



Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05495-2086

Agency of Human Services

## Comprehensive Orthodontic Treatment Prior Authorization Request Form

(Effective 08/01/07)

(Please Print or Type)

**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):

**\*Major Criteria:**

- Cleft palate
- 2 Impacted Cuspids
- Severe Cranio-Facial Syndrome (Treacher-Collins Syndrome, Marfan Syndrome, Pierre Robin Syndrome, etc. Specify: \_\_\_\_\_)

**\*Minor criteria:**

- 1 Impacted cuspid
- 2 Blocked cuspids, 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 (10+mm)
- Anterior crossbite (3+teeth)
- Posterior crossbite (3+teeth)
- Traumatic deep bite impinging on palate
- Overjet 8+mm (measured from labial to labial)

\*Eligibility for comprehensive orthodontic treatment requires that the malocclusion be severe enough to meet a minimum of **1 major** or **2 minor** diagnostic treatment criteria.

(Continue on back)

**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 (check one):  D8070  D8080  D8090

Please check appropriate option:  Single Arch:  Upper or  Lower  
 Both Arches

**7. Additional Information:**

Estimated time: \_\_\_\_\_

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

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

Submitted by: \_\_\_\_\_

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: \_\_\_\_\_

Submit this PA request and all supporting documentation to:

Office of Vermont Health Access  
Clinical Unit  
312 Hurricane Lane, Suite 201  
Williston, VT 05495  
Fax: (802) 879-5963