RYAN WHITE PROGRAM ORAL HEALTH CARE FORMULARY REVIEW REQUEST FORM

Date of Request: _____

Request for (check one):

___ Addition ___ Deletion

FOR OMB-GC USE ONLY

5/14/2026 Date Request Received

_____ Date of **Medical Care Subcommittee** Review/Action *(Approved? ___Yes ___No)*

_____ Date of **Care & Treatment Committee** Review/Action *(Approved? ___Yes ___No)*

_____ Date of **Miami-Dade HIV/AIDS Partnership** Review/Action *(Approved? ___Yes ___No)*

(1) Current Dental Terminology (CDT) code and description of dental procedure:

[Diagnostic: re-evaluation - post-operative office visit]

(2) Please list other procedures currently found in the local Ryan White Program Oral Health Care Formulary which are considered similar to the proposed addition/deletion.

(3) Should there be any restrictions on the use/availability of this procedure? ☐ Yes ☐ No ☐ N/A
If yes, please explain. _____

(4) Please indicate your reason for this request:

- ☐ New dental procedure available
- ☐ Dental procedure no longer used
- ☐ Change in dental code – The replacement code is _____
- ☐ Other (specify): _____

(5) Please justify the reason for the addition or deletion of this code. Provide appropriate references where applicable. Attach back-up documentation to support your request, as needed.

I understand that this request will be considered at the next meeting of the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee (MCSC). If approved by the MCSC, this request will then be reviewed by the Care and Treatment Committee, and by the full Partnership.

Signature of Dentist Requesting this Change: [redacted]

Name of Dentist Requesting this Change:

Phone Number:

Email:

Name of Organization/Clinic:

Please submit this request by email to: RyanWhiteProgram@miamidade.gov

DO NOT INCLUDE ANY CLIENT IDENTIFYING INFORMATION

RYAN WHITE PROGRAM ORAL HEALTH CARE FORMULARY REVIEW REQUEST FORM

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Request for (check one):

___ Addition ___ Deletion

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5/14/2026 Date Request Received CJS
_____ Date of **Medical Care Subcommittee** Review/Action *(Approved? ___Yes ___No)*
_____ Date of **Care & Treatment Committee** Review/Action *(Approved? ___Yes ___No)*
_____ Date of **Miami-Dade HIV/AIDS Partnership** Review/Action *(Approved? ___Yes ___No)*

(1) Current Dental Terminology (CDT) code and description of dental procedure:

[Diagnostic: caries risk assessment and documentation, with a finding of moderate risk] CJS

(2) Please list other procedures currently found in the local Ryan White Program Oral Health Care Formulary which are considered similar to the proposed addition/deletion.

(3) Should there be any restrictions on the use/availability of this procedure? ☐ Yes ☐ No ☐ N/A
If yes, please explain. _____

(4) Please indicate your reason for this request:
- ☐ New dental procedure available
- ☐ Dental procedure no longer used
- ☐ Change in dental code – The replacement code is _____
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_____ Date of **Miami-Dade HIV/AIDS Partnership** Review/Action *(Approved? ___Yes ___No)*

(1) Current Dental Terminology (CDT) code and description of dental procedure:

_____
[Diagnostic: caries risk assessment and doucmentation, with a finding of high risk] CJS

(2) Please list other procedures currently found in the local Ryan White Program Oral Health Care Formulary which are considered similar to the proposed addition/deletion.

_____
_____

(3) Should there be any restrictions on the use/availability of this procedure? ☐ Yes ☐ No ☐ N/A
If yes, please explain. _____
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(1) Current Dental Terminology (CDT) code and description of dental procedure:

-per visit
[Adjunctive General Services, Unclassified Treatment: palliative treatment of dental pain - per visit (treatment that relieves pain but is not curative; services provided do not have distinct procedure codes)] CJS

(2) Please list other procedures currently found in the local Ryan White Program Oral Health Care Formulary which are considered similar to the proposed addition/deletion.

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