VA Community
Care Network

Dental Utilization Inquiry Form

Submit this form with the clinical notes and radiographs to Dental Operations.

Email: LHICommitteeReview@Logisticshealth.com
Mail: VA Community Care Network
Credentialing / Dental Operations
3237 Airport Road MS-41
La Crosse, WI 54603

Veteran Information:					
Name: **Last**	**First**	M.I.	Gender:	**DOB: (mm/dd/yyyy)**	
Address: Street	Apt. #	City	State	ZIP Code	
Veteran Eligibility:					
☐ Urgent Care ☐ No Longer Eligible	☐ Community Care		Veteran SSN:		
Name of Provider:					
Name:	Specialty:	NPI #:			
Address: Street	City	State	ZIP Code		
Place of Service:					
Name:	Specialty:	**NPI #:** **TIN #:**			
Address: Street	City	**State**	ZIP Code		

Date(s) of Service
Service Date(s): (mm/dd/yyyy)

List Prescribed Treatment Plan:					
Visit	Tooth	Surfaces	ADA Code	Description	Fee

SEOC Detail (Services approved via SEOC):
Utilization Inquiry Detail Summary:
Utilization Requested Action:

Completed by:	
Name/Title:	Phone Number: Extension:
Name of Department:	Date Submitted: (mm/dd/yyyy)
VA Point of Contact for Dental Utilization Request:	
Name/Title:	Phone Number: Extension:

OptumServe Office use only:	
Completed by Name/Title:	Phone Number: Extension:
Name of Department:	Date Completed: (mm/dd/yyyy)
Inquiry Result:	