



Orthodontic Evaluation and Pre-Determination Form

Patient Name and Address:	CareSource Member ID Number:	
	Patient Date of Birth:	Patient Phone Number:
Provider Name and Address:	Provider Number:	
	Date:	Provider Phone Number:

Criteria for Comprehensive Orthodontic Treatment

****REQUIRED:** From the list below, please check the symptoms and signs or physical conditions you observe in this patient. Five checked boxes does not guarantee authorization, but will be considered with other supporting clinical information. Symptoms should be documented with additional supportive information as appropriate.

Dentofacial Abnormality

- Marked protruding upper jaw and teeth
- Underdeveloped lower jaw and teeth, receding chin
- Excessively spaced front teeth
- Upper or lower teeth protruding so much that lips cannot be brought together without strain
- Marked protruding lower jaw and teeth
- Extremely "crooked" front teeth
- Marked asymmetry of lower face or transverse deficiencies
- Clefts of lip or face
- Abnormalities of dental development
- Other _____

Tissue Damage Related to Malocclusion

- Marked recession of gums
- Loosened permanent teeth
- Other _____

Mastication Related to Malocclusion

- Extreme grimacing or excessive motions of the oral-facial muscles during swallowing
- Socially unacceptable behavior during eating because of necessary compensation or anatomic facial deviations
- Pain in jaw joints when eating
- Other _____

Respiration and Speech Related to Malocclusion

- Postural abnormalities with breathing difficulties
- Malocclusion of jaws related to chronic mouth breathing
- Lipping or other speech articulation errors in children 9 years or older
- History of or recommendation for speech therapy
- Other _____

****REQUIRED:** Please provide documentation of medical functional impairment directly related to the orthodontic condition. Attach additional pages, if necessary. The presence and degree of impairment can be documented through progress notes, interprofessional consultations, narratives and other diagnostics from the patient's general dentist, orthodontist, primary care provider, behavioral health specialist or speech therapist.

****Is there a participating CareSource orthodontia provider you would like to refer your patient to?**

Name of Provider: _____

Dentist Signature: _____	Date: _____
--------------------------	-------------

When faxing information, please remember to include all pages of supporting documentation along with this form.

Approved prior authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.