CONSIDERATION FOR ORAL SURGERY
RELATED TO ORTHODONTIC APPROVAL

ORAL SURGEON NAME: _____

NPI: _____ DATE OF CONSULTATION: _____

CLIENT NAME: _____ MEDICAID ID#: _____

REFERRING DENTIST NAME: _____

CONDITION REFERRED FOR: _____

_____

WERE XRAYS AND/OR RECORDS SENT WITH THIS REFERRAL? ☐ YES ☐ NO

BASED ON YOUR EXAMINATION AND REVIEW OF THE RECORDS, PLEASE PROVIDE YOUR TREATMENT PLAN FOR THIS CLIENT RELATED TO THEIR SURGERY/ORTHODONTIC NEEDS. PROCEDURE CODES, FEES, AND TIMELINES SHOULD BE INCLUDED IN YOUR RECOMMENDATIONS.

_____

_____

_____

ARE THERE ANY ALTERNATIVE RECOMMENDATIONS FOR THIS CLIENT?

_____

_____

_____

DID THE CLIENT REPORT ANY OF THE FOLLOWING CONDITIONS:

- ☐ JAW PAIN
- ☐ JOINT PAIN
- ☐ FACIAL PAIN
- ☐ HEADACHES
- ☐ EAR PAIN
- ☐ GRIND TEETH
- ☐ JOINT POP
- ☐ LOCKED JAW
- ☐ LIMITED MOUTH OPENING
- ☐ PROBLEMS WITH MASTICATION
- ☐ STRESS RELATED TO THEIR APPEARANCE

_____ _____

DENTIST'S SIGNATURE DATE

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.