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Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	Periodic oral evaluation	19 +		No	One per 6 months per dentist or dental group. Only one exam (D0120) every 6 months per dentist or dental group.	
D0150	Comprehensive oral evaluation	19 +		No	One comprehensive exam per patient per dentist or dental group per 12 months. Only one exam (D0120) every 6 months per dentist or dental group.	
D0210	Intraoral- complete series	19 +		No	One per 36 months, Either a D0210 or D0330	
D0220	Intraoral- periapical first film	19 +		No		
D0230	Intraoral- periapical each additional film	19 +		No		
D0240	Intraoral- occlusal	19 +		No		
D0272	Bitewing- two films	19 +		No		
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0330	Panoramic film	19 +		No	One per 36 months, Either a D0210 or D0330	
D1110	Prophylaxis- adult	19 +		No	One per 6 months. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	
D1120	Prophylaxis- child	19 +		No	One per 6 months.	
D1204	Topical application of fluoride w/o prophy- adult	19 +		No	One per 6 months.	
D1351	Sealant- per tooth	0-14		2,3,14,15,18,19,30,31	Once per lifetime. Covered on permanent molars	
D2140	Amalgam- one surface, primary or permanent	19 +	Teeth 1 through 32, A through T	No		

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D2150	Amalgam- two surfaces, primary or permanent	19 +	Teeth 1 through 32, A through T	No		
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2160	Amalgam- three surfaces, primary or permanent	19 +	Teeth 1 through 32, A through T	No		
D2161	Amalgam- four surfaces, primary or permanent	19 +	Teeth 1 through 32, A through T	No		
D2330	Resin- based composite- one surface, anterior	19 +	Teeth 6-11, 22-27, C-H, M-R	No		
D2331	Resin- based composite- two surfaces, anterior	19 +	Teeth 6-11, 22-27, C-H, M-R	No		
D2332	Resin- based composite- three surfaces, anterior	19 +	Teeth 6-11, 22-27, C-H, M-R	No		
D2335	Resin-based composite crown- anterior	19 +	Teeth 6-11, 22-27, C-H, M-R	No		
D2391	Resin- based composite- one surface, posterior	19 +	Teeth 4,5,12,13,20,21,28,29	No	Teeth 1,2,3,14-19, 30-32/ A,B,I,J,L,K,S,T are not covered for composites.	
D2392	Resin- based composite- two surface, posterior	19 +	Teeth 4,5,12,13,20,21,28,29	No	Teeth 1,2,3,14-19, 30-32/ A,B,I,J,L,K,S,T are not covered for composites.	

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D2393	Resin- based composite- three surface, posterior	19 +	Teeth 4,5,12,13,20,21,28,29	No	Teeth 1,2,3,14-19, 30-32/ A,B,I,J,L,K,S,T are not covered for composites.	
D2394	Resin- based composite- four surface, posterior	19 +	Teeth 4,5,12,13,20,21,28,29	No	Teeth 1,2,3,14-19, 30-32/ A,B,I,J,L,K,S,T are not covered for composites.	
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2721	Crown- resin with predominantly base metal	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph
D2750	Crown- porcelain fused to high noble metal	19 +	Teeth 1 through 32	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 60 months	Pre-operative radiograph of adjacent and opposing teeth.

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D2791	Crown- full cast- predominantly base metal	19 +	Teeth 1 through 32	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 60 months	Pre-operative radiograph of adjacent and opposing teeth.
D2792	Crown- full cast noble metal	19 +	Teeth 1 through 32	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 60 months	Pre-operative radiograph of adjacent and opposing teeth.
D2910	Recement inlay	19 +	Teeth 1 through 32	Yes	One per 60 months	Pre-operative radiograph of adjacent and opposing teeth.
D2920	Recement crown	19 +	Teeth 1 through 32	Yes	One per 60 months	Pre-operative radiograph of adjacent and opposing teeth.

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D2930	Prefabricated stainless steel crown- primary tooth	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph of adjacent and opposing teeth.
D2931	Prefabricated stainless steel crown- permanent tooth	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph of adjacent and opposing teeth.
D2932	Prefabricated resin crown	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		

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D2940	Sedative filling	19 +		No	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	
D2950	Core buildup, including any pins	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph of adjacent and opposing teeth.
D2951	Pin retention- per tooth, in addition to restoration	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph of adjacent and opposing teeth.

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D2954	Prefabricated post and core in addition to crown	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph of adjacent and opposing teeth.
D2970	Temporary crown (fractured tooth)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph of adjacent and opposing teeth.
D3110	Pulp cap- direct (excluding final restoration)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		Pre-operative radiograph.
D3220	Therapeutic pulpotomy	19 +		circumstances		Pre-operative radiograph.

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D3310	Anterior- one canal (excluding final restoration)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative and post-op radiographs of adjacent and opposing teeth with authorization. File radiograph with claim.
D3320	Bicuspid- two canals (excluding final restoration)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative and post-op radiographs of adjacent and opposing teeth with authorization. File radiograph with claim.
D3330	Molar- three canals (excluding final restoration)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative and post-op radiographs of adjacent and opposing teeth with authorization. File radiograph with claim.
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D3346	Retreatment of previous root canal therapy- anterior	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiographs of adjacent and opposing teeth with authorization. File radiograph with claim.
D3347	Retreatment of previous root canal therapy- bicuspid	19 +		No	Once per lifetime.	Pre-operative radiographs of adjacent and opposing teeth with authorization. File radiograph with claim.
D3348	Retreatment of previous root canal therapy- molar	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiographs of adjacent and opposing teeth with authorization. File radiograph with claim.

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D3351	Apexification/recalcification- initial visit	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiographs of adjacent and opposing teeth with authorization. File radiograph with claim.
D3410	Apicoectomy/periradicular surgery- anterior	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiograph of adjacent and opposing teeth.
D3421	Apicoectomy/periradicular surgery- bicuspid (first root)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiograph of adjacent and opposing teeth.

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				In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.		
D3426	Apicoectomy/periradicular surg (each additional root)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiograph of adjacent and opposing teeth.
D3430	Retrograde filling- per root	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiograph of adjacent and opposing teeth.

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D3450	Root amputation- per root	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiograph of adjacent and opposing teeth.
D3470	Intentional reimplantation (including necessary splinting)	19 +		In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	Once per lifetime.	Pre-operative radiograph of adjacent and opposing teeth.
D4210	Gingivectomy or gingivoplasty- four or more contiguous teeth or bounded teeth spaces per quadrant	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months. A minimum of four (4) teeth in the affected quadrant.	Periodontal charting pre-operative radiographs.

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D4211	Gingivectomy or gingivoplasty- one to three contiguous teeth or bounded teeth spaces per quadrant	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months. One (1) to three (3) teeth in the affected quadrant.	Periodontal charting pre-operative radiographs.
D4240	Gingival flap procedure, including root planning- four or more contiguous teeth or bounded teeth spaces per quadrant	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months. Crown Lengthening requires reflection of a flap.	Pre-operative radiograph and narrative with claim. There must be evidence of restorability.
D4249	Clinical crown lengthening- hard tissue	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months. Crown Lengthening requires reflection of a flap.	Pre-operative radiograph and narrative with claim. There must be evidence of restorability.

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D4260	Osseous surgery- four or more contiguous teeth	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months. Crown Lengthening requires reflection of a flap.	Pre-operative radiograph and narrative with claim. There must be evidence of restorability.
D4261	Osseous surgery- one to three contiguous teeth	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months. Crown Lengthening requires reflection of a flap.	Pre-operative radiograph and narrative with claim. There must be evidence of restorability.
D4263	Bone replacement graft- first site in quadrant	19 +	Per Quadrant	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.

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D4264	Bone replacement graft- each additional site in quadrant	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.
D4266	Guided tissue regeneration- resorable barrier, per site	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.
D4267	Guided tissue regeneration- non-resorable barrier, per site	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.

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D4270	Pedicle soft tissue graft procedure	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.
D4271	Free soft tissue graft procedure	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.
D4355	Full mouth debridement	19 +		No	One per 12 months.	Calculus must be abnormally heavy and visible on radiograph as well as diagnostic records shall be maintained in the patients records.

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D4910	Periodontal maintenance	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.
D4920	Unscheduled dressing change (by someone other than treating dentist)	19 +	Per Quadrant.	In certain circumstances although not a covered service, one or more of these services may be covered by the plan based upon the judgement of the administrators.	One per 24 months.	Periodontal charting pre-operative radiographs.
D5110	Complete denture- maxillary	19 +		Yes	One per 60 months.	Pre-operative radiographs.
D5120	Complete denture- mandibular	19 +		Yes	One per 60 months.	Pre-operative radiographs.
D5130	Immediate denture- maxillary	19 +		Yes	One per 60 months.	Pre-operative radiographs.
D5140	Immediate denture- mandibular	19 +		Yes	One per 60 months.	Pre-operative radiographs.
D5211	Maxillary partial denture- resin base	19 +		Yes	One per 60 months.	Pre-operative radiographs of adjacent and opposing teeth.
D5213	Maxillary partial denture- cast metal framework with resin denture bases	19 +		Yes	One per 60 months.	Pre-operative radiographs of adjacent and opposing teeth.
D5214	Mandibular partial denture- cast metal framework with resin denture bases	19 +		Yes	One per 60 months.	Pre-operative radiographs of adjacent and opposing teeth.
D5225	Maxillary partial denture- flexible base	19 +		Yes	One per 60 months.	Pre-operative radiographs of adjacent and opposing teeth.

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D5226	Mandibular partial denture- flexible base	19 +		Yes	One per 60 months.	Pre-operative radiographs of adjacent and opposing teeth.
D5281	Removable unilateral partial denture	19 +		Yes	One per 60 months.	Pre-operative radiographs of adjacent and opposing teeth.
D5410	Adjust complete denture- Maxillary	19 +		No	After initial 6 months post insertion	
D5411	Adjust complete denture- Mandibular	19 +		No	After initial 6 months post insertion	
D5421	Adjust partial denture- maxillary	19 +		No	After initial 6 months post insertion	
D5422	Adjust partial denture- mandibular	19 +		No	After initial 6 months post insertion	
D5510	Repair broken complete denture base	19 +		No		
D5520	Replace missing or broken teeth- complete denture	19 +		No		
D5610	Repair resin denture base	19 +		Yes	One per 60 months.	
D5620	Repair cast framework	19 +		Yes	One per 60 months.	
D5630	Repair or replace broken clasp	19 +		Yes	One per 60 months.	
D5640	Replace broken teeth- per tooth	19 +		Yes	One per 60 months.	
D5710	Rebase complete maxillary denture	19 +		Yes	One per 60 months.	
D5711	Rebase complete mandibular denture	19 +		Yes	One per 60 months.	
D5720	Rebase maxillary partial denture	19 +		Yes	One per 60 months.	
D5721	Rebase mandibular partial denture	19 +		Yes	One per 60 months.	
D5730	Reline complete maxillary denture (chairside)	19 +		Yes	Once per 24 months	
D5731	Reline complete mandibular denture (chairside)	19 +		Yes	Once per 24 months	

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D5740	Reline maxillary partial denture (chairside)	19 +		Yes	Once per 24 months	
D5741	Reline mandibular partial denture (chairside)	19 +		Yes	Once per 24 months	
D5750	Reline complete maxillary denture (lab)	19 +		Yes	Once per 24 months	
D5751	Reline complete mandibular denture (lab)	19 +		Yes	Once per 24 months	
D5760	Reline maxillary partial denture (lab)	19 +		Yes	Once per 24 months	
D5761	Reline mandibular partial denture (lab)	19 +		Yes	Once per 24 months	
D5820	Interim partial denture (maxillary)	19 +		Yes	Once per 24 months	
D5821	Interim partial denture (mandibular)	19 +		Yes	Once per 24 months	
D7140	Extraction	19 +		No		
D7210	Surgical removal of erupted tooth	19 +		No		Pre-operative radiographs of adjacent and opposing teeth with claim.
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7220	Removal of impacted tooth- soft tissue	19 +		No	Removal of asymptomatic tooth not covered.	Pre-operative radiographs of adjacent and opposing teeth with claim.
D7230	Removal of impacted tooth- partially bone	19 +		No	Removal of asymptomatic tooth not covered.	Pre-operative radiographs of adjacent and opposing teeth with claim.
D7240	Removal of impacted tooth- completely bony	19 +		No	Removal of asymptomatic tooth not covered.	Pre-operative radiographs of adjacent and opposing teeth with claim.

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D7461	Removal of benign odontogenic cyst or tumor- lesion diameter greater 1.25 cm	19 +		Yes		Copy of pathology report with claim.
D7471	Removal of lateral exostosis	19 +		Yes		Pre-operative radiographs and narrative of medical necessity.
D7472	Removal of torus palatinus	19 +		Yes		Pre-operative radiographs and narrative of medical necessity.
D7473	Removal of torusmandibularis	19 +		Yes		Pre-operative radiographs and narrative of medical necessity.
D7485	Surgical reduction of osseous tuberosity	19 +		Yes		Pre-operative radiographs and narrative of medical necessity.
D7510	Incision and drainage of abscess- intraoral soft tissue	19 +		Yes	By request and report	Narrative of medical necessity.
D7520	Incision and drainage of abscess- extraoral soft tissue	19 +		Yes	By request and report	Narrative of medical necessity.
D7960	Frenulectomy	19 +		Yes	By request and report	Narrative of medical necessity.
D7970	Excision of hyperplastic tissue- per arch	19 +		Yes	By request and report	Narrative of medical necessity.
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain	19 +		No	Not allowed with any other services other than radiographs.	
D9220	General anesthesia- first 30 minutes	19 +		No		Narrative of medical necessity shall be maintained in patient records.
D9221	General anesthesia- each additional 15 minutes	19 +		No	Maximum of 60 minutes (4 units)	Narrative of medical necessity shall be maintained in patient records.
D9230	Analgesia- inhalation of nitrous oxide	19 +		No		Narrative of medical necessity shall be maintained in patient records.
D9241	IV sedation- general dentist	19 +		Yes		By Report
D9242	IV sedation- each additional 15 min	19 +		Yes		By Report

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D9310	Consultation	19 +		No	Diagnostic service provided by dentist other than practitioner providing treatment.	
D9610	Therapeutic drug injection	19 +		No		By Report
D9910	Application of desensitizing medicament	19 +		No		By Report
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	19 +		No		By Report
D9930	Treatment of complications (post surgical)	19 +		No		By Report
D9940	occlusal equilibration by report	19 +		Yes	One per 24 months. Removable dental appliances which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.	Narrative of medical necessity shall be maintained in patient records.
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9941	Fabrication of athletic mouthguard	19 +		Yes	One per 12 months.	Narrative of medical necessity shall be maintained in patient records.
D9951	occlusal adjustment ltd	19 +		No	Not covered with any restorative procedure on same date of service. Two per 12 months.	Narrative of medical necessity shall be maintained in patient records.
D9952	occlusal adjustment complete	19 +		Yes	Not covered with any restorative procedure on same date of service. Two per 12 months.	Narrative of medical necessity shall be maintained in patient records.