VERMONT

Department of Vermont Health Access *Agency of Human Services*
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Interceptive Orthodontic Treatment Prior Authorization Request Form

(Effective 9/2017)

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):

***Maior Criteria:**	***Minor criteria:**	**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)	
☐ Severe Skeletal Class III	B☐ Crowding, per arch (10+mm)	
☐ Severe Cranio-Facial Syndrome (Treacher-Collins Syndrome, Marfan Syndrome, Pierre Robin Syndrome, etc. Specify: _____)	☐ 3 Congenitally missing teeth, per arch (excluding third molars)	
	☐ Open bite 4+teeth, per arch	
	☐ 1 Impacted cuspid	
	☐ Anterior crossbite (3+teeth)	
	☐ Traumatic deep bite impinging on palate	
☐ Posterior crossbite (3+teeth)	☐ Overjet 8+mm (measured from labial to labial)	

   *Eligibility for interceptive orthodontic treatment requires that the malocclusion be severe enough to meet a minimum of ***1 major*** or ***2 minor*** 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:** Interceptive Orthodontic Treatment (check one): ☐D8050 ☐D8060
   ☐ Upper Arch: ☐ Fixed ☐ Removable Appliance: _____
   ☐ Lower Arch: ☐ Fixed ☐ Removable Appliance: _____
   Number of Appliances Requested: _____
7. **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: _____