VERMONT

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Agency of Human Services

Treatment to Control Harmful Habits 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. **Proposed Treatment:**

Treatment to Control Harmful Habits (check one code): ☐ D8210 ☐ D8220
☐ Upper Arch: ☐ Fixed ☐ Removable Appliance: _____
☐ Lower Arch: ☐ Fixed ☐ Removable Appliance: _____

Number of Units Requested:_____

*Eligibility for Treatment to Control Harmful Habits requires documentation of the harmful habit.

4. **Additional Information:**

Estimated time: _____
Requested Fee: _____
Date Submitted: _____
Office Contact Number:_____
Provider Name/Practice Name:_____
Medicaid Individual and Group Provider Number(s):_____