



# Heritage Health Additional Encounter Request Form

Requests must be submitted in advance of treatment to [Centene Dental Services](#) and must include a completed current 2024 ADA form and all supporting documentation.

**Please Print:**

Clinic Name:			
Recipient Last Name:		First Name:	
Recipient ID#:		Recipient DOB:	
Provider Last Name:		Provider First Name:	
NPI#:		Provider Telephone:	

**Treatment Type:**  Crown  Endodontics  Removable Prosthesis Initial Dates of Service: \_\_\_\_\_

This request must include documentation supporting the need for the additional visits, including but not limited to chart documentation, 2024 ADA claim form, radiographs (if applicable), medical and dental history.

Explain below why the patient meets the criteria for a benefit limit exception and the number of additional visits requested. The explanation should be in narrative form and include a comprehensive justification (attach additional pages as necessary).

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[Centene Dental Services](#) will notify the Clinic of its decision within 14 days after receiving the required documentation.

Dental will notify the provider and recipient of its decision within 14 days after receiving a prospective benefit limit exception BLE request, or within 30 days after receipt of a retrospective BLE request.

**I attest that the information provided and statements made herein are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_