

**Department of Vermont Health Access** *Agency of Human Services*

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[www.dvha.vermont.gov](http://www.dvha.vermont.gov/)

Comprehensive Orthodontic Treatment Prior Authorization Request Form

(Effective 1/1/2022)

# 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

# Diagnosis:

Dentition: ☐ Primary ☐ Transitional ☐ Adolescent ☐ Adult Angle Class: ☐ I ☐ II ☐ III

Overbite: mm Overjet: mm Crowding: Maxillary mm

Mandibular mm

1. **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

**Automatic approval for up to 3 units if 1 of the following:** ☐ Severe skeletal Class III ☐ Posterior cross bite (3+teeth) Number of units will depend on Tx plan and number of appliances requested.

\*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.

# 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:

1. **Special Medical Consideration:** (Written documentation from a medical provider or outside specialist is required if you complete this section) Medical Condition Requiring Special Consideration:
2. **Proposed Treatment:** Comprehensive Orthodontic Treatment ☐ D8070 ☐ D8080 ☐ D8090
   * Upper Arch: ☐ Fixed ☐ Removable Appliance Specify type:
   * Lower Arch: ☐ Fixed ☐ Removable Appliance Specify type: Number of Appliances Requested:

# Additional Information:

Estimated time: Requested Fee: Date Submitted: / /

Office Contact Number: Provider Name/Practice Name: Medicaid Individual and Group Provider Number(s):

I certify that my examination of this patient and his/her diagnostic materials was conducted in conformance with the Laws and Regulations of The Board of Dental Examiners of the Vermont Secretary of State Office of Professional Regulation, and that my diagnosis of his/her condition as set forth herein is accurate to the best of my professional judgment.

Provider Signature: