**Comprehensive Orthodontic Treatment Prior Authorization Request Form**

(Effective May 2023)

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: Maxillary \_\_\_\_\_ mm

Mandibular \_\_\_\_\_ mm

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

**\*Major Criteria: \*Minor criteria:**

**Automatic 4 unit approval Note that option A & B cannot be on the same arch**

Cleft palate A 2 Blocked cuspids, per arch (deficient by at least 1/3 of needed space)

2 Impacted cuspids  B Crowding, per arch (10+mm)

Severe Cranio-Facial Syndrome  3 Congenitally missing teeth, per arch (excluding third molars)

(Treacher-Collins Syndrome,   Open bite 4+teeth, per arch

Marfan Syndrome, Pierre Robin  1 Impacted cuspid

Syndrome, etc. Specify:  Anterior crossbite (3+teeth)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Traumatic deep bite impinging on palate

Overjet 8+mm (measured from labial to labial)

Posterior crossbite (3+teeth) combined with another minor criteria

**Automatic approval for up to 3 units if 1 of the following:**  Severe skeletal Class III  Posterior cross bite (3+teeth)

\*Eligibility for 4 units of comprehensive 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:** Comprehensive Orthodontic Treatment  D8070  D8080  D8090

Upper Arch:  Fixed  Removable Appliance Specify type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lower Arch:  Fixed  Removable Appliance Specify type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Number of Comprehensive Units Requested**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. **Additional Information:**

Estimated time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested Fee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Submitted: \_\_\_/\_\_\_\_/\_\_\_\_\_\_

Office Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name/Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Individual and Group Provider Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_