Prior Authorization Criteria Checklist

Date of Prior Authorization Request:

MEMBER INFORMATION

Member Medicaid ID #:

Date of Birth:

Member Last Name:

First Name:

PRE-QUALIFYING CRITERIA

At least one of the following pre-qualifying criteria must be met for orthodontic treatment to be considered. Please indicate all of the criteria that are applicable to the authorization being requested for the member.

Check all that apply	Criteria
	Cleft lip, cleft palate, and other craniofacial anomalies
	Overjet of 9 millimeters or more
	Reverse overjet of 2 millimeters or more
	Extensive hypodontia with restorative implications (more than one tooth per quadrant) requiring pre-prosthetic orthodontics
	Anterior open bites greater than 4 millimeters
	Upper anterior contact point displacements greater than 4 millimeters
	Individual anterior tooth cross bites with greater than a 2 millimeter discrepancy between retruded contact position and intercuspal position
	Impinging overbite with evidence of gingival or palatal trauma
	Impeded eruption of teeth (except third molars)due to crowding displacement, presence of supernumerary teeth, retained primary teeth, and any pathological cause

REQUIRED DOCUMENTS

To facilitate faster turn-around-times for your requests, the following documents are **REQUIRED** with **EVERY** Orthodontic Authorization Request. Failure to include these documents could result in a delayed decision or a pended review. All prior authorization requests **MUST** include the following:

1. **A detailed treatment plan narrative**
2. **Panoramic x-ray**
3. **Cephalogram**
4. **Pre-treatment photographs**
5. **Completed orthodontic criteria checklist form**