Wyoming Department of Health

Telligen®

WYOMING MEDICAID SEVERE MALOCCLUSION
TREATMENT REQUEST FORM

CLIENT NAME	CLIENT ID	CLIENT DATE OF BIRTH	EXAM DATE	LOCATION
PROVIDER GROUP NAME	GROUP NPI	TREATING PROVIDER NAME	TREATING NPI	FEE

PART 1. TREATMENT REQUESTED

FULL TREATMENT ☐ INTERCEPTIVE TREATMENT ☐ TRANSFER CASE ☐

OF MONTHS: ______

REQUIRES MAXILLO-FACIAL SURGERY? YES ☐ NO ☐

EXPLAIN:

PART 2. DIAGNOSTIC INFORMATION

STAGE OF DENTITION: PRIMARY ☐ PERMANENT ☐ MIXED ☐

SKELETAL CLASSIFICATION

Class 1 [Class 2 ☐ Class 3 ☐ | TMJ YES NO

POSTERIOR CROSSBITE YES ☐ NO | TEETH INVOLVED: ______

MISSING TEETH (indicate related teeth)					LOCATION
ECTOPIC ERUPTION (EXCLUDING 3RDs):	YES		NO		
MISSING	YES		NO		
IMPACTED	YES		NO		
ANKYLOSED	YES		NO		
SUPERNUMERARY	YES		NO		
SEVERE TRAUMATIC DEVIATION (explain):	YES		NO		

PART 3. BRIEF INITIAL OPINIONS

ORAL HYGIENE: GOOD ☐ FAIR ☐ POOR ☐

RESTORATIONS COMPELTE: YES ☐ NO ☐
(if no< please explain plan)

PART 4. HLD INDEX (see instructions for scoring guidelines)

		HLD SCORE
CLEFT PALATE DEFORMITIES: *indicate with an **X***		
IMPACTED ANTERIOR TEETH: *indicate with an **X***		
DEEP IMPINGING OVERBITE: *indicate with an **X** only if tissue destruction*		
ANTERIOR CROSSBITE: *indicate with an **X** only if tissue destruction*		
SEVERE TRAUMATIC DEVIATION: *must document in Part 2- score 15 pts*		
OVERJET IN mm	x1=	
OVERBITE IN mm	x1=	
MANDIBULAR PROTRUSION IN mm	x5=	
OPENBITE IN mm	x4=	
ECTOPIC ERUPTION: count each tooth	x3=	
ANTERIOR CROWDING (score 1 pt for max and 1 pt for mand -- the max # of pts for this is 10)	x5=	
POSTERIOR UNILATERAL CROSSBITE: 4 points		
	TOTAL POINTS	

Treatment Narrative (provide any additional information that will substantiate your request for treatment):

PLEASE NOTE: the HLD scoring is a guideline for your use and reference for the program consultant. You will still be required to send in photographs and supporting radiographs. The program will make the final decision regarding medical necessity and scoring criteria.

Please submit this form with your prior authorization request via Qualitrac. If you do not have access to the Qualitrac portal please contact Telligen at (833) 610-1057 or wymedicaidum@telligen.com.

I certify that I am the Performing Provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge.
I certify that I performed the above noted examination on this client.

PERFORMING PROVIDER SIGNATURE	PRINT NAME	DATE