Please Print Information Requested Below

Patient's Name: _____ Member ID: _____

Address: _____
Street City/Town State Zip Code

AUTO-QUALIFIERS	CONDITION OBSERVED	
Cleft Palate or Cranio-Facial Anomaly	☐ Yes	☐ No
Deep impinging overbite with severe soft tissue damage (e.g., ulcerations or tissue tears – more than indentations)	☐ Yes	☐ No
Anterior Impactions where extraction is not indicated	☐ Yes	☐ No
Severe Traumatic Deviations – refers to facial accidents rather than congenital deformity. Do not include traumatic occlusions or crossbites.	☐ Yes	☐ No
Overjet (greater than 9 mm)	☐ Yes	☐ No
Reverse overjet (greater than 3.5 mm)	☐ Yes	☐ No
Severe Maxillary Anterior Crowding (greater than 8 mm)	☐ Yes	☐ No
HLD Scoring	**Measurement**	**Score**
Overjet (in mm)	# mm x 1	
Overbite (in mm)	# mm x 1	
Mandibular Protrusion (in mm) – See scoring instructions	# mm x 5	
Anterior Open Bite – Do not count ectopic eruptions, measure the opening between maxillary and mandibular incisors in mm	# mm x 4	
Ectopic Eruption (Number of teeth, excluding third molars) – This refers to an unusual pattern of eruption such as high labial cuspids. Do not score teeth in this category if they are scored under maxillary or mandibular crowding.	# mm x 3	
Anterior Crowding – If crowding exceeds 3.5 mm in an arch, score each arch	Maxilla: 5 pts Mandible: 5 pts Both: 10 pts	
Labio-lingual Spread (anterior spacing in mm) – See scoring instructions	# mm x 1	
Posterior Unilateral Crossbite – Must involve 2 or more teeth, one of which must be a molar	4 pts	
Posterior impactions or congenitally missing posterior teeth (excluding 3rd molars)	# teeth x 3	
	TOTAL	
Treatment will be authorized for cases with verified auto-qualifiers or verified scores of 22 and above.		

Medical Necessity Narrative

MEDICAL NECESSITY NARRATIVE	
Are you submitting a Medical Necessity Narrative?	☐ Yes ☐ No
If yes, are you submitting additional supporting documentation?	☐ Yes ☐ No The medical necessity determination does not involve any mental, emotional, behavioral, or other condition outside the professional expertise of the requesting provider and, therefore, the submitted narrative does not incorporate or rely on the opinion or expertise of anyone other than the requesting provider.

INSTRUCTIONS FOR MEDICAL NECESSITY NARRATIVE AND SUPPORTING DOCUMENTATION (if applicable)

Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate:

i. a severe deviation affecting the patient's mouth and/or underlying dentofacial structures;

ii. a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion;

iii. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion;

iv. a diagnosed speech or language pathology caused by the patient's malocclusion or

v. a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent.

Providers may submit a medical necessity narrative (along with the required completed HLD) in any case where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion.

Providers must submit this narrative in cases where the patient does not have an auto-qualifying condition or meet the threshold score on the HLD, but where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion.

MEDICAL NECESSITY NARRATIVE (continued)

The medical necessity narrative must clearly demonstrate why comprehensive orthodontic treatment is medically necessary for the patient. If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the narrative and any attached documentation must

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment;
iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);
iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such recommendation was made);
v. discuss any treatments for the patient's condition (other than comprehensive orthodontic treatment) considered or attempted by the clinician(s); and
vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of comprehensive orthodontic treatment.

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s) and appear on the office letterhead of said clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

Attestation

I certify under the pains and penalties of perjury that I am the prescribing provider identified on this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing Provider's Signature:

_____

(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable).

Printed Name of Prescribing Provider: _____

Date: _____