VERMONT

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Agency of Human Services

Limited Orthodontic Treatment Prior Authorization Request Form

(Effective 09/28/2017)

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: _____mm

3. **Diagnostic Treatment Criteria** (please check all that apply-do NOT check if criteria not met):
☐ 1 Ectopically erupted anterior tooth
☐ 1 Blocked cuspid, per arch (deficient by at least 1/3 of needed space)
☐ 3 Congenitally missing teeth, per arch (excluding third molars)
☐ Open bite 4+ teeth, per arch
☐ Crowding, per arch (8+mm)
☐ Anterior crossbite
☐ Posterior crossbite
☐ Traumatic deep bite impinging on palate
☐ Overjet 6+mm (measured from labial to labial)

*Eligibility for limited orthodontic treatment requires that the malocclusion be severe enough to meet a minimum of 1 of the 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:** Limited Orthodontic Treatment (check one): ☐ D8010 ☐ D8020 ☐ D8030 ☐ D8040

☐ 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 judgement.
Provider Signature: ____________________