# Partial Denture Delivery Receipt

| Date and Time of Acceptance: |
|---|
| |

| Provider Name: | Provider NPI: | Recipient Medicaid ID: | Recipient Name: |
|---|---|---|---|
| | | | |

Nevada Medicaid provides payment benefits of certain prosthodontics for qualified recipients. Education given by the dentist on the proper care of the prostheses is expected and included in the purchase of any prosthetic service. [Medicaid Services Manual (MSM) 1000, Section 1003.5.A.1]

Denture/partial relines and adjustments required within the first six months after the date of purchase are considered prepaid with Medicaid's payment for the prosthetic. [Medicaid Services Manual (MSM) 1000, Section 1003.5.A.7].

**Provider: Please check appropriate boxes below and sign this document.**

**Quantity and detailed description:**

| | | | |
|---|---|---|---|
| | D5211 Maxillary Partial Denture (Resin Base) | | D5213 Maxillary Partial Denture (Cast Metal Framework w/Resin) |
| | D5212 Mandibular Partial Denture (Resin Base) | | D5214 Mandibular Partial Denture (Cast Metal Framework w/Resin) |

**The signature of the provider below indicates the services provided meet the standard of care and are of an acceptable product quality.**

**Provider Signature:**_________________________________________________ **Date:** ______________________

**Recipient: Please acknowledge the statements below with your initials and sign this document.**

I approve of the tooth/teeth color. **Initial** _______

I approve of the tooth/teeth position and fit. **Initial** _______

I approve of the tooth/teeth size and shape. **Initial** _______

My partial denture(s) has been provided and placed in my mouth. **Initial** _______

My partial denture(s) has been adjusted by my provider to meet my needs. **Initial** _______

I understand that by signing this delivery receipt, Nevada Medicaid will deny any subsequent requests for a partial denture(s) within five (5) years without prior authorization approval. Upper and lower are independent for this requirement.
**Initial** _______

**The signature of the recipient, guardian or designated power of attorney below verifies the denture(s)/partial was received and is accepted/acceptable.**

**Recipient/Guardian/Designated Power of Attorney Signature:** ____________________________________________

**Date:** ______________________

**Provider: This form must be completed and all signatures present upon date of delivery. You may not bill Nevada Medicaid for partial dentures until they have been delivered to the recipient and this form is completed. The claim must not be submitted prior to the delivery date.**