

**Limited Orthodontic Treatment 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  NoOral Hygiene:  Good  Fair  Poor2. **Diagnosis:**Dentition:  Primary  Transitional  Adolescent  AdultAngle 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): 1 Ectopically erupted anterior tooth 1 Blocked cuspid, 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 (8+mm) Anterior crossbite Posterior crossbite Traumatic deep bite impinging on palate Overjet 6+mm (measured from labial to labial)

\*Eligibility for limited orthodontic treatment requires that the malocclusion be severe enough to meet a minimum of 1 of the 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:** Limited Orthodontic Treatment (check one):  D8010  D8020  D8030  D8040 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 judgement.

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