VERMONT

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Agency of Human Services

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:**

Automatic 4 unit approval

☐ Cleft palate
☐ 2 Impacted cuspids
☐ Severe Cranio-Facial Syndrome (Treacher-Collins Syndrome, Marfan Syndrome, Pierre Robin Syndrome, etc. Specify: ______________________)

***Minor criteria:**

Note that option A & B cannot be on the same arch

A☐ 2 Blocked cuspids, per arch (deficient by at least 1/3 of needed space)
B☐ Crowding, per arch (10+mm)
☐ 3 Congenitally missing teeth, per arch (excluding third molars)
☐ Open bite 4+teeth, per arch
☐ 1 Impacted cuspid
☐ 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): ______________________________