

**Treatment to Control Harmful Habits Prior Authorization Request Form**  
(Effective 09/28/2012)

1. **Patient Information:**

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent(s) Name: \_\_\_\_\_  
Patient Medicaid I.D. Number: \_\_\_\_\_  
Referring Dentist: \_\_\_\_\_  
Preventive and restorative treatment completed to date:  Yes  No  
Oral Hygiene:  Good  Fair  Poor

2. **Diagnosis:**

Dentition:  Primary  Transitional  Adolescent  Adult  
Angle Class:  I  II  III  
Overbite: \_\_\_\_\_mm Overjet: \_\_\_\_\_mm Crowding: \_\_\_\_\_mm

3. **Proposed Treatment:**

Treatment to Control Harmful Habits (check one code):  D8210  D8220  
 Upper Arch:  Fixed  Removable Appliance: \_\_\_\_\_  
 Lower Arch:  Fixed  Removable Appliance: \_\_\_\_\_  
Number of Appliances Requested: \_\_\_\_\_

\*Eligibility for Treatment to Control Harmful Habits requires documentation of the harmful habit.

4. **Additional Information:**

Estimated time: \_\_\_\_\_  
Requested Fee: \_\_\_\_\_  
Date Submitted: \_\_\_\_\_  
Office Contact Number: \_\_\_\_\_  
Provider Name/Practice Name: \_\_\_\_\_  
Medicaid Individual and Group Provider Number(s): \_\_\_\_\_

I certify that my examination of this patient and his/her diagnostic materials was conducted in conformance with the Laws and Regulations of The Board of Dental Examiners of the Vermont Secretary of State Office of Professional Regulation, and that my diagnosis of his/her condition as set forth herein is accurate to the best of my professional judgement.

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

Submit this PA request and all supporting documentation to:

Department of Vermont Health Access  
Clinical Unit  
312 Hurricane Lane, Suite 201  
Williston, VT 05495  
Fax: (802) 879-5963