VERMONT

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Agency of Human Services

Limited 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: _____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: ____________

   Number of 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): ____________________