER 12 MONTH	NO	
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	0-999	1 PER 12 MONTH	NO	
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	0-999	1 PER 12 MONTH	NO	
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	0-999	1 PER 12 MONTH	NO	
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	0-999	1 PER 12 MONTH	NO	
D2542	ONLAY - METALLIC - TWO SURFACES	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2543	ONLAY - METALLIC - THREE SURFACES	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2722	CROWN - RESIN WITH NOBLE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2740	CROWN - PORCELAIN/CERAMIC	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D2750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2790	CROWN - FULL CAST HIGH NOBLE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2792	CROWN - FULL CAST NOBLE METAL	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	0-999	1 PER 12 MONTH	NO	
D2915	RE-CEMENT OR RE-BOND CAST INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	0-999	1 PER 12 MONTH	NO	
D2920	RE-CEMENT OR RE-BOND CROWN	0-999	1 PER 12 MONTH	NO	
D2921	REATTACHMENT OF TOOTH FRAGMENT, INCISAL EDGE OR CUSP	0-999		NO	
D2929	PREFABRICATED PORCELAIN / CERAMIC CROWN - PRIMARY TOOTH	0-999		NO	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0-999		NO	
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	0-999		NO	
D2932	PREFABRICATED RESIN CROWN	0-999		NO	
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	0-999		NO	
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0-8		NO	
D2940	PROTECTIVE RESTORATION	0-999		NO	
D2941	INTERIM THERAPEUTIC RESTORATION - PRIMARY DENTITION	0-999		NO	
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	0-999		NO	
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2953	EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2955	POST REMOVAL	0-999		NO	
D2957	EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D2975	COPING	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D2980	CROWN REPAIR	0-999		YES	PRE-OP X-RAY OF CROWN AND NARRATIVE OF MEDICAL NECESSITY
D2981	INLAY REPAIR	0-999		YES	PRE-OP X-RAY OF RESTORATION AND NARRATIVE OF MEDICAL NECESSITY
D2982	ONLAY REPAIR	0-999		YES	PRE-OP X-RAY OF RESTORATION AND NARRATIVE OF MEDICAL NECESSITY
D2983	VENEER REPAIR	0-999		YES	PRE-OP X-RAY OF RESTORATION AND NARRATIVE OF MEDICAL NECESSITY
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D3220	THERAPEUTIC PULPOTOMY	0-999	1 PER TOOTH	NO	
D3221	PULPAL DEBRIDEMENT - PRIMARY AND PERMANENT TEETH	0-999	1 PER TOOTH	NO	
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH	0-18	1 PER TOOTH	NO	
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH	0-999	1 PER TOOTH	NO	
D3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH	0-999	1 PER TOOTH	NO	
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3320	ENDODONTIC THERAPY PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3330	ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3332	INCOMPLETE ENDODONTIC THERAPY	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - PREMOLAR	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3351	APEXIFICATION / RECALCIFICATION - INITIAL VISIT	0-999	1 PER TOOTH	NO	
D3352	APEXIFICATION / RECALCIFICATION - INTERIM	0-999	1 PER TOOTH	NO	
D3353	APEXIFICATION / RECALCIFICATION - FINAL VISIT	0-999	1 PER TOOTH	NO	
D3355	PULPAL REGENERATION - INITIAL VISIT	0-999	1 PER TOOTH	NO	
D3356	PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT	0-999	1 PER TOOTH	NO	

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D3357	PULPAL REGENERATION - COMPLETION OF TREATMENT	0-999	1 PER TOOTH	NO	
D3410	APICTOMY - ANTERIOR	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D3421	APICTOMY - PREMOLAR (FIRST ROOT)	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D3425	APICTOMY - MOLAR (FIRST ROOT)	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D3426	APICTOMY - EACH ADDITIONAL ROOT)	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D3428	BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY - PER TOOTH, SINGLE SITE	0-999	1 PER TOOTH	NO	
D3429	BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY - EACH ADDITIONAL TOOTH	0-999	1 PER TOOTH	NO	
D3430	RETROGRADE FILLING - PER ROOT	0-999	4 PER TOOTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D3450	ROOT AMPUTATION - PER ROOT	0-999	4 PER TOOTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D3471	SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR	0-999	1 PER TOOTH	YES	TREATMENT PLAN, FULL MOUTH RADIOGRAPHS
D3472	SURGICAL REPAIR OF ROOT RESORPTION - PREMOLAR	0-999	1 PER TOOTH	YES	TREATMENT PLAN, FULL MOUTH RADIOGRAPHS
D3473	SURGICAL REPAIR OF ROOT RESORPTION - MOLAR	0-999	1 PER TOOTH	YES	TREATMENT PLAN, FULL MOUTH RADIOGRAPHS
D3501	SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICTOMY OR REPAIR OF ROOT RESORPTION - ANTERIOR	0-999	1 PER TOOTH	NO	
D3502	SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICTOMY OR REPAIR OF ROOT RESORPTION - PREMOLAR	0-999	1 PER TOOTH	NO	
D3503	SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICTOMY OR REPAIR OF ROOT RESORPTION - MOLAR	0-999	1 PER TOOTH	NO	
D3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	0-999	1 PER TOOTH	YES	DATE OF SERVICE
D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH	0-999	1 PER 36 MONTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH	0-999	1 PER 36 MONTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D4212	GINGEVECTOMY/GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH	0-999	1 PER 36 MONTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH	18-999	1 PER 36 MONTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH	18-999	1 PER 36 MONTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4245	APICALLY POSITIONED FLAP	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4260	OSSEOUS SURGERY (INCLUDING FLAP AND CLOSURE) - FOUR OR MORE TEETH	18-999	1 PER 36 MONTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4261	OSSEOUS SURGERY (INCLUDING FLAP AND CLOSURE) - ONE TO THREE TEETH	18-999	1 PER 36 MONTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4265	BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4266	GUIDED TISSUE GENERATION - RESORBABLE BARRIER, PER SITE	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4267	GUIDED TISSUE REGENERATION	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4268	SURGICAL REVISION PROCEDURE, PER TOOTH	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROC, FIRST TOOTH, IMPLANT OR TOOTH POSITION	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT, FIRST TOOTH, IMPLANT OR TOOTH POSITION	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) FIRST	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) EACH ADDITIONAL	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURES, EACH ADDITIONAL	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT, EACH ADDITIONAL	18-999	1 PER TOOTH	YES	PRE-OP X-RAYS, PERIO CHARTING, NARRATIVE OF MEDICAL NECESSITY, PHOTO (OPTIONAL)
D4320	PROVISIONAL SPLINTING - INTRACORONAL	0-999		YES	DOCUMENTATION OF MEDICAL NECESSITY
D4321	PROVISIONAL SPLINTING - EXTRACORONAL	0-999		YES	DOCUMENTATION OF MEDICAL NECESSITY
D4341 *	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	18-999	1 PER 36 MONTH	YES	PERIODONTAL CHARTING AND PRE-OP X-RAYS
D4342 *	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	18-999	1 PER 36 MONTH	YES	PERIODONTAL CHARTING AND PRE-OP X-RAYS
D4346 *	SCALING IN MODERATE OR SEVERE GINGIVAL INFLAMMATION	10-999	1 PER 12 MONTH	NO	
D4355	FULL MOUTH DEBRIDEMENT	0-999	1 PER 36 MONTH	NO	
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE	0-999	1 PER 12 MONTH	YES	PERIODONTAL CHARTING
D4910 *	PERIODONTAL MAINTENANCE	0-999	2 PER 12 MONTH	NO	
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D5110	COMPLETE DENTURE - MAXILLARY	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5120	COMPLETE DENTURE - MANDIBULAR	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5130	IMMEDIATE DENTURE - MAXILLARY	0-999	1 PER 1 LIFETIME	YES	FMX OR PANOREX X-RAYS
D5140	IMMEDIATE DENTURE - MANDIBULAR	0-999	1 PER 1 LIFETIME	YES	FMX OR PANOREX X-RAYS
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE	0-999	1 PER 90 MONTH	YES	FMX OR PANOREX X-RAYS
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	0-999		NO	
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	0-999		NO	
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	0-999		NO	
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	0-999		NO	

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CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D5511	REPAIR BROKEN COMPLETE DENTURE BASE - MANDIBULAR	0-999		NO	
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	0-999		NO	
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	0-999		NO	
D5611	REPAIR RESIN PARTIAL DENTURE BASE - MANDIBULAR	0-999		NO	
D5612	REPAIR RESIN PARTIAL DENTURE BASE - MAXILLARY	0-999		NO	
D5621	REPAIR CAST PARTIAL FRAMEWORK - MANDIBULAR	0-999		NO	
D5622	REPAIR CAST PARTIAL FRAMEWORK - MAXILLARY	0-999		NO	
D5630	REPAIR OR REPLACE BROKEN RETENTIVE / CLASPING MATERIALS - PER TOOTH	0-999		NO	
D5640	REPLACE BROKEN TEETH - PER TOOTH	0-999		NO	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	0-999		NO	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH	0-999		NO	
D5710	REBASE COMPLETE MAXILLARY DENTURE	0-999	1 PER 36 MONTH	NO	
D5711	REBASE COMPLETE MANDIBULAR DENTURE	0-999	1 PER 36 MONTH	NO	
D5720	REBASE MAXILLARY PARTIAL DENTURE	0-999	1 PER 36 MONTH	NO	
D5721	REBASE MANDIBULAR PARTIAL DENTURE	0-999	1 PER 36 MONTH	NO	
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	0-999	1 PER 12 MONTH	NO	
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	0-999	1 PER 12 MONTH	NO	
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	0-999	1 PER 12 MONTH	NO	
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	0-999	1 PER 12 MONTH	NO	
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	0-999	1 PER 12 MONTH	NO	
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	0-999	1 PER 12 MONTH	NO	
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	0-999	1 PER 12 MONTH	NO	
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	0-999	1 PER 12 MONTH	NO	
D5850	TISSUE CONDITIONING, MAXILLARY	0-999	1 PER 12 MONTH	NO	
D5851	TISSUE CONDITIONING, MANDIBULAR	0-999	1 PER 12 MONTH	NO	
D5862	PRECISION ATTACHMENT, BY REPORT	0-999		YES	NARRATIVE DESCRIBING TYPE OF ATTACHMENT AND THE MEDICAL NECESSITY
D5863	OVERDENTURE - COMPLETE MAXILLARY	0-999	1 PER 90 MONTH	YES	PANOREX OR FMX
D5864	OVERDENTURE - PARTIAL MAXILLARY	0-999	1 PER 90 MONTH	YES	PANOREX OR FMX
D5865	OVERDENTURE - COMPLETE MANDIBULAR	0-999	1 PER 90 MONTH	YES	PANOREX OR FMX

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D5866	OVERDENTURE - PARTIAL MANDIBULAR	0-999	1 PER 90 MONTH	YES	PANOREX OR FMX
D5867	REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT	0-999		YES	NARRATIVE DESCRIBING TYPE OF ATTACHMENT AND THE MEDICAL NECESSITY
D5875	MODIFICATION OF REMOVABLE PROsthESIS FOLLOWING IMPLANT SURGERY	0-999	1 PER 1 LIFETIME	YES	NARRATIVE OF DATE OF IMPLANT PLACEMENT WITH CLAIM
D5899	UNSPECIFIED REMOVABLE PROsthODONTIC PROCEDURE, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D5911	FACIAL MOULAGE (SECTIONAL)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5912	FACIAL MOULAGE (COMPLETE)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5913	NASAL PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5914	AURICULAR PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5915	ORBITAL PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5916	OCULAR PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5919	FACIAL PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5922	NASAL SEPTAL PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5923	OCULAR PROsthESIS, INTERIM	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5924	CRANIAL PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5925	FACIAL AUGMENTATION IMPLANT PROsthESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5926	NASAL PROsthESIS, REPLACEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5927	AURICULAR PROsthESIS, REPLACEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5928	ORBITAL PROsthESIS, REPLACEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5929	FACIAL PROsthESIS, REPLACEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D5931	OBTURATOR PROSTHESIS, SURGICAL	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5933	OBTURATOR PROSTHESIS, MODIFICATION	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5936	OBTURATOR PROSTHESIS, INTERIM	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5937	TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5951	FEEDING AID	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5952	SPEECH AID PROSTHESIS, PEDIATRIC	0-18		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5953	SPEECH AID PROSTHESIS, ADULT	19-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5954	PALATAL AUGMENTATION PROSTHESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5958	PALATAL LIFT PROSTHESIS, INTERIM	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5959	PALATAL LIFT PROSTHESIS, MODIFICATION	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5960	SPEECH AID PROSTHESIS, MODIFICATION	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5982	SURGICAL STENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5983	RADIATION CARRIER	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5984	RADIATION SHIELD	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5985	RADIATION CONE LOCATOR	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D5986	FLUORIDE GEL CARRIER	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5987	COMMISSURE SPLINT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5988	SURGICAL SPLINT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D5991	VESICULOBULLOUS DISEASE MEDICAMENT CARRIER	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5993	MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	0-999		YES	PRE-OP X-RAY, NARRATIVE OF MED NECESSITY; CONGENITALLY MISSING PERMANENT TOOTH
D6011	SECOND STAGE IMPLANT SURGERY	0-999		YES	PRE-OP PERIAPICAL X-RAYS
D6055	CONNECTING BAR - IMPLANT SUPPORTED OR ABUTMENT SUPPORTED	0-999		YES	PRE-OP X-RAY, NARRATIVE OF MED NECESSITY; CONGENITALLY MISSING PERMANENT TOOTH
D6080	IMPLANT MAINTENANCE PROCEDURES, INCLUDING REMOVAL AND REINSERTION OF PROSTHESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6081	SCALING AND DEBRIDEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6092	RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D6100	IMPLANT REMOVAL, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D6101	DEBRIDEMENT OF A PERI-IMPLANT DEFECT AND SURFACE CLEANING	0-999		YES	PRE-OP X-RAYS AND NARRATIVE OF MEDICAL NECESSITY
D6102	DEBRIDEMENT/OSSEOUS CONTOURING OF PERI-IMPLANT DEFECT; INCLUDES SURFACE CLEANING	0-999		YES	PRE-OP X-RAYS AND NARRATIVE OF MEDICAL NECESSITY
D6103	BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT - NOT INCLUDING FLAP ENTRY/CLOSURE	0-999		YES	PRE-OP X-RAYS AND NARRATIVE OF MEDICAL NECESSITY

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	0-999		YES	PRE-OP X-RAYS AND NARRATIVE OF MEDICAL NECESSITY
D6110	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS MAXILLARY ARCH	0-999		NO	
D6111	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS MANDIBULAR ARCH	0-999		NO	
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6191	SEMI-PRECISION ABUTMENT PLACEMENT	0-999	1 PER IMPLANT BODY, 4 PER ARCH	YES	PRE-OP PERIAPICAL X-RAYS
D6192	SEMI-PRECISION ATTACHMENT PLACEMENT	0-999	1 PER IMPLANT BODY, 4 PER ARCH	YES	PRE-OP PERIAPICAL X-RAYS
D6199	UNSPECIFIED IMPLANT PROCEDURE, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D6210	PONTIC - CAST HIGH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6211	PONTIC - CAST PREDOMINANTLY BASE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6212	PONTIC - CAST NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6241	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6250	PONTIC - RESIN WITH HIGH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6252	PONTIC - RESIN WITH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6545	RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6720	RETAINER CROWN - RESIN WITH HIGH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6721	RETAINER CROWN - RESIN WITH PREDOMINANTLY BASE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6722	RETAINER CROWN - RESIN WITH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	0-999		YES	PRE-OP X-RAYS OF ADJACENT TEETH AND OPPOSING TEETH

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D6920	CONNECTOR BAR	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	0-999		NO	
D6940	STRESS BREAKER	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D6950	PRECISION ATTACHMENT	0-999	1 PER 12 MONTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D6980	FIXED PARTIAL DENTURE REPAIR	0-999	1 PER 12 MONTH	YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6985	PEDIATRIC PARTIAL DENTURE, FIXED	0-7		YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE, BY REPORT	0-999	1 PER 12 MONTH	YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D7111	EXTRACTION, CORONAL REMNANTS - PRIMARYTOOTH	0-999	1 PER TOOTH	NO	
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	0-999	1 PER TOOTH	NO	
D7210	EXTRACTION, ERUPTED TOOTH	0-999	1 PER TOOTH	NO	
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, UNUSUAL SURGICAL COMPLICATIONS	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D7250	REMOVAL OF RESIDUAL TOOTH (CUTTING PROCEDURE)	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS (EXCLUDING BWX)
D7251	CORONECTOMY	0-999	1 PER TOOTH	YES	PRE-OP X-RAYS AND NARRATIVE OF MEDICAL NECESSITY
D7260	OROANTRAL FISTULA CLOSURE	0-999		NO	
D7261	PRIMARY CLOSURE OF SINUS PERFORATION	0-999		NO	
D7270	REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED / DISPLACED TOOTH	0-20	1 PER TOOTH	NO	
D7280	EXPOSURE OF AN UNERUPTED TOOTH	0-20	1 PER TOOTH	YES	DIAGNOSTIC RADIOGRAPHS, DENTAL RECORDS, TREATMENT PLAN, APPROVED PRIOR AUTH FOR ASSOCIATED ORTHO SERVICES
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	0-20	1 PER TOOTH	YES	DIAGNOSTIC RADIOGRAPHS, DENTAL RECORDS, TREATMENT PLAN, APPROVED PRIOR AUTH FOR ASSOCIATED ORTHO SERVICES
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	0-20	1 PER TOOTH	YES	DIAGNOSTIC RADIOGRAPHS, DENTAL RECORDS, TREATMENT PLAN, APPROVED PRIOR AUTH FOR ASSOCIATED ORTHO SERVICES
D7285	INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	0-999		NO	

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D7286	INCISIONAL BIOPSY OF ORAL TISSUE - SOFT	0-999		NO	
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	0-999		YES	COPY OF PATHOLOGY REPORT WITH CLAIM
D7288	BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION	0-999		YES	COPY OF PATHOLOGY REPORT WITH CLAIM
D7290	SURGICAL REPOSITIONING OF TEETH	0-20	1 PER TOOTH	YES	PRE-OP X-RAYS AND NARRATIVE OF MEDICAL NECESSITY
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	0-20		YES	TREATMENT PLAN, RECENT DIAGNOSTIC RADIOGRAPHS AND PHOTOGRAPHS
D7292	TEMP ANCHORAGE DEVICE (SCREW RETAINED PLATE) REQ SURGICAL FLAP; INCLUDES REMOVAL	0-20		YES	TREATMENT PLAN, RECENT DIAGNOSTIC RADIOGRAPHS AND PHOTOGRAPHS
D7293	TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP; INCLUDES DEVICE REMOVAL	0-20		YES	TREATMENT PLAN, RECENT DIAGNOSTIC RADIOGRAPHS AND PHOTOGRAPHS
D7294	TEMPORARY ANCHORAGE DEVICE WITHOUT SURGICAL FLAP; INCLUDES DEVICE REMOVAL	0-20		YES	TREATMENT PLAN, RECENT DIAGNOSTIC RADIOGRAPHS AND PHOTOGRAPHS
D7295	HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH	0-999	1 PER QUADRANT	NO	
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH	0-999	1 PER QUADRANT	NO	
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH	0-999		NO	
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH	0-999		NO	
D7340	VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	0-999		NO	
D7350	VESIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS)	0-999		NO	
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	0-999		NO	
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	0-999		NO	
D7412	EXCISION OF BENIGN LESION, COMPLICATED	0-999		NO	
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	0-999		NO	
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM	0-999		NO	
D7415	EXCISION OF MALIGNANT LESION, COMPLICATED	0-999		NO	
D7440	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER UP TO 1.25 CM	0-999		NO	
D7441	EXCISION OF MALIGNANT TUMOR - LESION DIAMETER GREATER THAN 1.25 CM	0-999		NO	
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - DIA UP TO 1.25 CM	0-999		NO	

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - DIA GREATER THAN 1.25 CM	0-999		NO	
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - DIA UP TO 1.25 CM	0-999		NO	
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - DIA GREATER THAN 1.25 CM	0-999		NO	
D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT	0-999		NO	
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	0-999	1 PER SITE	NO	
D7472	REMOVAL OF TORUS PALATINUS	0-999	1 PER AREA	NO	
D7473	REMOVAL OF TORUS MANDIBULARIS	0-999	1 PER AREA	NO	
D7485	REDUCTION OF OSSEOUS TUBEROSITY	0-999	1 PER AREA	NO	
D7490	RADICAL RESECTION OF MAXILLA OR MANDIBLE	0-999	1 PER AREA	NO	
D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	0-999		NO	
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED	0-999		NO	
D7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE	0-999		NO	
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED	0-999		NO	
D7530	REMOVAL OF FOREIGN BODY FROM MUCOSA	0-999		NO	
D7540	REMOVAL OF REACTION PRODUCING FOREIGN BODIES	0-999		NO	
D7550	PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE	0-999	1 PER AREA	NO	
D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY	0-999		NO	
D7610	MAXILLA - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	0-999		NO	
D7620	MAXILLA - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	0-999		NO	
D7630	MANDIBLE - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	0-999		NO	
D7640	MANDIBLE - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)	0-999		NO	
D7650	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	0-999		NO	
D7660	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	0-999		NO	
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	0-999		NO	
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	0-999		NO	

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D7680	FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL	0-999		NO	
D7710	MAXILLA - OPEN REDUCTION	0-999		NO	
D7720	MAXILLA - CLOSED REDUCTION	0-999		NO	
D7730	MANDIBLE - OPEN REDUCTION	0-999		NO	
D7740	MANDIBLE - CLOSED REDUCTION	0-999		NO	
D7750	MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION	0-999		NO	
D7760	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	0-999		NO	
D7770	ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH	0-999		NO	
D7771	ALVEOLUS - CLOSED REDUCTION STABILIZATION OF TEETH	0-999		NO	
D7780	FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE APPROACHES	0-999		NO	
D7810	OPEN REDUCTION OF DISLOCATION	0-999		NO	
D7820	CLOSED REDUCTION OF DISLOCATION	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7830	MANIPULATION UNDER ANESTHESIA	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7840	CONDYLECTOMY	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7850	SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7852	DISC REPAIR	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7854	SYNOVECTOMY	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7856	MYOTOMY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7858	JOINT RECONSTRUCTION	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7860	ARTHROTOMY	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7865	ARTHROPLASTY	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7870	ARTHROCENTESIS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D7872	ARTHROSCOPY - DIAGNOSIS, WITH OR WITHOUT BIOPSY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7873	ARTHROSCOPY - LAVAGE AND LYSIS OF ADHESIONS	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7874	ARTHROSCOPY - DISC REPOSITIONING AND STABILIZATION	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7875	ARTHROSCOPY - SYNOVECTOMY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7876	ARTHROSCOPY - DISCECTOMY	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7877	ARTHROSCOPY - DEBRIDEMENT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	0-999		NO	
D7899	UNSPECIFIED TMD THERAPY, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7911	COMPLICATED SUTURE - UP TO 5 CM	0-999		NO	
D7912	COMPLICATED SUTURE - GREATER THAN 5 CM	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7940	OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7941	OSTEOTOMY - MANDIBULAR RAMI	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7943	OSTEOTOMY - MANDIBULAR RAMI WITH BONE GRAFT: INCLUDES OBTAINING THE GRAFT	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7944	OSTEOTOMY - SEGMENTED OR SUBAPICAL	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7945	OSTEOTOMY - BODY OF MANDIBLE	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7946	LEFORT I - (MAXILLA - TOTAL)	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7947	LEFORT I - (MAXILLA - SEGMENTED)	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D7948	LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES) - WITHOUT BONE GRAFT	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7949	LEFORT II OR LEFORT III - WITH BONE GRAFT	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7952	SINUS AUGMENTATION VIA A VERTICAL APPROACH	0-999	1 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7955	REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT	0-999		NO	
D7961	BUCCAL/LABIAL FRENECTOMY (FRENULECTOMY)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7963	FRENULOPLASTY	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7971	EXCISION OF PERICORONAL GINGIVA	0-999		YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	0-999	2 PER AREA	YES	NARRATIVE OF MEDICAL NECESSITY, XRAYS OR PHOTOS OPTIONAL
D7979	NON-SURGICAL SIALOLITHOTOMY	0-999		NO	
D7980	SURGICAL SIALOLITHOTOMY	0-999		NO	
D7981	EXCISION OF SALIVARY GLAND, BY REPORT	0-999	1 PER AREA	NO	
D7982	SIALODOCHOPLASTY	0-999		NO	
D7983	CLOSURE OF SALIVARY FISTULA	0-999		NO	
D7990	EMERGENCY TRACHEOTOMY	0-999		NO	
D7991	CORONOIDECTOMY	0-999	2 PER SIDE	NO	
D7993	SURGICAL PLACEMENT OF CRANIOFACIAL IMPLANT - EXTRAORAL	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7994	SURGICAL PLACEMENT - ZYGOMATIC IMPLANT	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7995	SYNTHETIC GRAFT - MANDIBLE OR FACIAL BONES, BY REPORT	0-999		NO	
D7996	IMPLANT - MANDIBLE FOR AUGMENTATION PURPOSES (EXC ALVEOLAR RIDGE)	0-999		YES	NARRATIVE OF MEDICAL NECESSITY
D7997	APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE)	0-999		NO	

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT	0-999		YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	4-8		YES	HLD SCORESHEET, NARRATIVE, GD ATTESTATION, PHOTOS, X-RAYS
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	6-14		YES	HLD SCORESHEET, NARRATIVE, GD ATTESTATION, PHOTOS, X-RAYS
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	8-20		YES	HLD SCORESHEET, NARRATIVE, GD ATTESTATION, PHOTOS, X-RAYS
D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	8-20		YES	HLD SCORESHEET, NARRATIVE, GD ATTESTATION, PHOTOS, X-RAYS
D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	4-8		YES	HLD SCORESHEET, NARRATIVE, TX PLAN, GD ATTESTATION, PHOTOS, X-RAYS, MED NARR IF APPL
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	6-20		YES	HLD SCORESHEET, NARRATIVE, TX PLAN, GD ATTESTATION, PHOTOS, X-RAYS, MED NARR IF APPL
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	8-20		YES	HLD SCORESHEET, NARRATIVE, TX PLAN, GD ATTESTATION, PHOTOS, X-RAYS, MED NARR IF APPL
D8210	REMOVABLE APPLIANCE THERAPY	0-20	2 PER 1 DAYS	YES	TREATMENT PLAN AND NARRATIVE OF MEDICAL NECESSITY
D8220	FIXED APPLIANCE THERAPY	0-20		YES	TREATMENT PLAN AND NARRATIVE OF MEDICAL NECESSITY
D8660	PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT	0-20	1 PER 12 MONTH	NO	
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	0-20	24 PER 1 LIFETIME	YES	TX NOTE, DOC COMPLIANCE, GD ATTEST, PHOTOS, PAN, COPY INITIAL APPROVE IF APPLICABLE
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, PLACE RETAINERS)	0-20		YES	DIAGNOSTIC QUALITY POST TX PHOTOS
D8681	REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT	0-20	1 PER 1 DAYS	NO	
D8695	REMOVAL OF FIXED ORTHODONTIC APPLIANCES	0-999		NO	
D8696	REPAIR OF ORTHODONTIC APPLIANCE - MAXILLARY	0-20		NO	
D8697	REPAIR OF ORTHODONTIC APPLIANCE - MANDIBULAR	0-20		NO	
D8698	RE-CEMENT OR RE-BONDING FIXED RETAINERS - MAXILLARY	0-20		NO	
D8699	RE-CEMENT OR RE-BONDING FIXED RETAINERS - MANDIBULAR	0-20		NO	
D8701	REPAIR OF FIXED RETAINERS, INCLUDES REATTACHMENT - MAXILLARY	0-20		NO	

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CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D8702	REPAIR OF FIXED RETAINERS, INCLUDES REATTACHMENT - MANDIBULAR	0-20		NO	
D8703	REPLACEMENT OF LOST OR BROKEN RETAINER - MAXILLARY	0-20		NO	
D8704	REPLACEMENT OF LOST OR BROKEN RETAINER - MANDIBULAR	0-20		NO	
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT	0-20		YES	ORIGINAL APPROVAL, GD ATTESTATION, DIAG. QUALITY PHOTOS AND/OR PAN, TX HISTORY
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN - MINOR PROCEDURE	0-999	1 PER 1 DAYS	NO	
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES	0-999	2 PER 12 MONTH	NO	
D9211	REGIONAL BLOCK ANESTHESIA	0-999	2 PER 12 MONTH	NO	
D9212	TRIGEMINAL DIVISION BLOCK ANESTHESIA	0-999	2 PER 12 MONTH	NO	
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D9223	DEEP SEDATION / GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	0-999	7 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D9230	INHALATION OF NITROUS/ANALGESIA, ANXIOLYSIS	0-999	1 PER 1 DAYS	NO	
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE	0-999	7 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	0-999	1 PER 1 DAYS	YES	NARRATIVE OF MEDICAL NECESSITY WITH PRE AUTHORIZATION
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN	0-999		NO	
D9311	CONSULTATION WITH A MEDICAL HEALTH CARE PROFESSIONAL	0-999	2 PER 12 MONTH	NO	
D9410	HOUSE/EXTENDED CARE FACILITY CALL	0-999	1 PER 1 DAYS	NO	
D9420	HOSPITAL OR AMBULATORY SURGICAL CENTER CALL	0-999	1 PER 1 DAYS	NO	
D9430	OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS)	0-999		NO	
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION	0-999		NO	
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS	0-999		YES	DESCRIPTION OF DRUGS AND PARENTERAL ADMINISTRATION WITH PRE AUTHORIZATION
D9630	DRUGS OR MEDICAMENTS - DISPENSED FOR HOME USE	0-999		YES	DESCRIPTION OF DRUGS AND PARENTERAL ADMINISTRATION WITH PRE AUTHORIZATION

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	PRIOR AUTH	REQUIRED DOCUMENTS
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	16-999	1 PER 12 MONTH	YES	NARRATIVE OF MEDICAL NECESSITY
D9911	APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH	16-999	1 PER 12 MONTH	YES	NARRATIVE OF MEDICAL NECESSITY
D9920	BEHAVIOR MANAGEMENT, BY REPORT	0-999	2 PER 1 DAYS	NO	
D9930	TREATMENT OF COMPLICATIONS (POST SURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT	0-999		NO	
D9943	OCCLUSAL GUARD ADJUSTMENT	0-999		NO	
D9944	OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH	18-999	1 PER 24 MONTH	YES	NARRATIVE OF MEDICAL NECESSITY
D9945	OCCLUSAL GUARD-SOFT APPLIANCE, FULL ARCH	18-999	1 PER 24 MONTH	YES	NARRATIVE OF MEDICAL NECESSITY
D9951	OCCLUSAL ADJUSTMENT - LIMITED	0-999		NO	
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	0-999	1 PER 1 LIFETIME	NO	
D9971	ODONTOPLASTY 1 - 2 TEETH; INCLUDES REMOVAL OF ENAMEL PROJECTIONS	0-999	1 PER 1 LIFETIME	NO	
D9974	INTERNAL BLEACHING - PER TOOTH	0-999	1 PER 1 LIFETIME	YES	ENDO FILL X-RAY, NARRATIVE OF MEDICAL NECESSITY, PHOTO OPTIONAL
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT	0-999		YES	DESC PROCEDURE, NARR OF MED NEC, HOSPITAL/OUTPATIENT FACILITY NAME (AS NEEDED)

* Additional Coverage for members with Special Health Needs

CODE	DESCRIPTION	AGE	FREQUENCY LIMIT	AUTH	REQUIRED DOCUMENTS
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	0-999	4 PER 12 MONTH	NO	
D1110	PROPHYLAXIS - ADULT	16-999	4 PER 12 MONTH	NO	
D1120	PROPHYLAXIS - CHILD	0-15	4 PER 12 MONTH	NO	
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	0-999	4 PER 12 MONTH	NO	
D1208	TOPICAL APPLICATION OF FLUORIDE	0-999	4 PER 12 MONTH	NO	
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	0-999	1 PER 12 MONTH	NO	
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	0-999	1 PER 12 MONTH	NO	
D4346	SCALING IN MODERATE OR SEVERE GINGIVAL INFLAMMATION	0-999	4 PER 12 MONTH	NO	
D4910	PERIODONTAL MAINTENANCE	0-999	4 PER 12 MONTH	NO	