

## Interceptive Orthodontic Treatment Prior Authorization Request Form

(Effective 08/15/2013)

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. **Diagnostic Treatment Criteria** (please check all that apply-do NOT check if criteria not met):

**\*Major Criteria:**

- Cleft palate
- Severe Skeletal Class III
- Severe Cranio-Facial Syndrome  
(Treacher-Collins Syndrome,  
Marfan Syndrome, Pierre Robin  
Syndrome, etc. Specify: \_\_\_\_\_  
\_\_\_\_\_)
- Posterior crossbite (3+teeth)

**\*Minor criteria:**

- 1 Impacted cuspid
- 2 Blocked cuspids, per arch (deficient by at least 1/3 of needed space)
- 3 Congenitally missing teeth, per arch (excluding third molars)
- Open bite 4+teeth, per arch
- Crowding, per arch (10+mm)
- Anterior crossbite (3+teeth)
- Traumatic deep bite impinging on palate
- Overjet 8+mm (measured from labial to labial)

\*Eligibility for interceptive orthodontic treatment requires that the malocclusion be severe enough to meet a minimum of **1 major** or **2 minor** diagnostic treatment criteria.

4. **Other Functional Impairment:**

If the patient does not meet the above criteria, but has a functional impairment that is equal to or greater than the severity of a functional impairment resulting from meeting those criteria, please briefly describe below and attach detailed written documentation from your office: \_\_\_\_\_

5. **Special Medical Consideration:** (Written documentation from a medical provider or outside specialist is required if you complete this section)

Medical Condition Requiring Special Consideration: \_\_\_\_\_

6. **Proposed Treatment:** Interceptive Orthodontic Treatment (check one):  D8050  D8060

- Upper Arch:  Fixed  Removable Appliance: \_\_\_\_\_
- Lower Arch:  Fixed  Removable Appliance: \_\_\_\_\_

7. **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 judgment.

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