**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_