**Comprehensive Orthodontic Treatment Prior Authorization Request Form**

(Effective October 2024)

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

[ ]  \_\_ Previous Orthodontic Treatment paid by DVHA, Date started

 Month/year\_\_\_\_\_\_\_\_\_

\*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. If Previous Limited is checked, maximum Comprehensive units allowed = 3.

 [ ]  Does not qualify, sent by request for review

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 Duration of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

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