Orthodontia Prior Authorization Request Form

SUBMISSION INFORMATION
Submit completed form through the Qualitrac Portal. Faxed, mailed, or phoned in requests will not be accepted.

INFORMATION			
Member Name	Date of Birth		Member ID
Street Address			
City		State	Zip Code
Treating Provider Name	Assessment Date		

	REQUIRED DOCUMENTATION
☐	Full mouth panoramic photos or cephalometric films. **Must be clear in diagnostic quality.**
☐	Photos **Must be clear in diagnostic quality.**
☐	Handicapping Labio-Lingual Deviations Index
☐	Description of the member's condition and diagnosis
☐	Diagnostic procedures
☐	Treatment plan

MEDICAL NECESSITY CERTIFICATION
I certify under the pains and penalties of perjury that I am the prescribing provider identified below. Any attached statement on my letterhead has been reviewed and signed by me. I certify the medical necessity information on this form is true, accurate, and complete, to the best of my knowledge. Treating Provider's Signature Date:

Cleft Palate (Score: X if present; 0 if not)	
Deep Impinging Overbite (Score: X if present; 0 if not)	
Anterior impactions (Score: X if present; 0 if not)	
Posterior impactions (Score: 5 if present; 0 if not)	
Severe traumatic deviations (Score: 15 if present; 0 if not)	
Overjet in millimeters (as measured in centric relation)	
Overbite in millimeters (as measured in centric relation)	
Mandibular protrusion in millimeters _____ X 5	
Open bite in millimeters _____ X 4	
Ectopic eruption (number of teeth, excluding third molars) _____ X 3	
Anterior crowding (Score: 5 per arch; 0 if not present) Maxilla: _____ Mandibullar: _____	
Labio-lingual spread in millimeters (anterior spacing)	
Posterior unilateral crossbite (Score: 4 if present; 0 if not)	
Bilateral crossbite (Score: 8 if present; 0 if not)	
Anterior crossbite (Score: 4 if present; 0 if not)	
Total	

Description of the Member's Condition and Diagnosis

Diagnostic Procedures

Treatment Plan

Additional Remarks