PRIOR AUTHORIZATION (PA) SAMPLE LETTER

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 04/01/2003 RECIPIENT NAME xxxxxx xxxxx
PRIOR AUTH. NBR 999999999 RECIPIENT NUMBER 9999999999999

xxxxxxxxx xxxxx xxxx *
xxxx xxxxxxxx
xxxxxxxxxxxx xx 99999

PROVIDER NUMBER 9999999

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT THE REQUEST FOR PRIOR AUTHORIZATION OF DENTAL SERVICES FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE	UVS	AMOUNT	DATES OF SERVICE	STATUS
D2930-STAINLESS STEEL CROWN	2	.00	01/01/2003-01/01/2004	APPROVED
D3310-ENDODONTIC 1 CANAL	1	.00	01/01/2003-01/01/2004	DENIED-460

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW,
460 – ENDODONTIC DENIED BECAUSE OF MISSING TEETH

IF FURTHER CLARIFICATION IS NEEDED, CONTACT LSU SCHOOL OF DENTISTRY, DENTAL PRIOR AUTHORIZATION UNIT AT 504-619-8589.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY. PAYMENT ON A CLAIM WILL ONLY BE MADE WHEN THE CLAIM IS BILLED CORRECTLY AND ALL CONDITIONS FOR PAYMENT ARE MET.

ALL CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE APPROPRIATE REFERRALS TO BE PAID.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING